Civil Rights Issues in Health Care Delivery

A Consultation
Sponsored by
the United States
Commission on
Civil Rights,

Washington, D.C.,
April 15-16, 1980

U.S. COMMISSION ON CIVIL RIGHTS

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- Investigate complaints alleging that citizens are being deprived of their right to vote by reason of their race, color, religion, sex, age, handicap, or national origin, or by reason of fraudulent practices;
- Study and collect information concerning legal developments constituting discrimination or a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, age, handicap, or national origin, or in the administration of justice;
- Appraise Federal laws and policies with respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, handicap, or national origin, or in the administration of justice;
- Serve as a national clearinghouse for information in respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, handicap, or national origin;
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Introduction

In April 1980 the United States Commission on Civil Rights sponsored a two-day consultation on Civil Rights in Health Care Delivery. The purpose of the consultation was to investigate the Federal role in assuring both adequate care and equal treatment for all Americans in delivery of physical health care services. The consultation brought together Federal officials whose agencies fund various health care programs, researchers into various aspects of health care, and representatives of health advocacy groups concerned with the provisions of adequate health care. The participants described the current status of Federal involvement in the provision of physical health care and presented potential solutions where problem areas were identified.

The consultation was divided into five sections, each intended to examine specific issues within the overall topic:

(1) Overview

This session examined the emergence of the Federal role in physical health care and analyzed its current status; use of facilities and services by race, ethnicity, sex, and place of residence; incidents of discriminatory treatment in the physical health care delivery system; and Federal responsibility for ensuring equal treatment in the receipt of health care services.

(2) Rural Health Care

During this session, participants examined the provision of services in rural areas, focusing particularly on community health service clinics, Indian health, and migrant health.

(3) Urban Health Care

Participants in this session reviewed problems of health care delivery in urban areas, particularly status of clinics, hospital closings, and the maldistribution of practitioners.

(4) Legislative Initiatives

This session described the current status of Federal health care programs, such as Medicaid and Medicare, and legislative initiatives, especially national health insurance.

(5) Training of Health Care Professionals

Issues covered in this session included medical school admissions policies following the decision of the Supreme Court of the United States in *Regents of the University of California v. Bakke*, [1] premedical school training, and recruitment of women and minority medical school candidates.

Four major issues emerged from the consultation that relate particularly to civil rights concerns: (1) fragmentation of Federal policies and programs in health care; (2) civil rights enforcement; (3) residency and utilization of health care services and facilities; and (4) training of health care professionals.

Fragmentation of Federal Policies and Programs

Fragmentation in health care occurs in policy formulation, program implementation, and decisionmaking at the Federal level, as well as in the division of responsibility for providing adequate health care among different levels of government and the private health care and insurance industry. This fragmentation has a detrimental effect upon the ability of the Federal Government to assure that minorities, women, and older persons have an equal opportunity to receive adequate health care.

Fragmentation has resulted partially from the fact that Federal health care legislation has been passed in a piecemeal fashion, with no apparent overall philosophy or set of goals. Major Federal programs include funding for community health services, State health planning, hospital construction, migrant health services, Indian health service, Medicaid, and Medicare. These programs are administered by at least three separate agencies within the Public Health Service of the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare): the Health Services Administration (HSA), the Health Resources Administration (HRA), and the Health Care Financing Administration (HCFA).

In addition to Federal agencies, State and local governments and private physicians and insurers are involved in decisionmaking regarding delivery of health care services. There are 204 Health Systems Agencies and 57 State Health Planning and Development Agencies. These agencies and State Boards of Health often influence the distribution of Federal funds and set eligibility criteria for the receipt of Federal funds under certain programs, such as Medicaid. Hospitals and private physicians control to a large extent payments made under Medicaid and Medicare. Private insurers determine to a great degree the cost of medical services.

Because of the involvement of so many entities, health care may not be provided to some who are eligible. For example, discussion at the consultation revealed that American Indians often have problems receiving care from non-Indian Health Service facilities. Many are sent to the Federal Indian Health Service facility, even though this is a secondary facility for those Indians unable to travel to primary facilities. Furthermore, State Medicaid agencies do not always reimburse the Indian Health Service for treatment of Indians eligible for Medicaid, even though they are required to do so.

Fragmentation has led to what Dr. Philip R. Lee, director of the Health Policy Program, University of California at San Francisco, called "gross inequities between States and between local areas." It has also led to increased cost in the provision of health care, a devastating result for the 42 million Americans with no health insurance or inadequate insurance. Because public and private insurance pays for the "usual, customary, and reasonable" fees of physicians and hospitals, health providers are able to raise their prices and still be confident of reimbursement. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, indicated that 60 percent of hospital revenues come from these "cost-based reimbursement plans," Medicare, Medicaid, or Blue Cross. She added:

> Regardless of the source of payment, giving hospitals a blank check and assuring them that no matter what they charged, they would be paid, certainly contributed to the problem of rising costs.

Finally, fragmentation has produced less accountablity to the Federal Government for the expenditure of Federal funds. One example of this is the Medicare "Part B" program, which pays private physicians for the cost of medical care of older persons. The Department of Health and Human Services mantains that this is not "Federal financial assistance," inasmuch as it is a direct payment to the beneficiary for services rendered by a health provider, paid for by participants in the program through premiums. In fact, less than one-third of expenditures under Medicare are provided from premiums paid by participants in the program. Furthermore, even though physicians are beneficiaries under the Medicare Part B program, the Department of Health and Human Services contends that they are not covered by Title VI of the Civil Rights Act of 1964, which prohibits discrimination in programs receiving Federal financial assistance.[2]

Civil Rights Enforcement

The issue of accountability for the use of Federal funds relates directly to the enforcement of provisions in the Civil Rights Act of 1964 and the Hospital Survey and Construction Act—or the Hill-Burton Act—of 1946. Title VI of the Civil Rights Act of 1964 states:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the

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[1] 438 U.S. 265 (1978).

[2] Patricia Roberts Harris, Secretary of Health and Human Services, letter to Louis Nunez, Staff Director, U.S., Commission on Civil Rights, June 9, 1980.

> benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.[3]

Title VI has become a major tool used by the Federal Government to ensure nondiscrimination. In the past 16 years, it has been used successfully to secure compliance by recipients of Federal funds. Since the ultimate sanction is termination of Federal financial assistance, there should be strong incentive on the part of fund recipients to comply with the law.

In the area of funding for health care, however, the former Department of Health, Education, and Welfare brought enforcement proceedings only rarely under Title VI, especially since 1970. Most of that Department's civil rights effort was in the area of education, attempting to bring school districts into compliance with the law. As Roma Stewart, then Director of the Office for Civil Rights at the newly created Department of Health and Human Services (HHS), told the Commission: "The record of achievement in elimination of discrimination in health is bleak in comparison to what has been accomplished in the schools." In fact, no recipient of Federal health funds has had its funds terminated since 1973. Since 1970 only nine institutions have been subject to administrative proceedings that might have led to termination of funds.[4]

Another participant, Dr. Kenneth Wing, from the School of Public Health, University of North Carolina, charged that discrimination in health care had not really been defined and that the "principle of nondiscrimination in delivery of health services and particularly government-funded health services has never really been accepted." Support for this charge was given by Sylvia Drew Ivie, then director of the National Health Law Program and later Director of the Office for Civil Rights at HHS. She indicated that, despite a 1976 Department of Justice mandate to the Department of Health, Education, and Welfare (HEW) for the development of guidelines implementing Title VI, guidelines that would assist in determining discrimination and in obtaining compliance from hospitals, nursing homes, and health planning agencies have never been issued. Ms. Stewart testified that 11 guidelines on different aspects of health funding were to be released by the end of the calendar year 1980. The guidelines were issued by the end of that year as policy clarifications of old regulations. No new regulations were issued.

Effective use of enforcement proceedings under Title VI could have a profound effect on the operation of health programs. The Federal Government spent over $56 billion in 1979 on health care programs.

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[3] 42 U.S.C. 2000d (1970).

[4] Roma J. Stewart, then Director, Office for Civil Rights, Department of Health and Human Services, letter to Arthur S. Flemming, Chairman, U.S., Commission on Civil Rights, May 22, 1980. No administrative proceedings were initiated between May 22, 1980, and Jan. 12, 1981.

Of this amount $34 billion went to hospitals for various programs, $8 billion to physicians, and over $5 billion to nursing homes.[5] Thus, the termination of Federal funds would have such a great impact on the operation of health care facilities that vigorous enforcement of Title VI would encourage facilities to eliminate discrimination in health care programs receiving Federal financial assistance.

Enforcing civil rights laws, in part, means investigating complaints or conducting compliance reviews following disbursement of Federal funds. Program office staff at the Department of Health and Human Services often assume that the responsibility for ensuring nondiscrimination lies with the Office for Civil Rights (OCR). Memoranda of Understanding between OCR and the Public Health Service (PHS) and between OCR and the Health Care Financing Administration (HCFA), however, give OCR primary responsibility for developing guidelines and providing assistance to the program agencies.[6] Nevertheless, PHS and HCFA are responsible for "incorporating civil rights concerns into regular program review and audit activities,. . .monitoring, in arrangement with OCR, existing civil rights compliance agreements," and performing other functions related to assuring nondiscrimination in programs funded by the respective agencies.[7]

The Public Health Service, or more specifically, the Health Resources Administration (HRA), also has responsibility for enforcing the "free service" requirement of the Hill-Burton Act. This act predates Title VI by 18 years, and requires that hospitals that receive Federal construction funds under the act must provide "a reasonable volume of services" free of charge to those unable to afford the cost of hospital care.[8] In 1964 the act was amended to allow the Surgeon General to require that hospitals receiving funds make services available to all persons living in the vicinity of the hospital.[9] In 1975 Congress added another amendment, requiring HEW to develop regulations implementing the "uncompensated service" and "community service" provisions.[10] Four years passed before final regulations were issued, and according to information provided at the consultation, regulations still have not been implemented in a systematic way.

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[5] Robert Gibson, "National Health Care Expenditures, 1979", *Health Care Financing Review* (Summer 1980), p. 33.

[6] "Memorandum of Understanding Between the Office for Civil Rights and Public Health Service," July 27, 1979; "Memorandum of Understanding Between the Office for Civil Rights and the Health Care Financing Administration," July 27, 1979.

[7] Ibid.

[8] 42 U.S.C. section 291c(e), 291e(b)(3)(1976); 42 C.F.R. section 53.111.

[9] Pub. L. No. 88–443, section 3(a), 78 Stat. 451, 454 (1964).

[10] Pub. L. No. 93–641, Section 4, Title XVI, Part A, section 1602, 88 Stat. 2258 (1975) (current version at 42 U.S.C.A. section 300s (Supp. 1980)). The current version, which was enacted in 1979, essentially recodifies the provision of the 1975 Act.

Residency and Utilization of Physical Health Care Facilties

Related to the issue of enforcement of civil rights laws is utilization of health care facilities and services. Because the provision of health care is largely a private industry, health care providers are not distributed randomly throughout the country. Particularly in areas with large minority populations, physicians and hospitals are few, while in white, more affluent neighborhoods, health care providers abound. This maldistribution of services has had a deleterious impact on the availability to minorities of adequate health care, and consequently, on the health status of minorities.

Lu Ann Aday, research associate at the University of Chicago's Center for Health Administration, presented information regarding differentials in utilization of physical health care facilities on the part of different groups. Particularly affected by accessiblity to health care providers are inner-city or rural areas. Facilities in rural areas are often remote, resulting in both substantial travel time and long waiting periods by patients. In urban areas blacks tend to rely heavily on hospital emergency rooms and outpatient departments for regular care and are less likely to have a private physician. The closing or relocating of hospitals in urban areas can therefore have a devastating effect on health care received by inner-city residents. Ironically, it is in those areas that hospitals are most likely to be closed. In a study of metropolitan areas between 1937 and 1977, Dr. Alan Sager of Brandeis University found that the higher the percentage of blacks in a neighborhood, the more likely a hospital would be closed or relocated. In areas less than 25 percent black, only 14 percent of all hospital were closed and relocated. By comparison, in neighborhoods where more than three-fourths of the population was black, nearly half of all hospitals—47 percent—were closed or relocated.[11]

A reason often given for such closings is that, since those areas with large minority populations are also less affluent and less financially able to sustain an ongoing hospital, the operation of the hospital is not efficient. It is argued that "financially distressed" hosptials—whether public or private—cannot remain open without substantial third-party funding sources.

Regardless of the reasons, hospital closings have a detrimental impact upon the quality of health care for those persons affected. If the hospitals are receiving Federal financial assistance, the Department of Health and Human Services has responsiblity for ensuring that the people served continue to receive adequate health care.

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[11] Alan Sager, "Urban Hospital Closings in the Face of Racial Change" (statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives), Mar. 14, 1980.

Henry A. Foley, Administrator of the Health Resources Administration told the Commission:

> Institutions which serve as the primary source of care in underserved areas must be kept viable, or acceptable alternatives must be developed. The assumption should not be made that all hospitals in financial trouble should necessarily be saved. . .Federal policies should encourage significant restructuring of local health delivery systems in order to produce institutions with a promise of future viability. Such restructuring must take account of the total health resources of the area, and should emphasize the appropriate use of ambulatory care as opposed to institutional treatment.

Training of Health Care Professionals

Difficulties encountered by minorities and women in securing adequate physical health care can be traced in part to their underrepresentation as physicians and related health care professionals. In referring to a report titled "The Treatment Practices of Black Physicians," Henry Foley stated that in 1975, 87 percent of patient visits to black physicians were by black patients, while 90 percent of patient visits to white physicians were by white patients. Dr. Philip Lee, former Assistant Secretary of HEW for Health and Scientific Affairs, and currently director of the Health Policy Program of the University of California at San Francisco, stated: ". . .if we train more minorities [to become physicians] and give them more opportunities, there is no question that minorities would have greater access to health care."

The fact is that minorities and women remain underrepresented in the Nation's medical schools. According to data submitted by Magdalena Miranda, Chief, International Education Programs Section, Health Resources Administration, in 1979–80 women constituted 27.8 percent of all first-year medical students (25.3 percent of all applicants were women), while "underrepresented minorities" (blacks, American Indians, and Hispanics) were 11.6 percent. Special admissions programs have been developed by many medical schools to provide minorities greater opportunities for medical training. Set-aside programs which allot a certain number of slots for minority medical school applicants have been challenged successfully in courts. In 1978 the Supreme Court of the United States in *Regents of the University of California v. Bakke* declared that although race alone could not be used to determine eligibility for medical school, it could be used as one factor to produce diversity within the student body.[12]

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[12] 438 U.S. 265 (1978).

Despite the decision in *Bakke* permitting medical schools to consider race in determining eligiblity, the proportion of first-year medical school students that is minority has not increased and, in some cases, has actually decreased. For example, in 1974–75, blacks represented 7.5 percent (1,106) of all first-year medical students, but by the 1979–80 academic year, this had fallen to 6.5 percent (1,108). The percentage of Hispanics has risen only slightly during the period, from 2.0 percent (296) to 2.2 percent (376). American Indians constituted only 0.4 percent (63) of all first-year medical students in 1979–80, down from 0.5 percent (71) in 1974–75. During the same period, the percentage of all applicants to medical schools who were accepted increased from 35 to 47 percent, while the percentage of minority applicants accepted fell from 44 to 41 percent.

Applications as well as enrollments by minorities have leveled off during recent years. One possible explanation is that medical schools have not pursued recruitment vigorously since special admissions programs were attacked. According to Alonzo Atencio, assistant dean and assistant professor of biochemistry at the University of New Mexico, the use of race or ethnicity as a factor in determining admission to medical schools depends on the commitment on the part of a particular institution to increase the percentage of minority students, since there is no legal requirement that race or ethnicity be considered. Dr. Atencio also pointed to a shift in Federal programs from scholarships to loans as a factor in discouraging some minority applicants. Attending medical school for 4 years requires a substantial financial commitment; minorities may be reluctant to borrow the amount necessary to finance a medical education. Although the Federal Government provides funds to needy medical students through the National Health Service Corps, participants in this program obligate themselves to working in an underserved area after completing medical school in exchange for Federal funding. Minorities have also been reluctant to participate in this program, since they cannot choose the geographical area of service upon graduation. Still, of the total National Health Service Corps scholarships granted in 1979, 19.5 percent went to blacks, 3.9 percent to Hispanics, and 1.2 percent to American Indians.

Conclusions and Recommendations

Participants at the Commission's consultation on Civil Rights Issues in Health Care Delivery provided evidence that discrimination continues to exist in the provision of physical health care. Due to increasing costs, maldistribution of health care providers and resources, and overt disparate treatment, minorities, women, and older persons do not have equal opportunities to secure adequate physical health care. While participants agreed on the problem, they differed on the remedy. Increased Federal expenditures on health care, more effective enforcement of civil rights laws, and national health insurance were suggested ways to reduce and eventually to eliminate disparities between the health status of minorities and women, and white males. Each of these ways is important and needs to be considered before a strategy for ensuring equal opportunity in health care can be developed.

In the meantime, the Commission presents the following general recommendations based on evidence presented in connection with the April 1980 health care consultation.

1. The Office for Civil Rights at the Department of Health and Human Services (HHS) should issue regulations defining discrimination in health care and describing procedures for compliance with Title VI of the Civil Rights Act of 1964 and the Hill-Burton requirements. When administrative proceedings do not result in compliance within the prescribed period of time, Federal funds to the noncomplying physician or institution should be terminated.

Enforcement of civil rights requirements in health care programs has been almost nonexistent, particularly during the last decade. The former Department of Health, Education, and Welfare has not systematically implemented Title VI, which bans discrimination on the basis of race and national origin, in regard to health care. As the Commission noted in its recent *Report to the President and the Congress,* Federal departments responsible for Title VI implementation have not enforced it vigorously. They have frequently failed to issue regulations, initiate enforcement proceedings, or terminate Federal financial assistance when compliance cannot be achieved. That report can be applied to health programs administered by HHS as well, when it states: "It must be clear that fund termination will be invoked when timely compliance cannot be achieved."

2. The Department of Health and Human Services should reverse its position concerning the coverage under Title VI of physicians in the Medicare Part B program.*

Current HHS policy exempts physicians who treat Medicare patients under Part B of that program from coverage of Title VI on the ground that the individual rather than the physician is the ultimate beneficiary of the program. In fact, physicians do receive Federal money (only one-third of the expenditures are covered by premium payments by participants), just as they do in the Medicaid program, under which physicians are covered by Title VI.

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* Commissioner Stephen Horn dissents from this recommendation.

3. All Federal agencies dispensing health care funds should include civil rights concerns and civil rights compliance in their operations, as required of the Public Health Service and the Health Care Financing Administration by Memoranda of Understanding between those agencies and the Office for Civil Rights.

Agency officials administering Federal funds too often ignore their responsibility for ensuring that those funds are spent in a nondiscriminatory manner. If implementation of Federal civil rights policy is to be effective, it needs to command the attention of officials responsible for making decisions regarding the disbursement of Federal funds.

4. The Office for Civil Rights at HHS, in conjunction with the Health Resources Administration, should develop procedures for examining hospital closures, (a) to determine the extent of negative impact their closure or relocation would have on the health care of minorities, older persons, and other low-income persons living in the area that the hospital services, and (b) to establish adequate alternative health care provisions for area residents before the hospital is closed or relocated.

In many cities across the country "financially distressed" hospitals are closing their doors in minority neighborhoods, meaning that residents must turn to alternative health care providers, such as outpatient clinics, or travel to hospitals distant from their neighborhoods. One study showed that the greater the percentage of minorities in a neighborhood, the more likely it is that a neighborhood hospital would close or be relocated. Because of potential detrimental impact on health care to minorities and older persons, decisions regarding closure or relocation must be weighed carefully and alternative health care provisions must be established.

5. The Federal Government should undertake and expand programs aimed at encouraging minority and female students to apply to and to attend medical school. The Federal Government should also act to guarantee equal opportunities in premedical school education in order to assure the admission and retention of minority and female medical school applicants and students. Sufficient funds should be made available to make the opportunity for a medical school education financially feasible for potential minority and female students unable to afford its high cost. Additionally, National Health Service Corps rules should be amended to allow participants a range of choices in selecting the underserved area where they will work.

Women and minorities are still underrepresented in the Nation's medical schools. In fact, minority enrollment as a percentage of total enrollment, as well as the percentage of minority applicants accepted into medical school, has actually decreased in recent years. This decline may be due in part to the fact that loans are replacing scholarships as a major source of money for minorities to attend medical school. The requirement that National Health Service Corps participants serve in a geographical area not chosen by them may also discourage many minorities from applying for this program. In order to increase the number of minority and female doctors, the Federal Government should take steps to encourage medical schools to recruit and retain minority students interested in medical careers.

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CHAIRMAN FLEMMING. I will ask the meeting to come to order. The United States Commission on Civil Rights has convened this consultation in order to examine civil rights issues and health care delivery.

This examination will address the role of the Federal Government in helping to ensure both adequate health care for all Americans and equal access to physical health care services and facilities.

Participants will focus on two important aspects of physical health care delivery: Discrimination in physical health care delivery and remaining gaps in the provision of adequate health care for problems that currently exist.

Time constraints do not permit presentations by persons other than those invited by the Commission. We do welcome, however, submission of materials by others who would like to contribute to the exploration of the issues. The materials submitted in this way will be considered for possible inclusion as part of the final record of the consultation.

My colleagues and I believe that the provision of adequate health care is of vital concern to minorities, women, older persons, and handicapped individuals. We believe that an examination of physical health care delivery will provide baseline information which may be used in the future to review other aspects of health care such as incidents of disease and mental health.

We deeply appreciate the cooperation and help of those who will be presenting papers or serving as respondents to those who do present papers.

I am asking my colleague, and the Vice Chairman of the Commission, Commissioner Horn, to preside during the morning session. Commissioner Horn.

VICE CHAIRMAN HORN. Thank you, Mr. Chairman. In this morning's session, we will review the overview of the Federal Government's role in health care delivery.

The first presenter, Dr. Philip R. Lee, is one of the most knowledgeable experts in this country on this subject. He comes from a family of distinguished doctors, a family that has cared about the state of American health over the years.

After his graduation from Stanford University, as an undergraduate and then from its school of medicine, he has not only pursued the practice of a physician but, more important, he has served as a critic and guide to what American health practices ought to be.

Over the years his extensive publications have helped to set the tone for both policymakers and nonpolicymakers, those in medicine and those outside medicine alike. During the Johnson administration he served as Assistant Secretary of HEW for Health and Scientific Affairs.

He then returned to California where he is professor of social medicine, University of California, San Francisco. He also served as chancellor of the University of California Medical Center in San Francisco. He is now the director of the health policy program at that institution.

We are delighted to have Dr. Lee, who will capsulize his life experience in about 25 minutes.

STATEMENT OF PHILIP R. LEE, M.D., DIRECTOR, HEALTH POLICY PROGRAM, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

DR. LEE. I am delighted to be here, and I indicate special appreciation to two Commission members. One is the Chairman, whose work in the 1950s and whose friendship with my father had a great influence on my own career in public service, and Steve Horn who, as the legislative assistant to Senator Thomas H. Kuchel, introduced me to the intricacies of politics and public policy in the very early days of Medicare. (As a matter of fact it was known as the Kuchel-Anderson Bill.)

So, I have both a personal and professional tie that is deep to the Chairman and the Vice Chairman. I am delighted to be here.

For the past 45 years, the United States has been moving towards a national health policy. We go in fits and starts. We don't have, perhaps, a coherent policy, but there are many pieces that are in place.

Progress, particularly in the last decade, has been made in understanding the basic health problems that face the Nation and in understanding the role of factors other than medical care that affect our health. Biological factors, the social, the cultural, the environmental, and the behavioral factors are all important to our health. Federal policies have emphasized medical care and biomedical research. Federal programs have also been designed largely to expand, support, or strengthen the role of the private sector.

Many of the programs evolved because of a failure on the part of the private sector, for example, the support of biomedical research. The Hill-Burton program was designed to correct major inequities in hospital construction and availability of hospitals throughout the country and particularly to improve the availability of hospitals in rural areas. Other Federal programs were designed because of the high costs of private sector services, and the failure of private health insurance for the aged. The result was Medicare.

Some Federal programs affected everyone. Others affect a small but needy segment. Some of the programs have been very successful, and others fail to achieve limited objectives.

There are at least six different approaches that might be taken to assessing the effects of Federal policies on the disadvantaged. One is to trace the development of legislation. In the report which we have submitted to the Commission, we do that in brief. Another would be to look at the budget. Every year the Congressional Budget Office and the Office of Management and Budget (OMB) publish special analyses of the Federal budget. The OMB, of course, publishes the President's budget as it is submitted to Congress each year. The Brookings Institution and a number of individual scholars who analyze the budget have told us a great deal about the potential effects of programs, as well as who is getting what in terms of distribution of resources.

I would say parenthetically that we have heard a great deal about the so-called "graying" of the budget. The term is shorthand for how much of the Federal budget is spent for the elderly. Of course, included in that are the social security payments, an earned right dispensed separate from a trust fund which is from general appropriations. And, in my judgment, social security should be separated from the general revenue fund and the general budgets. It would give a different picture of the "graying" of the budget if that was done. Medicare is also included as an expenditure on behalf of the elderly. In fact, all the money goes to doctors, hospitals, and other providers of health care. We could talk, rather than about the graying of the Federal budget, about the medicalization of the Federal budget, which might be more accurate.

Another approach, which has been taken by Lu Ann Aday (who will be presenting later) and her University of Chicago colleagues, Odin Andersen and Ron Andersen, is to examine access to care and the importance of various programs providing access to care. We can also examine policies and programs affecting particular population groups. That is what I intend to do in this presentation with respect to the elderly.

We have included as attachment to our presentation a report on services for the elderly, the health status of the elderly, and the cost of health care for the elderly. That appeared in *Health USA* by Dr. Kovar for the National Center for Health Statistics (see exhibit 18).

There have been a number of studies to examine the extent of discrimination, and the Commission itself has carried out several studies looking at the effect of discrimination in particular health care programs.

I will not review the report or our analysis of the legislative score card except to mention that, as the years go by, more and more health legislation is dealt with by the Congress. We thought of the 1950s as a period when the base was built for the present Federal policies: The development of biomedical research, the strengthening and expansion of the Hill-Burton Program, the articulation of Federal-State categorical programs, such as venereal disease control, tuberculosis control. The principles that were later to be applied in a number of other programs were established during this period. In the 1960s, particularly from 1963 to 1967, there was a rapid expansion in the numbers of programs.

In the 1970s even more legislation was considered by each Congress than the one before. The workload on the committees and the range and complexity of the problems increase as each decade goes by. That will be a factor in the eighties.

Looking at Federal health expenditures (and I've mentioned Office of Management and Budget and the Brookings Institution), we see a tremendous increase in the number of Federal programs and expenditures for health and health care. In 1953, for example, when HEW was established, there were about 70 programs administered by the Department—A total budget of $6.5 billion and $300 million spent for health programs. By 1968 there were over 250 programs with expenditures in the Department of $40 billion, and $9.3 billion spent for health programs. Estimates for 1980 indicate that the expenditures will be $193 billion in the Department and the total health expenditures (this includes the Department but also programs beyond that), $56.5 billion. As we have grown in size, the Federal role has increased substantially in the health care area.

Today, I want to examine different approaches and provide a framework for analysis rather than describing specific outcomes of the analysis. I will focus my discussion particularly on the aged. I will look at the social context of health policy development and the factors that will affect health policy in the eighties.

Inflation, which is certainly the dominant issue, affects public policy in 1980. This not only has a profound effect on the Federal budget, which we are witnessing today, but on individuals and their attitude towards government and taxes. We have seen in California a number of taxpayer initiatives—the so-called taxpayers' revolt.

We have seen within the Federal Government a shift from social programs and expenditures to defense expenditures. We have also seen, because of the various factors putting pressure on the budgets, a reduction of services, particularly for the disadvantaged. Many of those don't show up immediately, as we have seen in California. But they do begin to show up within a year or two, and the problems increase very rapidly.

Another factor that will profoundly affect public policy in the 1980s is new federalism which evolved in the 1970s with revenue sharing and block grants to States in major areas such as community development and social services.

Some programs, like Medicaid, that were not originally designed with new federalism in mind, have become part of the new federalism strategy. With new federalism there is decentralization and limited Federal oversight. Unfortunately, I think, the evidence is strong there is decreased accountability for Federal expenditures.

There is a transfer of costs to State and local governments. The Federal Government is transferring costs to the State, and the State is transferring the costs to the local government.

Fragmentation is another consequence of present policies. Variation in State and local government policies and programs are producing fragmentation of services. It is both power fragmentation and program fragmentation. With the thousands of local governments and innumerable agencies involved, there is tremendous difficulty in really developing coherent policies very often. There are multiple programs, multiple jurisdictions, multiple authority, and multiple agencies.

It appears that rather than a need based assessment, the assessment often is politically based, and it permits the role of interest groups to be increased. There have been a number of articles, including lead stories in *Time* magazine and other national magazines, about the influence of the special interest groups in Washington. We also see that at the State level. In California last year, the special interests spent $27.9 million. The California Medical Association was number 2 among the spenders, and the Dental Association was among the top 10. Thus, the provision interest groups are able to exert a powerful influence because of the decentralization to States with revenue sharing and new federalism.

The third factor affecting health policy is the fiscal crisis. I have mentioned the shift of expenditures from Federal to State and local governments. Fiscal crisis has been defined as a threat to the fiscal integrity of government, usually at the local level. We have seen that in New York City and in Cleveland.

Fiscal strain is evident at all levels of government: at the county level, the city level, and at the State level. There is increased demand for expenditures which often is attributed to the increased demand for service or the greater numbers of people eligible for services. In health care, the increased expenditures are primarily due to inflation—the increase in the price of the services without an increased number of people utilizing the services.

The second factor affecting health care costs has been the increased complexity of care. More laboratory tests, X-rays, and drugs are now used in diagnosis and treatment.

Another dimension of the fiscal crisis in the 1970s was the recession. We can certainly anticipate another recession in the near future. The impact of that is yet to be determined. I personally believe the impact will be far more serious with particularly detrimental effects for the disadvantaged, who are more vulnerable than the rest of the population. We also find with fiscal strain and crisis various cost-cutting measures affecting the delivery of services to the aged, to the poor, and to other disadvantaged groups.

Finally, two other factors that are related to health policy and the disadvantaged, particularly the aged. First is the public perception or what has been called the social construction of reality. This term was coined by Berger and Luckman a number of years ago. The term was used to describe the definition of reality becoming widely shared and institutionalized as part of the collective store of knowledge, whether or not the perceptions really relate to the reality. The perceptions of government, of public officials, of government programs and regulation are an example of the social construction of reality—the change in attitudes from the 1960s to the 1970s. The change in perceptions of medical care in the past 15 years is another example. The problems in the 1960s and 1970s were access and quality. The problem in the late 1970s was cost. Cost is the predominant issue today.

The perceptions of disadvantaged groups in our society also reflect the social construction of reality: The perception of blacks, of women, of other minorities, or the aged. I will talk more about the public perceptions of the aged as they affect policy in a moment.

Second, the role of medical care and the influence of medicine on public policy are of increasing importance. The growth in the size of the medical care enterprise in the last 20 years, in the scope and responsibilities of medicine, and in the technology in health care reflects this changing role. With it has come an expanded role of government. Government has increased its support of research, of health manpower training, the construction and financing of hospitals, and finally in the financing of medical care, and with that an increased role in planning and regulation.

Just one item that indicates the influence of medicine. We have been aware of cost as a major problem and the helplessness of Congress and virtually all State governments to do anything about the principal factor in the increasing costs—namely, behavior of physicians. It is now clear between 70 and 90 percent of all costs of medical care are physician generated. We hear about consumer demand, related to the fact that most people have health insurance and therefore few constraints on demands for medical care.

The fact is doctors, not consumers, are largely responsible. They put patients in the hospitals, often unnecessarily. The incentive, however, both for hospitals, which are cost based, and for physicians, who are paid on a fee for service basis, (both by Medicare and many private health insurance programs) is to hospitalize patients and use ancillary services.

The physicians set their own fees, and the government pays those fees which are called usual, customary, and reasonable (UCR). The UCR reimbursement methods have not been changed for 15 years, despite the fact it has been recognized for a decade that it is the way we pay doctors and hospitals that is the principal cost of the enormous inflation in medical care costs. At least 50 percent of the cost is solely due to price increases. That is an indication of the power of the interest groups.

Let's turn briefly from discussing the factors influencing health policy and look at the elderly. First, there are very real needs. Large numbers of people—22 million—are 65 years of age or older. By the year 2000, there will be 31.8 million.

The aged, on the average, are poorer than the rest of the population. Inadequate income is recognized as the most serious problem facing the elderly. We have a large group of poor people, who bear a heavy burden of chronic illness and disability, who must use a large number of health services.

The social construction of reality has had a profound effect on the policies and programs for the aged. I draw particularly for this analysis in Dr. Carroll Estes' book *The Aging Enterprise* in which this analysis was first put together in this form.

First, the aged are perceived as a problem in our society. As a problem, they need special programs. The so-called age segregated policies.

The problems are seen as resolvable by the application of services at the individual level, the so-called services strategy. The services strategy, however, has different effects on different social classes. For the nonpoor, we have Medicare. They use more Medicare than the poor elderly. We also have social security, tax benefits, and pensions. For the newly poor, often considered to be the deserving poor, social security and Medicare are available as well as programs funded by the Older Americans Act. These include recreation, lifestyle support, transportation, meals, and nutrition programs. For the chronically poor elderly, the so-called undeserving poor, policies are largely determined by the States. Medicaid, the SSI supplement, and other services are basically left to the States for the elderly who have always been poor.

Another perception that society has of aging is based on a biomedical model, which is basically one of inevitable physical decline. We gradually deteriorate as we get older. It is inevitable. It is not a disease. It is a continuous, progressive decline.

Another perception is that the problems of the elderly have reached a crisis. Each interest group says their particular service solution is the way to go. We need more medical care, more social services, or more other kinds of services.

Finally, it is not possible to redistribute the wealth. It is only possible with great sacrifice on the part of the younger generations to keep the old basically where they are economically. We have all shared many of these views and values. Many of us who have been in policymaking positions were very strongly influenced by them in the 1960s with the development of the Older Americans Act, Medicare, and a number of other social programs to serve the elderly. It has been true and remains today that the social construction of reality has had profound impact on public policy. Earlier I mentioned the graying of the budget. It is a myth, but people begin to act on that as if it were the reality. Policies begin to flow from that. People begin to question social security. Despite the fact there is tremendous support for social security among the great majority of the public, people begin to have doubts about it. Will it meet my needs when I retire? Will it continue? There begin to be questions because of myth perpetuated.

Inflation has had a profound effect on the cost of medical care and what older people must pay for their medical care. We detail that in the report. Just a couple of figures—the per capita cost of care for the elderly rose from $455 to $1,521 annually between 1966 and 1976. The out-of-pocket costs of medical care now exceed the total costs of medical care for the elderly before the enactment of Medicare. The Medicare premiums are rising and payments to physicians have risen rapidly because many doctors no longer take assignments. The aged not only pay the premium and the coinsurance, but the increased fee the doctor charges.

The hospital deductible must also be paid if an elderly person is hospitalized. The cost of out of hospital prescription drugs must also be paid directly out of pocket. If an old person is unlucky enough to have to go to a nursing home, the cost of the nursing home must be paid until they spend down what savings they have until they are eligible for Medicaid. Unfortunately, too many elderly end up in that situation.

There is no single factor that has as adverse an effect on the elderly as the rising cost of medical care. Energy costs, housing costs, food costs, all have been significant, but I would say medical care is the most important.

The elderly and other disadvantaged are the victims of new federalism policies and the fiscal crisis. Increasingly, the responsibility to meet the needs is delegated to the States and the local governments. We find that the State governments try to shift the burden to the local government. We see the impact of cost constraints affecting Medicaid programs, Title XX social services, and other service programs in State after State. States restrict reimbursement for nursing homes in order to contain cost and the elderly are denied access to such care. In a State like California, half the nursing homes will not take Medicaid patients.

An elderly Medicaid beneficiary in San Francisco, for example, may have to go 100 miles to be placed in a nursing home because of the low levels of reimbursement and the high cost of nursing home care in San Francisco. That is hardly a humane way to provide for a person who is suffering from the kinds of illnesses and disabilities that require nursing home care.

The policy process is another factor affecting health policies and services for the aged. I have mentioned the role of the interest groups, particularly the role of medicine. Hospitals also exert a very strong influence. There are two ways in which this influence is exerted. One is the influence on the adoption of the services strategy and the allocation of resources for medical care, as opposed to an income strategy for the elderly. If the increased expenditures due to inflation in medical care costs could be transferred as income support for the elderly, their entire situation would improve significantly. The medical care strategy and the high cost of medical care precluded not only effectively dealing with the income problems of the elderly, but the housing and the nonmedical support systems.

Social supports and social services have had a low priority in the medical care system. The primary factor leading people into nursing homes is not their physical condition, but their social status. The great majority of the people are over 75. As a matter of fact, half of them are over 80. It is the loss of social support for these old people which is the triggering factor. The death of a spouse or family member, the loss of other support systems is more important than their medical problms. Yet, we have little in a clearly articulated policy that provides adequate support for social networks, particularly for the very old.

The other result of new federalism and the medicalization of policy is the gross inequities between States and between local areas. Although some inequities have been corrected in access to care, quality of care, levels of income support, the differences between States are very great.

What are the prospects for the future? I think we need to have a very serious reexamination of our basic strategies—the services strategy and income strategy. That needs to be done with a long term view in mind and not with a 1980 budget balancing act in mind. The kinds of decisions that will be made in the current environment will have very negative, long term consequences for the elderly if they are adopted as long term policies. We need a much longer range view. We need a more careful examination of social security, of Supplemental Security Income as the keys to income support.

That is the primary strategy. I think the best health program actually would be an adequate income for all, not only the elderly, but for the entire population. We have pensions. We have jobs, an area which has been largely untapped. There are a variety of policies that have precluded or limited opportunities for the elderly to continue to work. The services strategy needs to be reexamined, particularly the balance between medical care, housing, social support systems, transportation, and other social services. Social supports and social services have been seriously underfunded in relation to the way in which medical care is supported. We also need to examine the new federalism strategy and decide if that is the way, as a nation, that we want to go. Are there particular policies that are so important that they have to be national policies? They cannot be a compilation of 50 State policies or 5,000 policies that emanate from local government. Medicare is a good example. National health insurance would be a good example. Social security is the primary example of a national policy. We have a national policy for social security. We do not leave it up to State government. But we still leave too much income maintenance up to the discretion of the States through the supplements of SSI payments.

I think we also in the process need to reexamine our perceptions, the social construction of reality, if you will, and be very aware of and alert to the kinds of myths that get perpetuated.

We ought to try to look at the realities as they relate to the aged. Who they are. What they can accomplish. What they have accomplished. But most particularly, what they can continue to contribute to our society and not perceptions that see them as some kind of dependent population, dependent on the younger, so-called working age population for their sustenance and support.

Thank you very much.

Discussion

VICE CHAIRMAN HORN. Thank you very much. Your paper, "The Federal Government, Health Policy, and Health Care of the Disadvantaged" which you prepared along with Carroll Estes and Sharon Solkowitz and in collaboration of several others, will be included in the record.

That has been the most helpful statement I have seen in pulling together all of the Federal policies. I thank you for that. I call on my colleagues to ask you questions, starting with Chairman Flemming.

CHAIRMAN FLEMMING. First of all, I would like to express deep appreciation for the paper and also, Dr. Lee, for your presentation here this morning. It seems to me it has provided us with an excellent bird's eye view of some of the fundamental issues that confront us as far as the field of aging is concerned.

As you know and appreciate, fairly recently Congress amended the law governing the operations of the Civil Rights Commission to include jurisdiction in the field of aging.

As I have worked in that particular area, there is one other aspect that has been a concern to me. That is, whether or not in making services available to older persons through the various programs that you have identified, we have done so, as a society, in such a way as to discriminate oftentimes, against members of minority groups.

I will take one area—the area of homes for older persons, whether we are thinking of the home for the aged, as it is sometimes called, or whether we are thinking of nursing homes or other types of institutions. As I have become aquainted with those institutions, I have also been impressed by the fact that they are essentially segregated institutions. I recently have become very much interested in the hospice movement as I am sure you have.

As I have come in contact with that, I have been impressed with the fact that it is emerging as essentially a segregated movement. Obviously, this is in conflict with Title VI of the Civil Rights Act.

I am wondering whether or not your observation coincides with my observation. If so, do you have any suggestions as to what the Federal Government might do in terms of utilizing the authorities that are available to it in order to break up these segregated practices in the delivery of services, in this particular instance, to older persons although it carries over to other age groups?

DR. LEE. I think the observation is absolutely correct. There is no question, for example, in nursing homes, that in relation to the population of the elderly that there are many fewer Hispanics, fewer blacks, fewer Asians in nursing homes.

My guess would be that is also true in congregate housing, where people often buy into those in order to have a lifetime living arrangement. The lower income elderly have no chance to get in.

With the enactment of Medicare and the application of the Civil Rights Act, hundreds of hospitals were desegregated. There was no question that the most powerful force for the desegregation of the hospitals in the United States following the enactment of civil rights was Medicare. The fact was that with Medicare many hospitals were going to have a third, and in some cases half, of their income cut off if they did not eliminate the segregation that was practiced at that time. It is now hard to even imagine the degree of segregation of many of the hospitals in the country in 1965—separate wards, separate rooms, separate bathrooms, separate eating facilities. We hear the same arguments today. You threaten the old person's health if you put a black person and elderly white person together in a nursing home. We heard the same argument in 1965. Of course the arguments were hogwash.

I think we need to use the power of the reimbursement system to continue to correct inequities in the care of the aged. Medicaid pays for half of the nursing home care and this can be a powerful force. There must be a careful examination on the part of the Department of Health and Human Services as to the extent of discrimination and the ability of the Federal Government to use its very great economic power to eliminate discrimination and segregation in the nursing homes.

To do this will require visits to nursing homes, it will require much more rigorous examination of the problem, and it will require the kind of vigorous enforcement and cutting off payments that were applied to hospitals by Medicare. It will be said old people will suffer if we do that, and it is going to be elderly poor who will suffer if we do that. But there are many who are now suffering because they are being denied what is necessary care.

CHAIRMAN FLEMMING. Thank you very much.

VICE CHAIRMAN HORN. Commissioner Freeman.

COMMISSIONER FREEMAN. Dr. Lee, this is quite an education in terms of your paper. I want to pursue the points the Chairman was making, not just with respect to the segregation within the facility, but the denial of opportunity with respect to the staffing of the health centers, the community health centers, and the hospitals.

Would you comment on whether there has been any significant change with respect to the inclusion of minorities on the staffs of hospitals, nursing homes?

DR. LEE. If we look at the health care industry, as it is called (because of its size, the economists find that term appropriate), there are approximately 6-1/2 million people employed in hundreds of different types of jobs. Between the middle 1960s and the end of the 1970s, it grew at a rate twice that of most of the other service sectors. It provided a great many new jobs. Many of those jobs were entry level jobs. Some of the people who came in at entry level jobs moved up reasonably in line with their ability and the opportunities available. Many hospitals, and I would include in that many academic medical centers, still practice institutional racism. At the University of California, San Francisco, which has been a leader in providing equal opportunity, we have not eliminated the barriers, even on paper. We are totally in compliance with the Civil Rights Act. We have affirmative action in employment. There is outreach. There is every effort made to recruit openly and to recruit in the minority community for the jobs at all levels. At the top level at UCSF and in virtually all of those institutions, the jobs are filled largely by white males. There are few women who have moved up to high management jobs. There are a few, but relatively few.

With the size of the industry, with the magnitude of the underwriting of the hospital enterprise, not only the support for research and education, but with Medicare and Medicaid payments, the Federal Government has powerful tools to use in continuing to correct these problems.

I think more should be done. I don't have a good answer as to how to do it institutionally or across the board. We have grown lax or less vigorus in civil rights enforcement than we should in some of these areas where there is not overt discrimination. In many institutions, you could not demonstrate, with even a careful civil rights compliance audit, evidence of discrimination. Yet, I think opportunities are being denied. I think the opportunities that should be there are far more limited than the capability of the minorities who are seeking advancement, not original placement but advancement within the institution.

Opportunities are far less than they should be. The solution is very hard to put a finger on. There is no single solution because of the diversity of the institution and the differences in institutional behavior.

Some hospitals and academic health science centers are doing an excellent job. There are too many doing far less than they could be doing.

VICE CHAIRMAN HORN. Commissioner Saltzman.

COMMISSIONER SALTZMAN. In the last decade, has health care services to women and minorities and handicapped improved?

DR. LEE. Has it improved? I would say it has improved very substantially. This has been true in several areas particularly.

The access of poor families to adequate medical care has improved. Poor children have access to better care and poor pregnant women now have access to decent maternity care and good prenatal care. We have seen a dramatic drop in infant mortality in the United States. The drop has been more significant in low-income and minority populations, although it has been across the board. It has been greater there. This relates, in part, to improved access to medical care.

Infant mortality for minorities is still above the rate for whites. It has improved. Medicaid is partly responsible for that. Many outreach programs, neighborhood health centers, health care centers for high risk pregnant women, and the WIC program have contributed. The feeding programs for women and children to improve the nutrition of low-income individuals has contributed, I think, to the declining infant mortality rate among minorities.

COMMISSIONER SALTZMAN. All of these factors seem to result from Government intervention in health care services.

DR. LEE. The results can be traced to the intervention of the Government, first in paying to provide greater access to care, but also in creating the capacity to provide the care. In paying to train the doctors and nurses providing the services, in paying to create the facilities through Hill-Burton, and now through loan guarantees and supporting medical research that undergirded improvements in care, the Federal Government has played the key role in producing the changes.

COMMISSIONER SALTZMAN. You place a special emphasis on adequate income.

DR. LEE. You better believe it.

COMMISSIONER SALTZMAN. Why would that, more than any other kind of effort, in the next decade bring improvement to the delivery of health care services to minorities and women?

DR. LEE. Adequate income is essential for all of us to make choices with respect to food, housing, and lifestyle. We have heard a great deal about improving our health by improving our health related behaviors. The choices we have with an adequate income relate not only to the food we can buy and the housing we can live in, but the stress inducing environments we work and live in and also to the way in which the health professionals respond to us. People who have an adequate income are often treated differently by health professionals than those who are poor.

We recently had an experience in my family, with my father who was in an automobile accident, that illustrates the importance of an adequate income. He was severely injured last November. He had seven broken bones, a head injury, and was in the hospital for 2 months. Thanks to Medicare, we could afford the costs.

He could have ended up senile and in a nursing home. He is now home, independent, and writing a book. The two things he has given up are driving an automobile and practicing medicine at the age of 84. But because he had an adequate income, he could have help brought into his home. He could maintain has sanity. He did not become senile. Quite the reverse. He has had a network of social supports and necessary services because he had an adequate income. It makes a tremendous difference.

If he was poor, he probably would be dead by now.

COMMISSIONER SALTZMAN. In looking ahead, the increasing expenditure in government programs may not be as vital at this point, in terms of what we are already doing, as providing an adequate income for minorities, aging.

DR. LEE. Absolutely right. Yes, sir. More important than more money for medical care.

VICE CHAIRMAN HORN. We have two new colleagues of the three that the President has recently nominated with us. I would call on Commissioner-designate Berry.

COMMISSIONER-DESIGNATE BERRY. Dr. Lee, do you believe that the minority poor might receive more access to health care if there were more minority health professionals and if there were more institutions devoted to the health care of minorities, for example, nursing homes?

If you do believe that, do you think the programs for supporting the training of minority students in health care as doctors, nurses, etc., administered by the Federal and State governments ought to be increased and expanded? Do you think it might be a good idea to have a grant program to start up nursing homes devoted to, as a priority, caring for this particular group of people?

DR. LEE. On the training of health professionals, I think that if we train more minorities and gave them more opportunities, there is no question that the minorities would have greater access to health care.

There is very substantial evidence that the minority health professionals provide far more care to other minorities than do the nonminorities. In terms of the total volume of care, because there is such a small number of minorities in the health professions, particularly medicine and dentistry, only a small percentage of the care is currently provided by minorities.

The key to minority recruitment and retention is adequate aids. That is just where the money is being cut out. We are forcing minority students and other low-income students to borrow huge sums of money. In the future they may not even go to professional schools, even if they are admitted, because the funds aren't available. Students see they are going to have to borrow 40, 50 or $60,000. That is more money than they have heard of. A middle-income white from a professional family does not hesitate to borrow the money. They are comfortable. They are not as concerned. They know they can go out in the suburbs, start a practice and pay off the loan with no problem. For minority and low-income persons that is not so. To shift the burden from grants which have been available to students in the first couple of years to loans is a very great mistake. Of course, we are subsidizing the banks and not the students with the loan programs.

COMMISSIONER-DESIGNATE BERRY. What would you think about the last part, the money for nursing homes?

DR. LEE. I don't believe that any group in the population is served by the segregated facility. I think to the extent we maintain or have special facilities, I think it would be a mistake. I think we need to open up the access to those facilities. More importantly, we need to provide the social supports and income in the communities so people can stay at home.

COMMISSIONER-DESIGNATE BERRY. What about giving incentive to people who will serve people who don't have great access to nursing homes as a dollar formula?

DR. LEE. I think that is an excellent idea. We have not tried it yet, but it is a good idea.

COMMISSIONER-DESIGNATE BERRY. You seem to emphasize, again in answer to my colleague Saltzman, the idea of an adequate income as a possible solution to problems. You also talked about the elderly poor having the ability to allocate their income themselves among housing and health care, food, and the like.

That would be helpful, leading to a certain amount of autonomy for them. You seem to support that idea. On the other hand, when you got to the question of State programs and block grants and whether they should be Federal programs, you seem to want less autonomy for State governments in terms of what they do.

I think governors and mayors like those block grants and would like more of them. You seem to believe that health care autonomy for States has not worked out as well.

DR. LEE. The inequities that have come as a result of new federalism policies and of Medicaid policies, where there is great State discretion in terms of eligibility, terms of levels of reimbursements, and scope of services, are so great that something has to be done to correct those. That is true in medical care and social services and in housing. We cannot, if we are going to meet the Nation's needs, permit the degree of discretion that we now permit the States without accountability. The States get large amounts of Federal money for these services. The results are very inequitable. The people who pay the biggest price are the minorities, the poor, and elderly. I would give more autonomy to the individual and less to the States. Income is one of those areas.

We should also have national health insurance as a national policy with a basic scope of benefits that is provided for everyone. There are some additional things you may not provide as national policy. Let the discretion rest with the States with respect to certain discretionary services. In Canada, for example, they cover all hospital services and all physicians services. They leave it to the provinces whether they cover nursing homes or whether they cover prescription drugs. Some do. Some don't. They have varying coverages. I think that kind of care coverage as a national committment, even with shared financing by the State, would be the way to go rather than the kind of inequities that have resulted from the present policies.

COMMISSIONER-DESIGNATE BERRY. Thank you.

VICE CHAIRMAN HORN. Commissioner-designate Ramirez.

COMMISSIONER-DESIGNATE RAMIREZ. I am brand new to this Commission, and I have not had a chance to read your paper; but in your talk you talked about social support services.

Where I thought you were going was in indicating that more attention to the total ecology of the aging person, to their family needs, to their economic needs, to their housing needs, might result in better health and the need for less medical care.

In fact, you seem to be pretty strong in that belief. To what extent are people who are being trained in medical schools, first of all, being trained to understand that dynamic?

Secondly, and more particularly, to what extent are people who are being trained in medical schools being trained to understand that dynamic in its particular manifestation among minorities? I am particularly interested in terms of Hispanic families, for example, and the tremendous role that the family ecology has on the care of the Hispanic elderly.

I have a father story to tell also and a lot of uncle stories to tell. It seems to me that the medical profession either ignores that dynamic in our community or inevitably, if it recognized it, does the wrong thing about it.

I was wondering if there is any kind of thought among your colleagues as to the need to begin to train people to that sensitivity, to the ecology of all persons but very specifically to the reality for minority elderly.

DR. LEE. I would completely agree with the need. The needs are not being met. Increasingly, unfortunately, in most medical schools, we are teaching more and more about the technology. As science advances, there is more basic science to teach. I am talking about biomedical science, not social science.

In the clinical years, more and more time is spent in dealing with technological advances. Coronary intensive care, neonatal and respiratory intensive techniques must be taught. The proliferation of technologies has posed a tremendous challenge in teaching. The students and the faculty, too, feel they have to master those technologies. So, they do. They do that by going often into a subspeciality. They become a cardiologist, an arthritis specialist, or a chest surgeon. Even in medical schools, they begin to develop those pathways, ignoring the ecological approach to health and care.

It is the care of the family and the individual that suffers. It is interesting that the Administration on Aging, in some grants given to medical schools, is insisting there be a minority component in the training programs. Unless there are minority faculties and students involved, you cannot understand the relationships among different ethnic groups that relate to health and health care. The problem exists for Hispanics more than blacks. The absence of Hispanics from medical school faculties in most parts of the country, even those areas like California where the population is changing very dramatically, has an important effect. Although there are many more Hispanic students, it will be 10 to 15 years before they are on the faculty in influential roles. This discontinuity between the needs which you have identified and described and what we teach is going to get worse before it begins to get better, unfortunately.

VICE CHAIRMAN HORN. Thank you.

Staff Director Nunez.

MR. NUNEZ. I was interested and I would like to get back to your concern about the need for adequate income. The Commission on Civil Rights focuses on civil rights issues. Primarily as we look at health care and the disadvantages of the minority and the elderly, I was wondering whether the enormous range of civil rights enforcement mechanics that we have in our society to insure nondiscrimination is the correct strategy for the minority and the aging or whether the strategy should be focused on providing an adequate income to allow this category of citizens to participate on an equal basis or have all the access.

DR. LEE. I think it has to be multiple strategy. Medicare alone would not have provided black people in the South with access to decent medical care. There had to be a forceful enforcement of the Civil Rights Act to desegregate the hospitals.

So, just providing adequate income will not ensure equity, unfortunately. Our society has not reached the point where we don't discriminate. Even though we have made a great deal of progress in the last 25 years, we have a long way to go.

There is still institutional racism even when there is not overt discrimination. There was a Civil Rights Commission report in the 1960s that first used the term institutional racism. I think that probably still persists. I think the Commission is one of the instruments for rooting out or helping us root out that problem.

VICE CHAIRMAN HORN. Thank you very much. You mentioned your father, Dr. Russel Lee. I think many of us know that he is without question one of the major pioneers in medicine and health in this century. I am sorry to have learned about his accident.

When I was a sophomore at Stanford in 1951, he convinced me that I should be—and I have been since then—for national health care. Now that he can no longer practice, he can perhaps read some of the 12 to 14,000 books in his library.

Thank you for appearing. We appreciate your comments.

CHAIRMAN FLEMMING. I concur in Commissioner Horn's comments relative to your father. He has been one of my heroes in this area.

DR. LEE. Thank you. I will extend these comments to him.

VICE CHAIRMAN HORN. Our next witness is Lu Ann Aday. Dr. Aday is currently research associate at the Center for Health Administration Studies at the University of Chicago. After receiving her baccalaureate in economics from Texas Tech University, she did her masters and doctorate in sociology at Purdue.

She is presently an associate editor for the *Journal of Health and Social Behavior.* She has made an important contribution through her publications in the area of health care, as well as in her role as a critic and a reviewer of the vast literature that has grown up in this field.

As an applied social scientist, we are delighted to have your perspectives on the problems before the Commission.

STATEMENT OF LU ANN ADAY, PH.D., SENIOR RESEARCH ASSOCIATE, CENTER FOR HEALTH ADMINISTRATION STUDIES, UNIVERSITY OF CHICAGO

DR. ADAY. I am delighted to be here to discuss with you some of our own work and the points of view of other investigators and other parties interested in the whole area of equity of access to medical care, particularly for women, the poor, ethnic minorities, and handicapped.

The question is whether or not there is equity in the American health care system.

Drawing on findings from a 1976 national survey of access to medical care conducted by the Center for Health Administration Studies at the University of Chicago, I shall attempt to provide some empirical input which should be helpful in addressing this issue.

Access, in our analytic framework, is defined as those dimensions which describe the potential and actual entry of a given population group to the health care delivery system. A special case of access which is of particular interest is the problems people experience in obtaining care once a need is perceived.

The greatest equity of access is said to exist when need, rather than structural or other individual characteristics, determines who gains entry to the health care system. To the extent that having a family doctor, insurance coverage, or actual utilization is a function of a person's general physical health or of particular presenting complaints then an equitable system is said to exist.

Inequity is indicated, however, if services are distributed on the basis of demographic variables such as one's race, level of income, or where one lives.

In the findings I shall be discussing access indicators for different age, sex, race, income, and place of residence. Groupings have been examined, adjusting for the variant needs of each, so that the inequity due to other population or health care system characteristics can be more clearly identified.

Also, the statistical procedure used adjusts the access scores for any particular group for other characteristics of the people in this group, so that the findings for different races, for example, control for any differentials among them in their income levels, where they live, and their age and sex distributions. What are the implications regarding current profiles of access that may be drawn from the findings for different target groups?

Because the elderly have been a special target of major health policy initiatives during the past 20 years via the Medicare program, let us focus on their access profiles in particular.

The elderly do not compare that unfavorably to the national average in terms of the proportion of them that report having a regular source of medical care. Around 11 percent, 2 million elderly, do not.

The fact that this number of elderly do not have a regular place to go for medical care may still be interpreted as a problem, since this is a group which tends to require the services of a physician for illness-related care on a more regular basis than do the young.

Most of the elderly who do have some place they usually go do have one doctor that sees them there. The vast majority of the elderly go to private doctors' offices rather than hospital outpatient departments or emergency rooms or public clinics.

The impact of Medicare is reflected in the fact that almost no one 65 years of age or over is uninsured, although more than a third of the elderly do report that Medicare is their only form of third-party coverage.

About one-fifth of the elderly, over 4 million people, did not see a physician at all in the year. The number not seeing a dentist is much higher, almost 14 million individuals, primarily reflecting the lower dental care need for this age group, particularly compared to young children 6 to 17 years of age.

Levels of dissatisfaction expressed by the elderly tend to be somewhat lower than that registered by parents of young children about their child's health care, however.

In general, access measures then do not suggest that there are substantial potential or realized access problems for the elderly at the present time. As Dr. Lee suggested, there are potential financial problems that result, especially for the elderly who are only covered by Medicare, from not being fully insured for some services. These problems should be mentioned even though they are not addressed directly in our general access study.

While a greater proportion of the elderly's expenses are paid by third parties, their per capita out-of-pocket expenditures are considerably higher than those of any other age group. This happens because their total expenditures are high and some services such as drugs, dental care, and many appliances such as eyeglasses are not covered by Medicare. A related problem is the limited coverage of Medicare for long term illness and nursing home care.

Medicare currently limits coverage to 90 consecutive days in the hospital, and nursing home coverage is provided for 100 days but only if preceded by a stay in an acute hospital. Consequently, it is possible for elderly persons with extended illnesses to exhaust Medicare, supplementary insurance coverage, and whatever personal reserves they have and subsequently become dependent on Medicare and welfare.

These financial problems, while not highlighted in our own study, do indicate the need for supplementary third-party financing for the catastrophic and long term cost of illness experienced by the elderly.

As has been the case traditionally, women are more likely to report having a regular source of care and higher physician and dentist contact rates in general than are men. There are no substantial sex differences in our data along general convenience and satisfaction dimensions, however.

Women do, however, have special health care needs associated with their childbearing responsibilities—prenatal care and gynecological-related screening for cervical and breast cancer, for example.

Though a vast majority of women do see a physician during the first 3 months of pregnancy, there is evidence that low-income women may still be less apt to do so. Further, though over half of the adult women in this country have a pap smear or breast exam at least once a year, low-income females and those who are poorly educated are less likely to have these exams.

There is also the fact that women may have to see more than one type of physician in order to have their total health care needs met—an obstetrician-gynecologist in addition to an internist or general practitioner, for example. These unique health care problems of women and their implications for the type and frequency of contacts with the health care system then should be taken into account in evaluating women's overall medical care access.

The gaps between whites and nonwhites with respect to both potential and realized access indicators have narrowed considerably over the past 25 years. Racial inequities do persist along certain access dimensions, however, even when income differences are controlled.

Urban blacks are much more likely than other groups to use hospital emergency rooms or outpatient departments as their regular source of care and hence much less likely to have a regular family doctor they would go to should the need arise.

Urban and rural Southern blacks tend to average long waits before being seen when they go for care. These findings may reflect the types of services that are available in the areas in which minorities reside, the overcrowded nature of the facilities (large urban emergency rooms and outpatient departments), poor scheduling systems on the part of providers, or the unwillingness or reluctance of private physicians to see minority patients.

A large proportion of the Spanish heritage population has no form of public or private coverage, and a large number of urban blacks have only publicly subsidized health insurance—that is, Medicaid, Medicare, or other reduced price form of care.

The realized access rates for physician and dentist services remain low for the Spanish heritage and rural Southern black population groups in particular. Nonwhites tend to be more dissatisfied than whites with cost of care. Urban blacks are unhappier than majority whites with the average time they have to wait to see a doctor when they go, undoubtedly because of the fact that their waits are longer at the places they tend to go.

As with the race variable, though the access gaps by income have narrowed considerably, income remains an important determinant of whether or not a person does have a regular source of care and, if so, what kind; whom they see; how long they may have to wait on average when they go; whether or not they are insured and how (public or private coverage); whether or not they have actually seen a doctor and particularly a dentist in the year; and whether they are satisfied with the cost of their medical care.

Where one lives also continues to influence one's potential and realized access rates. Inner-city residents, for example, make extensive use of hospital outpatient departments and emergency rooms as their regular source of medical care. Rural farm dwellers, who most often see general solo practice providers, report particularly long waits at their regular source of care and low physician contact rates overall.

In general, people who live in large urban centers are more apt to have seen a dentist than those who reside in other areas.

In summary, though many medical access inequities have narrowed, great possibilities would seem to exist through various health care reorganization strategies for continuing to improve the potential and realized access to general health care services.

System reorganization approaches, such as enrolling groups of individuals in health maintenance organizations or converting the fragmented services of hospital outpatient departments to comprehensive, family-centered group practice models, could help to reduce the inconvenience and dissatisfaction which the poor and ethnic, especially urban and rural Southern black, minorities now frequently experience in obtaining care through existing arrangements.

Encouraging physicians and patients to set up appointment systems to reduce the queues for care in big city outpatient departments and overcrowded solo general practitioners' offices in the rural South could bring about improvements in access, as would efforts to ensure that patients are able to have one provider they can identify and relate to as their family doctor.

Major financing initiatives, such as Medicare and Medicaid, have been credited with reducing many of the historical inequities, by race and income in particular, over the past two decades. There is evidence that the relative status of certain groups could still be enhanced if more universal third-party financing were available.

Ethnic minorities, especially the Spanish heritage population, have lower rates of third-party coverage than do the majority white population. Educational and occupational status differences help explain these differentials. Poorly educated ethnic minorities are less likely to be in jobs that provide such coverage.

Further, the marginal working poor are still not poor enough to qualify for Medicaid. Special attention should, it seems, be devoted to those groups that fall between the gaps of existing third-party schemes in designing new Federal financing initiatives.

There is evidence that financial barriers significantly affect individuals' potential and realized access and how satisfactory they consider their experience in obtaining care to be. Options that focus on providing coverage to those persons who currently have no protection against the potentially high cost of illness and the integration of these financing mechanisms with models of service delivery that attempt to contain the cost and ensure the quality and convenience of care to consumers are needed to reduce the persisting inequity.

Discussion

VICE CHAIRMAN HORN. Thank you very much. Your paper "Achieving Equity of Access To The American Health Care System: An Empirical Look At Target Groups" will be included in the record.

COMMISSIONER FREEMAN. In many of the urban communities, such as St. Louis and New York, the municipal hospitals have been closing. There has been a great deal of controversy around the closing of these hospitals.

The allegations have been that this was a deliberate effort. The consequences are a denial of health services. Have you found any alternative other than the neighborhood health centers? Would you comment on this closing phenomenon.

DR. ADAY. I think that is a good point to bring up at this time. Those facilities are a key source of care for minority populations. I am aware of some of these closings.

I might mention we are involved in a study now which is concerned with the evaluation of the impact of the provision of programmatic funds by the Robert Wood Johnson Foundation to various municipal hospital programs in five cities. They are Baltimore, St. Louis, Cincinnati, Milwaukee, and San Jose.

This program intended to encourage those municipal hospital systems to reorganize and reorient the kinds of primary care which are provided in their facilities into more comprehensive family-centered care arrangements.

This is an effort to build and improve upon a system that is in place and has traditionally been an important source of care. To the extent that those arrangements are, in a sense, torpedoed by these closing decisions, I think that does suggest a significant kind of problem.

In terms of the alternatives that are available, another programmatic option which we are evaulating at this point is an initiative on the part of community hospitals to develop and encourage group practice arrangements so that community hospitals, which perhaps are not as tied to municipal funding sources, can develop commitments to delivering primary care. These facilities would have what is called "single portal entry" care, in that all groups from the community would have access to this arrangement.

Most communities should have some continuing hospital institution engaged in the business of delivering care. To the extent that those hospitals can be encouraged to become more involved and develop a commitment to the delivery of primary care, then perhaps this offers some stability in the care-giving arrangements in many communities.

VICE CHAIRMAN HORN. Commissioner Saltzman.

COMMISSIONER SALTZMAN. Dr. Aday, you focused on, it seemed to me, the solution to some of these problems where access is based on the equity of need. What about the services before need arises, before a health crisis develops? What are the conditions of equity there?

DR. ADAY. Once again, the gaps in inequity by race and income in terms of preventive service use have narrowed substantially over time. I think a group which requires particular attention though in thinking about equity of access along a preventive dimension would be low-income children.

Children are a group which have made great use of preventive services and an age group in which those kinds of investments are best and most appropriately made. So, I think that the income differential, particularly for this group, is one that persists.

There is evidence also with respect to certain kinds of tests that minority children in the rural South may be less apt to receive them—the baby shots, measles, vaccinations, and so on. I think the inequity on that dimension in some respects parallels that along the need-based measures. But I think there are these particular groups where investments in that area are particularly important and for which there is still remaining inequity.

COMMISSIONER SALTZMAN. In preventive health care relative to equity for minorities, the handicapped, and women, would you place emphasis for the solution for continuing to narrow the gap on governmental programs or on an income-based approach?

DR. ADAY. I quess my own emphasis would be more in the direction of governmental programs, at least programs of service delivery which focus upon that component of care. I think education is really, in some respects, a more significant correlate of preventive health care behavior than is income.

There is a lot of overlap between those indicators. Traditionally, and I think it is also the case now, level of education and the whole body of attributes which are assumed in varying educational levels of individuals do affect attitudes towards health maintenance. This is an important area on which to focus.

So, to the extent that educational efforts, like the Early Periodic Screening, Diagnosis, Treatment (EPSDT) program, which is linked to the Medicaid program, are encouraged and nurtured, I think that would be an important area and direction in which to move.

VICE CHAIRMAN HORN. Commissioner-designate Berry.

COMMISSIONER-DESIGNATE BERRY. I wonder, Dr. Aday, even though you see correlation between race and lack of access in the crisis situations or situations where people are actually sick, could it be that the reasons for the inequities are primarily economic factors and have nothing to do with race?

Because there is correlation does not mean there is a cause and effect relationship. Could one say, if people had more income and perhaps more education they would have greater access, or not? Do you think race really does make a difference?

DR. ADAY. I think it depends on the dimension of access we are examining. The tables in my paper present a better empirical picture of the respective effects of income and race. It seems the race variable, controlling for income differences among different groups and age and sex distributions or where people live, seems to be an important correlate of where people go for care.

As I mentioned, the minorities tend to make greater use of hospital outpatient departments and emergency rooms. There may be a reason for that. These are facilities that are most available in the areas in which they reside.

Private practitioners may be reluctant to accept minority patients, or people on Medicaid, many of whom are minorities. So, I think race continues to be a significant predictor of where people go for care on a routine basis.

Another dimension of access, which is certainly important, is whether or not a person has seen a physician in a year. This is an indicator of realized access. Where one may go for care and the insurance coverage say something about potential access.

The fact of going to care or not is an indicator of actual access. Along that dimension, the race differentials have narrowed substantially. There is in effect no difference in the proportion of whites and nonwhites overall contacting a physician in a year. The number of Spanish heritage individuals contacting physicians in a year is still low, however. So, one could argue that at least in terms of this particular dimension of realized access some increases in equity have occurred.

COMMISSIONER-DESIGNATE BERRY. Why is the percentage for the Spanish heritage low?

DR. ADAY. Well, there are a number of hypotheses that you can explore. Insurance coverage status in this group is an important one. Others include their occupational status, the entitlement to services which might be available through that, or the fact of being migrants, who are very reluctant to make contacts with formal systems. One can assume hypotheses about cultural factors or attitudes towards the mainstream medical system. Many I think are significant, mutable factors which policy can do something about.

COMMISSIONER-DESIGNATE BERRY. On the other question, do you know anything at all about access of the handicapped to medical care?

DR. ADAY. In our study, we did not address that very directly. It seems to me one of the dimensions which is really important to consider for that group, however, is the income situation. The handicapped, whether through cause or effect, tend to have much lower incomes.

I think another important dimension is the form of coverage available to those individuals. The disabled tend to be unemployed. They cannot work. Most people obtain insurance coverage benefits throughout employment. This remains a substantial problem for the handicapped.

The level of expenditures for the handicapped is much greater than for the nonhandicapped individuals, nondisabled population. The distribution of expenditures for the handicapped is also much different than that of the general population.

The kinds of expenditures for the handicapped are apt to be for costly hospital services, whereas for the general population there are more expenditures for routine physician or dentist care than the higher cost of hospital services. So, I think these are the policy-relevant financial areas which are important to consider for that group.

COMMISSIONER-DESIGNATE BERRY. You believe there may be inequities, but we don't know for sure?

DR. ADAY. I indicated I do not deal with them directly in our study. But the Social Security Administration surveys of the disabled are a good data source for dealing with that question.

VICE CHAIRMAN HORN. Commissioner-designate Ramirez.

COMMISSIONER-DESIGNATE RAMIREZ. Dr. Aday, I was very interested in your statement that a large proportion of the Spanish heritage population and large numbers of the rural blacks have no private or public coverage.

I am not expert in the area, but I believe that eligibility criteria for public coverage in many States as a result of the new federalism requires the absence of the principal breadwinner for benefits not extended to intact families.

I wonder if that is not a reason why rural Southern blacks and the Spanish heritage populations have lower access rates. They are ineligible by virtue of maintaining their families intact, and that may be part of the problem?

DR. ADAY. Let me mention that the proportion uninsured is higher for the Spanish heritage. It is less for the rural southern blacks, however.

Medicaid is tied to categoric programs such as AFDC and also programs to the blind or disabled. Eligibility is available to individuals who are deemed medically indigent by these programs' criteria. That is certainly a useful hypothesis to explore.

I would assume that the number of intact families in the Spanish heritage community may be larger than that in the urban black community. I don't know the facts on that exactly. From the point of view of that being a correlate of this type coverage, it is an hypothesis to explore concerning the whole issue of how one's eligibility for coverage is linked with other categoric criteria.

Karen Davis will probably present data tomorrow looking at how coverage status varies by different income and racial groups in the Medicare and Medicaid programs and what factors may account for those differentials.

COMMISSIONER-DESIGNATE RAMIREZ. I think that is worth looking into, particularly in the Southwest. We are hanging onto a higher incidence of intact families among Spanish populations than the country as a whole, and certainly far more than what we should expect given the pressures they are under.

One of the pressures is that simple fact. My husband comes back, and I am going to lose my hospital card. It is a simple policy decision that could be made. It would have far reaching benefits beyond just the medical.

VICE CHAIRMAN HORN. Staff Director Nunez.

MR. NUNEZ. I have no questions.

VICE CHAIRMAN HORN. Chairman Flemming.

CHAIRMAN FLEMMING. I would make this comment. I would like to express to Dr. Aday my appreciation for making it possible for us to have an empirical fix on some of these areas. It seems to me that what you have provided us in your paper and what you have provided in response to questions does help to provide a foundation for action programs that, hopefully, will begin to close even more effectively the gaps that you have identified.

We appreciate your contribution. Thank you.

VICE CHAIRMAN HORN. Next is Sylvia Drew Ivie, discussing minorities and access to health care.

Ms. Ivie has been an attorney for the National Health Law Project since 1976 and has served as its executive director for the past year. Her responsibilities include providing auxiliary legal assistance to neighborhood legal services attorneys involved with health care issues such as Medicare and Medicaid entitlements, nondiscriminatory access to hospitals built with Federal funds, racial discrimination in health care delivery, and consumer participation in statutorily mandated health planning efforts.

Prior to joining the National Health Law Program, Ms. Ivie served as senior trial deputy in the office of the Los Angeles City Attorney. Her professional background also encompasses a 6-year tenure with the National Association for the Advancement of Colored People, where she briefed and argued more than 35 cases in various Federal courts of appeal and briefed several cases argued before the Supreme Court of the United States.

As in the case of Dr. Lee, our first witness, we have the daughter of a distinguished medical pioneer in this nation. I have often thought, in business, usually the first generations are the robber barons and the second and third generations do good works. Here, we have an example of both the first and second doing good work.

She graduated from Vassar College and the Howard University School of Law. Her father was a pioneer in American medicine. Dr. Charles Drew, who taught at the Howard University Medical School for a number of years, was the developer of blood banks to store blood as plasma until needed. He died for want of a transfusion when he was denied access to acute health care services after an automobile accident that took place while traveling through North Carolina.

STATEMENT OF SYLVIA DREW IVIE, ESQ., EXECUTIVE DIRECTOR, NATIONAL HEALTH LAW PROGRAM

Ms. IVIE. Thank you very much. May I state for the record that I do not believe that my father died in North Carolina for want of appropriate medical attention. I believe that he was provided necessary care. Many others however, similarly situated then and now have died because of their race and their consequent inability to get necessary care.

The myth that surrounds his death is appropriate symbolically for the pattern of health care provided for minorities at that time and that continues in many ways unchanged today. The health status of minority people in this country is worse for every group from the cradle to the grave. It is worse in large part because of racial discrimination.

While there have been, for example, decreases in infant mortality overall, the gap between white and black infant mortality is growing. Black infants are twice as likely to die before the age of 1 year as are white infants today.

Self-assessment of health status of adult minority people and whites by the Department of Health, Education, and Welfare indicates that while only 11 percent of white persons interviewed perceive their health to be fair or poor, 19 percent of blacks and 13 percent of the Hispanic persons interviewed had such a perception of their health.

Among the elderly population, 65 percent of the blacks and 65 percent of the Hispanics believed they were in poor health, while only 38 percent of the whites believed they were.

In terms of psychological well-being, HEW has conducted an investigation in which 70 percent of the white males interviewed indicated that they felt they had positive well-being. Fifty-eight percent of the white females had a similar assessment. Only 54 percent of the black males, however, felt that their physical well-being was positive. A startling 37 percent of the black females gave positive assessments. HEW concluded that over half the adult black female population in this country lives in a state of psychological distress.

Survival rates among minority persons, according to a HEW study, have not changed in the last 50 years. For example, where 70 percent of white males survive to the age of 65, 55 percent of all other males survive to that age. The differential has not changed.

So, while we hear reports of narrowing of gaps, improvement of overall health care, improvement of coverage for payment of health care, I think there is cause to be very alarmed about the status of health of minorities in this country in general and the failures of various Federal programs that have been discussed here today. What are the causes of this inferior health status? We have talked a little here today about income. Blacks are three times as likely to have an income below $5,000 as are whites.

Hispanics, on current data (which we all know to be inadequate), are two times as likely to have incomes below $5,000. The relevance of poverty in the minority groups to need for health care coverage is reflected in the fact that the major program for financing health care among minorities, Medicaid, is nearly half minority in enrollment. You cannot look at this issue without the juxtaposition of race and income, in my opinion. Environment is another critical determinant of this poor health status. Low-income minorities live in inner cities.

The National Center for Health Statistics conducted a study of 19 major cities and found that in all but 5, people living in the poverty areas were 50 percent nonwhites. As a result of that living pattern, minorities are exposed to over 50 percent more of the environmental health hazards that suburban livers experience.

Nutrition is an often cited third cause of lower health status of minority groups. There is a great deal of debate about how much nutrition is responsible for that lower health status. I believe it to be an important part because of the relative poverty of minority groups.

But I caution you not to spend a great deal of time on that issue, since I believe it is part of the pattern of blaming minority people and poor people for their own health care status. If they would only eat better. If they would only sleep better. If they would only move out of the ghetto. Then, they would not be sick.

I think it is for other groups to look at that issue. I would hope this group would look at a fourth and I think a major cause of the poor health status of minorities. That is their inability to get access to quality care.

Minority people, as you heard from Dr. Aday, rely heavily on outpatient services and emergency rooms. They live in inner cities in predominant numbers. Hospitals in these areas are closing. A study conducted by Alan Sager at Brandeis University of hospital closings in the past 40 years in the Northeastern United States shows that disproportionate numbers of hospitals closed in that period were closed in neighborhoods that were 50 percent or more minority.

Eighteen percent of the hospitals that closed were in neighborhoods that were not majority black. Forty-five percent of the hospitals that closed were in neighborhoods which were majority black. There is a direct correlation between who lives around the hospital and whether it is closed. These hospitals, when they are closed, are generally not reopened. There is not a concomitant available facility in the community for people deprived that care.

Minorities have inadequate health care access because, even if a hospital is available, they are uninsured. It is estimated there are 30 million people in this country who have no insurance or inadequate insurance. Disproportionate members of that group are, of course, minority people.

Minorities have poor health status and inadequate access to care because large numbers are monolingual in languages other than English, and hospitals provide no bilingual service. Bilingual services are an important component of adequate access to care.

An 8-year-old girl in Phoenix, Arizona, went into a hospital after being mauled by a German shepherd dog. She spoke no English. Her father spoke limited English. She was taken into a treatment room after a long delay while there was discussion concerning whether the father's insurance was acceptable. It finally was not accepted, but the child was admitted after a preservice deposit. The father was not allowed in the treatment room despite the fact that the child was crying and in fear.

The child's bites were treated on her arms and legs. Her clothing was not removed. When her father took her home, he removed her clothes and found other bites under the clothing. He took her back to the hospital, where he was treated very rudely. Only after great insistance was she treated further. A week later another physician found the wounds had become infected for failure to properly clean them during the treatment process. That factual situation is not unusual. It reflects a series of inadequacies in the delivery system vis-a-vis that family and that community.

I mention this at this moment to raise the issue of the inappropriateness of that service in terms of language. Had that hospital had any staff available, I believe that not only in terms of the actual transmission of information concerning where the injury had been received but the whole receptivity to the people on a cultural basis would have been different.

Minorities lack access to adequate medical care because of nonavailability of physicians. Minority physicians continue to be a scarcity in this country. Only 2 percent of the physicians in the country are black; there are only 250 Mexican American and 72 Indian physicians, according to a recent report. The percentage of minority students in medical schools nevertheless is decreasing.

Even if there were adequate numbers of minority physicians, there has been since its inception and continues today to be an enormous problem on the part of Medicaid recipients in getting physicians to treat Medicaid patients. A scarcity issue exists also with respect to denial of staff privileges by white institutions to black and brown doctors.

Access also is unavailable to minority communities because there is inappropriate planning. The Government has set up an Indian health service program for Indian people. But urban Indians are not eligible for care at Indian health service hospitals, despite the fact that the majority of Indian people now live in urban areas. The total unconsciousness on the part of the planners of who the people are who need to be served has had disastrous results for urban Native Americans.

Beyond the various practices of unavailability of service outlined, there is inappropriate service provided. A huge volume of money, over 40 percent of the Medicaid dollar, has been provided for nursing home care. There is general agreement today that institutionalized nursing home care may not be the most appropriate care to give to elderly citizens. Yet that is where we are funneling all the money. Because of racial discrimination, minorities account for only 4 percent of the residents of nursing homes. Thus, they are doubly disadvantaged. They have a poor system, and they have no access to it even though it is poor. It was estimated in 1976 that 500 percent more was spent on white persons than was spent on minorities in nursing homes.

Minorities are denied an opportunity to impact on this nonavailability of services and inappropriate design of services by denial of participation in various health planning processes at local, State, and Federal levels. This problem may be addressed by some very strong health planning guidelines that have been just issued by HEW. I hope it will receive the support of this body.

VICE CHAIRMAN HORN. We have 1 minute.

MS. IVIE. I want to tell you what the experience has been for legal service lawyers across the country in seeing discrimination in health care delivery. We are still in a pattern of treatment and care that existed before 1964. Health has not been identified as a civil rights issue by public interest reformers.

It needs that kind of attention. The problems are there. Some of them are absolutely blatant. We are litigating at this moment a case of a segregated physician's room in Tallahassee, Tennessee, where "White" and "Colored" signs in the two rooms were taken down only in the late sixties.

Patterns of segregated waiting rooms have been reported to us from other portions of Florida, Mississippi, and Texas. I believe it to be a prevalent pattern of care in the South. The treatment afforded to minorities is discriminatory.

A study was conducted in Baltimore that documented that minorities, regardless of income, not just the poor minorities, were two to four times as likely to be treated by those in training rather than the staff physicians at the hospital. When minority patients are treated, they are treated diagnostically, not in terms of their whole health presentation. They are overprescribed with drugs. They are oversurgeried, particularly in the area of sterilization. They are presumed, in many instances, to be illegal when they are American citizens.

In a recent situation in Los Angeles, California, a Spanish-speaking man came in with multiple stab wounds, conscious, speaking Spanish to the staff, which was monolingual in English. Again, long delays took place concerning whether he had insurance, whether it was adequate, whether he was a citizen. While this long discussion was going on with his wife (who also spoke limited English), the patient died. He was an American citizen. The staff had never absorbed that fact.

Most of these patterns of discrimination are found in the private health sector. But the major discrimination that I think goes on against minorities has to do with our whole public hospital system. No problem is as systemic as the whole structure of health care we provide in the public hospital system. I have said that they are closing.

The ones still open are providing generally a poorer quality of care than the private system because inadequate funds are being allocated by State and local governments for those services. The facilities have inadequate numbers of nurses. They have inadequate numbers of physicians. Their equipment is often inadequate.

In Martin Luther King Hospital in Los Angeles, an intern told me it was better not to come in for emergency care there on a busy night because the hospital did not have enough surgical packets to treat all emergency patients when they come in.

Their low level of funding means that these hospitals don't have money to set up adequate billing systems. So people who come in and are covered under Medicaid, for example, are not providing that fiscal resource to the facility to help it provide better quality care. Reimbursement provided by major Federal programs such as Medicaid is inadequate for public hospitals. Those institutions are often the only source of care for minorities in a given community.

In sum, I think there are enormous problems in quality, quantity, and availability of care for minorities in this country. That pattern is exacerbated by almost total failure of the Federal Government to adequately address these issues.

We do have tools to do it. Let me say briefly they involve enforcement of Hill-Burton free service and community service obligations, enforcement of Title VI of the 1964 Civil Rights Act, and enforcement of health planning requirements.

No guidelines, for example, have been issued (despite a 1976 Justice Department mandate) detailing what constitutes discrimination in hospital, nursing homes, and health planning. HEW has developed drafts and redrafts of guidelines, and none have been issued.

There is no assurance form for reporting for Hill-Burton hospitals giving the date of service, who is being served, what race, and what care is being provided. There are major policy proposals that can be made by this body and other government agencies to support and prevent further closure of public hospitals as are outlined in my paper.

I will stop at this point. Thank you.

Discussion

VICE CHAIRMAN HORN. Thank you very much for that overview. Your paper "Ending Discrimination In Health Care: a Dream Deferred" will be inserted in the record.

COMMISSIONER SALTZMAN. The reference you have to a research paper by Allan Sager, with respect to his conclusion that overbedding was not the predictor of the closing of the urban hospitals but the percentage of blacks in the population. The footnote refers to an article in a newspaper.

MS. IVIE. I do not have the document. I will be happy to furnish it.

VICE CHAIRMAN HORN. Please do. It will be inserted in the record. (See exhibit 1.)

COMMISSIONER SALTZMAN. Also, in answer to what was a question to Dr. Lee as to whether health care of minorities, of women, and the aged improved over the last decade, his response was rather a strong yes. I gather from your paper you would have to say no, the gap in health care services has widened rather than improved.

How do you reconcile the conflicting points of view?

MS. IVIE. I think we are both correct. There are more minority people getting health care today than there were some years ago. But the differential between minority persons getting health care and the majority person getting health care in many important areas is widening.

So, while as a whole the groups are better off, as compared with the majority group we are worse.

COMMISSIONER SALTZMAN. I see. That is what our social indicators study says.

VICE-CHAIRMAN HORN. Commissioner-designate Berry.

COMMISSIONER-DESIGNATE BERRY. I wonder if you have the impression that the Federal Government ought to be responsible for seeing to it that hospitals stay open in those areas where minority populations are using public hospitals and the hospitals are closing. Is that the proper conclusion to reach?

MS. IVIE. Yes, I do believe that the Federal Government is responsible. The hospitals which are receiving Federal funds and State agencies which are receiving Federal funds are prohibited under Title VI from taking actions which discriminate by intent or effect. Closing of those facilities constitutes effective discrimination.

COMMISSIONER-DESIGNATE BERRY. The reason for closings are due to the race discrimination?

MS. IVIE. I believe that is the proper conclusion in relation to Dr. Sager's statistics.

COMMISSIONER-DESIGNATE BERRY. There is also no absence of civil rights laws or medical policy on the books that would address these problems, but there is an absence of civil rights enforcement, is that correct?

MS. IVIE. I think that is a critical point. I don't think it is the only factor. I think until we have civil rights enforcement of the measures that are on the books and recognize the correlation between poverty and race, inadequate health care will continue to be the norm for 30 million people.

COMMISSIONER-DESIGNATE BERRY. We think now there is greater interest in the civil rights community in lawsuits against HEW. That might influence the Office for Civil Rights in responding to some of these problms.

MS. IVIE. I think we are seeing that rather dramatically.

VICE CHAIRMAN HORN. Commissioner-designate Ramirez.

COMMISSIONER-DESIGNATE RAMIREZ. Have you investigated the participation in the public hospital and other public delivery system points, the participation by minorites in the government of those entities? If you have found what I suspect you have found, are there legal mechanics in the areas that you have identified that could change what I suspect would be a dismal picture?

MS. IVIE. The picture is very dismal. Since the health planning mechanics were set up in the 1974 Health Planning and Resources Development Act, the participation of minorities at all levels has been minimal, if existing at all, even where they have participated. There has been absolute refusal of those bodies to consider availability of health care facilities to minority groups.

Health planning decisions arise in connection with approving new equipment, purchases, or new facility development in those communities. There has been a refusal of those health planning agencies to say to a hospital, have you provided care to those unable to pay? Have you provided access to minorities?

If you have a hospital built with Hill-Burton funds, have you provided access for Medicaid people? There are guidelines on health planning statutes now which I think can remedy that, if those guidelines or regulations are passed. I urge you to review those and add your voice in support for their need.

CHAIRMAN FLEMMING. You mentioned the possibility of getting enforcement under Hill-Burton and under Title VI. Are there any major cases pending at the present time seeking to obtain enforcement through either one of those groups? It is a followup of Dr. Berry's question.

MS. IVIE. Yes. There are cases pending. In one case being litigated by Marilyn Rose, who is one of the leading advocates of equal access for minorities in this area, the Department of HEW has stipulated that they will issue, by the end of this month, a data collection survey on race to be filled out by all hospitals receiving Federal funds.

I hope there will not be, as we have grown accustomed to there being, great delays in the issuance of that document.

CHAIRMAN FLEMMING. What is the nature of that action?

MS. IVIE. It is a Hill-Burton action against a hospital in Ohio which has not provided adequate access to the poor or minorities.

CHAIRMAN FLEMMING. Is it pending in Federal court?

MS. IVIE. Yes.

CHAIRMAN FLEMMING. Do you know of a similar action in Title VI?

MS. IVIE. There are major suits pending in a number of areas in the country. There are several in New York City concerning closure of those facilities. There is a Title VI suit filed in Memphis, Tennessee, challenging the inability of minorities to get into nursing homes there. There are Title VI actions in California challenging the refusal of hospitals to provide adequate bilingual services. This issue is being addressed in a judicial context.

CHAIRMAN FLEMMING. I agree with you completely. We do have laws on the books that could be utilized for the purpose of closing or helping close this particular gap. It seems to me a situation where after a lapse of years we still have not gotten regulation under Title VI dealing with this particular area. It is an indefensible situation.

I think pressure should be brought to bear through the courts and in other ways.

VICE CHAIRMAN HORN. Mrs. Freeman.

COMMISSIONER FREEMAN. The Title VI cases filed, have they been filed by private individuals?

MS. IVIE. They have been filed by public interest law firms and legal services, generally.

I would mention I think it is rather anomalous that this whole civil rights approach to health care issues has come from people who are health advocates rather than people who are civil rights advocates. I hope there will be a bringing together of that interest. Both groups need each other.

COMMISSIONER FREEMAN. I would agree with that comment. The other question: It is the responsibility, is it not, of the provider of the Federal funds to at least monitor and assure compliance with Title VI. So, actually the first responsibility to assure compliance is with the Department of Health and Human Services?

MS. IVIE. Absolutely.

VICE CHAIRMAN HORN. Staff Director Nunez?

MR. NUNEZ. I note our next presenter is the Director of the Office for Civil Rights, Ms. Ivie. I am sympathetic with your feeling of concern that very little has been done. In a sense, there is a new opportunity as the Department splits off from the Office of Education.

Your professional assessment, looking at priorities and enforcement strategies: What do you believe could be the focus of the enforcement effort or should be in the next several years?

MS. IVIE. I think there is a need for immediate collection of data. I think there is a need for reorientation of compliance of enforcement by the Government. Compliance enforcement to date has centered on an individual complaint.

We filed, for example, an individual complaint on behalf of a Mississippi woman who had a baby in the hospital parking lot after being denied access to the facility. A year before this, another black woman had had her baby in the same parking lot. The first lady had litigated the issue. The Department of HEW investigated the complaint and found there was no discrimination vis-a-vis this one individual.

It did not look beyond the facts of the individual case to see the whole pattern of access for minority people in that community. Unless you look at the whole systemic pattern, you are not going to get at the problems minorities have. Administrative investigations should be handled like class actions in Federal courts. That would make a difference.

The whole issue of racial disparities in expenditures under Medicare, Medicaid must be looked at by the Department. Dr. Lee talks about the aged population in terms of their coverage in Medicare. Dr. Aday's report indicates there are no substantial problems for the aged because of Medicare.

But minority aged people are not eligible for or not covered by Medicare. They have a shorter life span. They don't live to age 65 to get it. The occupations in which they are involved (domestic and farmworkers) don't pay into social security. You have to have social security eligibility before you can get into Medicare.

So what is happening is those millions and millions of Federal dollars are not reaching minority communities. It seems to me it should be investigated by the new Department.

MR. NUNEZ. Thank you.

VICE CHAIRMAN HORN. We appreciate very much having your perspective and this factual presentation as to how the human health care service department, in particular, ought to conduct its strategy. Thank you.

VICE CHAIRMAN HORN. Next is Roma Stewart, Director of the Office for Civil Rights, Department of Health and Human Services, who will discuss the Federal responsibility for insuring equal access.

Ms. Stewart is Phi Beta Kappa from Fisk University, where she received her bachelor of arts degree. Later, she secured her law degree from the Georgetown University Law Center. She has been Director of the Office for Civil Rights since December 1979, a recent appointee who is obviously in a position to take a fresh look and not get blamed for past misdeeds, I would think.

Ms. Stewart has been active with the NAACP Legal Defense Fund; she is a member of the D.C. Bar and serves on the Executive Committee of the Washington Lawyers' Committee on Civil Rights Under Law.

In the 1960s, she helped to desegregate the Chicago hospitals. She has had a long career in the area of civil rights access, and now she is in a position where she can do something about it from the vantage point of the Federal Government.

STATEMENT OF ROMA STEWART, DIRECTOR, OFFICE FOR CIVIL RIGHTS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

MS. STEWART. Thank you very much. Thank you for this opportunity to present a report from HEW on civil rights and health care, on civil rights issues, problems, and opportunities. First, I would state that we are building a new and stronger and more effective enforcement program in the field of health care. We expect much more progress in the coming months.

For 15 years, the Federal enforcement effort under Title VI of the Civil Rights Act of 1964 has been aimed primarily at discrimination in schools and colleges. A series of strong Supreme Court decisions, the high visibility of the notoriously discriminatory dual schools, the expansion of federally funded education programs, and outside pressures on the Government are some of the factors that led to concentration of Federal resources in education.

Consequently, the record of achievement in elimination of discrimination in health is bleak in comparison to what has been accomplished in the schools. That picture is changing for the better for a number of reasons. Chief among them, perhaps, is the impending division of the Office for Civil Rights, with two-thirds of the staff going to the new Department of Education and one-third remaining in what will soon be the Department of Health and Human Services. With the division of resources, Health and Human Services will have its own civil rights investigators and management team, operating as we do now from Washington headquarters and 10 regional offices.

For the first time, we will have a full-fledged operation that can concentrate exclusively on an increased investigative effort, development of policy, immediate and long-range planning, and the development of a data collection program.

All these steps are essential to a strong enforcement effort. After the division between the two Departments, which is scheduled to occur on May 7, the HHS civil rights program will have 590 positions. If the administration's FY 1981 budget request is approved by Congress, that number will increase by 100 positions. We have asked for an authorization of $21,931,000 for the Health and Human Services civil rights program.

The reorganization of the civil rights program is a new factor that we must contend with this year. We are now compelled to spend much of our management time in Washington and in the field offices in an effort to ensure that both Departments can effect the changeover as smoothly as possible.

Even though we are diverted for a brief time from total concentration on enforcement, the opportunities posed for an improved health and civil rights program more than offset the temporary inconvenience.

In building a new program, OCR analyzes the health care problems in three general categories, all of them related: barriers to access to health care facilities by minorities and handicapped persons; disparities in the quality of care extended to minorities and handicapped persons; the extent to which civil rights issues are taken into account by health planning agencies in their project reviews and planning.

This first year we will concentrate on the barriers to access. For minorities, the handicapped, and the aged, the barriers come in many forms and are frequently hidden behind an economic shield that tends to obscure or afford a rationalization for the adverse impact on minorities. For example, many hospitals admit only patients referred by doctors. Minority group patients who frequently rely on Medicare and Medicaid do not always have a physician to open the hospital door.

Many doctors refuse to serve Medicare and Medicaid patients. Faced with such barriers, the minority citizen often enters the hospital through the emergency room door. Even then, some hospitals give the emergency patient only immediate, life-sustaining treatment plus the name and address of another hospital that takes care of poor people.

Some hospitals require a deposit before admission, setting entry rates so high that minority citizens are effectively barred at the admissions desk because they cannot afford to pay.

Still other hospitals have policies in connection with Medicare and Medicaid that raise barriers to minorities. For instance, hospitals that deny services to obstetrics patients have been the target of complaints by women turned away from the emergency ward and referred to hospitals many miles away.

We have found cases in which the hospital might be willing to take patients reliant upon Medicaid but no physician on the hospital staff will take them as patients, again creating a restrictive situation.

Other problems are related to special Federal funding. For example, recent regulations which implement the community services assurance that was given by thousands of hospitals and nursing homes in return for Federal Hill-Burton funds preclude discrimination on any ground unrelated to the individual's need or the availability of services. This community service obligation also bars denial of emergency care to patients who cannot pay. Hill-Burton facilities are required to accept Medicare and Medicaid patients.

We are pleased that the Public Health Service and OCR have recently signed a memorandum of understanding which allows the two agencies to combine their resources most effectively to see that hospitals meet their community service obligations. Community service reviews will be incorporated in the compliance reviews undertaken by OCR. If civil rights violations are found, OCR will secure a remedy. Where the community service assurances have not been honored but no civil rights violations exist, PHS will help OCR to resolve the issues.

HEW recently dealt with one case involving the community service obligation. St. David's Hospital in Texas, which received Hill-Burton funds, refused to become a Medicaid provider. HEW and the Department of Justice sued for injunctive relief.

We have just won a favorable ruling in that case, setting a precedent which should help to open hospital doors for many minority patients. All of these practices may violate Title VI if they are applied unequally to minorities or if the burden falls disproportionately on minorities.

Further, OCR is particularly concerned about still another practice that is heavily weighed against access for minorities—the relocation or closure of hospitals. Inner-city hospitals are often the only source within a reasonable distance to offer minority citizens access to emergency and outpatient care.

Nevertheless, economic reasons appear to dictate closing of some community facilities. As a factual matter, hospitals used by minorities in the inner city tend to be older and in need of renovation. Arguments for closing these old facilities appeal to the public. It is estimated that between 1975 and 1977, 200 hospitals throughout the country closed down.

The Federal Government itself with its emphasis on cost containment may inadvertently contribute to the relocation or closure problem. Reductions in hospital beds are encouraged by HEW. OCR must insure that no civil rights are violated in this process.

Many problems of access result from direct discrimination, which clearly violates the Civil Rights Act. For example, OCR has found that physicians who serve on the staffs of more than one hospital may routinely refer nonminority patients to one hospital and minority patients to another.

Some of these forms of direct discrimination occur as vestiges of historical patterns of racial segregation. In Louisiana, for example, separate hospitals were built for blacks. Race, not ability to pay, determined which hospital was open to the patient. Until 1964 the Federal Government made grants and loans to segregated hospitals under the Hill-Burton Act. Further, until the mid-1960s many nonpublic hospitals did not give staff privileges to black physicians.

American Indians are often denied inpatient and emergency care by hospitals. OCR finds that some hospitals routinely refer them to the Indian Health Service facilities, even though these regional care facilities are located many miles away. This is a violation of Title VI. Indian health facilities are a supplemental resource and other federally assisted hospitals are not relieved of their obligation to accept patients without discrimination.

Some nursing homes, especially fraternally-owned ones, explicitly refuse to admit people of a particular race or national origin. In general, blacks are barred from nursing homes by so many obstacles that they are often reduced to living in unlicensed and substandard boarding homes where they cannot receive Medicaid benefits and where the quality of care is inferior.

Minorities comprise 7 percent of all patients admitted to the Nation's 19,000 nursing homes, which is a disproportionately low percentage. Placement policies of referral agents, such as hospitals, often result in racially identifiable nursing homes where the quality of care for minorities is inferior.

Minorities and handicapped persons also complain that, once admitted to homes, they are assigned to isolated or segregated accommodations. Nursing homes also discriminate by consistently ruling out admission of patients with certain handicapping conditions, like deafness or blindness, and refusing to hire qualified handicapped persons.

Out of its experience to date in health care investigations, OCR has identified many other problems including: refusal by some hospitals to provide inpatient care to persons addicted to drugs or alcohol; segregation of patients based on whether they are clinic patients or private patients, creating racial segregation in parts of the hospital; denial of staff privileges to doctors on the basis of race; denial of equal services to Hispanics and Asians in hospitals and health maintenance organizations which have no bilingual staff; denial of equal care to hearing impaired patients by hospital emergency wards because no interpreters are provided; failure of some health care programs to refer handicapped and minority persons to mental health agencies for counseling or psychological help.

All these problems of accessibility raise questions about the quality of care in hospitals, nursing homes, and other facilities, and this is the second major area that OCR will emphasize in developing policy and carrying out investigations.

Minorities often say that, even when health care is available, the quality of that care is suspect when compared to the quality of care for nonminorities.

The third area in our health care program is the role of federally funded health planning agencies and the extent to which they encourage and enforce policies which foster equality. Health planning as discussed here is the process by which resources are developed to meet present and future needs of the community under the Health Planning and Resources Development Act of 1974.

These health planning agencies have explicit responsibilities to monitor and control the growth of the State or regional health delivery system. The civil rights implications of this new structure are potentially far-reaching but have not been fully explored.

As federally-supported bodies, these agencies—HSAs [Health Systems Agencies] and SHPDAs [State Health Planning and Development Agencies]—have a responsibility to assure that health resources are developed and allocated without discrimination and that the health planning needs of minorities are considered and met. OCR has an obligation to hold them to their legal mandate and is attempting to develop a comprehensive policy for working with these agencies.

In FY 80, OCR plans to undertake 275 Health and Human Services compliance reviews. Plans include the following: 17 reviews for discrimination in accessibility and admissions in hospitals, nursing homes, and extended care facilities; 17 reviews of delivery of services in the provision of Medicaid and Medicare services; 59 reviews of hospitals for discrimination on the basis of national origin or handicap, including bilingual services and capability for meeting the needs of patients with visual or hearing impairments; 59 reviews of welfare agencies for discrimination in the provision of services to minorities and the handicapped; 17 reviews of child welfare referral practices, including foster care, bilingual services, and location of services in terms of accessibility for minorities and the handicapped; 17 reviews of planning activities by health services agencies; 59 reviews of supportive services to the elderly and disabled; 30 reviews of mental health centers and mental health hospitals in terms of equal care and bilingual services.

In addition to the compliance reviews, regional offices will continue to conduct individual complaint investigations and to commence them promptly upon receiving complaints. OCR will undertake more comprehensive compliance reviews of whole systems of health care. We plan a training program this summer to improve the quality of systemwide compliance reviews and complaint investigations.

To obtain more specific data on institutions, OCR is preparing a hospital survey form to help target hospitals which may not be in compliance with the civil rights laws or with their community service obligations under the Hill-Burton Act.

We have also identified the types of data needed for use by health planning agencies. Specifically, OCR believes that these agencies cannot adequately plan for the needs of minorities and other medically underserved persons unless they collect and analyze demographic data and medical indicators of need.

As a final note on OCR plans, I would like to point out that OCR has gained considerable experience in the health field in its extensive investigation of and subsequent legal proceedings against a number of New Orleans hospitals.

In 1971 HEW was sued in *Cook v. Ochsner*, U.S. District Court for the Eastern District of Louisiana, for not enforcing Title VI with respect to seven hospitals in New Orleans. In 1974 OCR agreed in a consent decree to conduct a Title VI review of all hospitals in New Orleans. Central to the review was the collection from all federally aided New Orleans hospitals of data on the number of patients admitted, according to race, method of payment, admission date, and name of admitting physician. Mercy and Southern Baptist Hospitals refused to provide the data until OCR obtained a court order requiring them to do so.

A summary of Title VI proceedings in those cases appears in the background paper which OCR submitted to the U.S. Commission on Civil Rights earlier this month in preparation for this session today. It shows some of the problems we face in reviewing health care institutions and some of the legal processes we use for obtaining remedies.

As Director of the Office for Civil Rights, I am encouraged about the prospects of developing and carrying out a civil rights program directed to the problems of racial and ethnic minorities, handicapped people, and older people in getting proper health care.

We need and seek the support of the Commission and of all Federal agencies whose responsibilities embrace health care and civil rights. Our health care civil rights enforcement program is coming of age at last. We welcome criticisms, relevant information, and, most of all, constructive suggestions in the building of a new program.

Discussion

VICE CHAIRMAN HORN. Thank you very much. Your paper "Health Care and Civil Rights" will be inserted.

I want to ask you some questions to clarify the compliance review strategy. How much staff did you say was moving to the Department of Education, 66 percent? Two-thirds are going to the new Department of Education?

MS. STEWART. That is right.

VICE CHAIRMAN HORN. Do you feel that is a fair allocation, based on the work load?

MS. STEWART. Based on the past work load allocated between Health and Human Services and the Education area, it is a fair distribution. Most of the work had been previously allocated to the Education area, largely because of the pressures in the courts. With the addition of 100 new positions which we hope to have at the beginning of the next fiscal year, this amount will be adequate to support the new program, the new directions undertaken.

VICE CHAIRMAN HORN. If you receive the 100 new positions beginning October 1980, do you feel that they will give you adequate resources to begin the conduct of the 275 compliance reviews, or will those reviews begin this fiscal year?

Ms. STEWART. They have begun.

VICE CHAIRMAN HORN. What is your estimated number of compliance reviews in fiscal '80, '81, '82? Have you worked out a strategy, yet?

Ms. STEWART. Yes. I do not know the exact number of compliance reviews for fiscal '80–'81. I believe it is approximately 300.

VICE CHAIRMAN HORN. Will there be any different allocation between types of health care facilities within that overall number, or generally are these proportions going to be about the same: 17 in hospitals, 17 in delivery of services, 59 reviews, etc.?

Ms. STEWART. By that time we hope to have results of surveys and research. Also, more information from community organizations and complaints which will assist us in targeting new reviews and assessing priorities. We would like to target compliance reviews on those areas where the need is apparently the greatest.

VICE CHAIRMAN HORN. Is it fair to conclude from hearing the proportion of staff that was allocated—and is going to be allocated—in this area, that despite the 100 new positions, HEW really has not reviewed as carefully as it might have access to health care and that most of its energies have been consumed by problems of desegregation and education?

Ms. STEWART. That is correct.

VICE CHAIRMAN HORN. You are now attempting to make up for that?

Ms. STEWART. That is true.

VICE CHAIRMAN HORN. You are now preparing your budget request to OMB for '81–'82? Are there plans to ask for additional positions besides the 100 you hope to receive in October 1980?

Ms. STEWART. It is difficult to say what we will do in that respect. We don't really know what the office will look like after the split between the two Departments. We have not yet identified those individuals who will go and those who will stay.

We don't know what the distribution will be in each office. We will have a great deal of building to do. We don't have very much time to do it in if our programs are going to continue without hindrance. I think within the next 30 days, I would be able to answer that question more specifically.

VICE CHAIRMAN HORN. Under your revised strategy do you see a different allocation of positions for compliance review and enforcement between the national and the regional offices or will the roles of those offices remain approximately the same as at present?

MS. STEWART. The roles will remain approximately the same. The investigations and compliance reviews take place in the regional offices. However, we have been attempting in recent months to increase the communication between the regional offices and the office in Washington, D.C., so that our compliance effort will move forward more smoothly and expeditiously.

VICE CHAIRMAN HORN. In the employment field, since Title VII was passed, there has been an attempt to have both a Federal (EEOC) effort and a cooperative relationship between the local, State, and Federal agency. Has there been any attempt to leverage HHS interest in this area with State departments concerned with public health and hospitals, etc., in order to assure a broadening basis of compliance assistance?

MS. STEWART. We have been working with State agencies. However, State agencies, to my knowledge, have exhibited the kinds of enforcement authority that there is in the area of employment. Title VII of the Civil Rights Act proves State agencies can take the lead and must take the lead in employment cases. We do not have a similar provision in our law.

VICE CHAIRMAN HORN. Is there thought of requesting such a provision of the Congress? Do you feel that would be helpful?

MS. STEWART. I think it is always a good plan to have as many or as much responsibility allocated in civil rights enforcement as possible. The experience has been that many of the State agencies have been less effective in enforcing civil rights matters than the Federal agencies with the same authority. For example, in Title VII area, there are only a handful of State agencies which are doing a superb job in this respect.

VICE CHAIRMAN HORN. Thank you. Commissioner Berry.

COMMISSIONER-DESIGNATE BERRY. I am aware there is a memorandum of understanding between OCR and the Public Health Service. Could you tell me how far along you are in implementing OCR monitoring of the management process or insuring the PHS monitoring of that process so that nondiscrimination is enforced?

MS. STEWART. The memorandum of understanding was signed in December. Staff of both organizations have been working very closely together to implement that. One of the side effects of that memorandum of understanding has been an additional document which has been signed.

An additional regulation was sent to the Secretary which was published in the *Federal Register* last month in which a hospital, in order to get a certificate of need, must state whether or not it is in compliance. It must make a survey of its own compliance standards. This is another step forward in the same direction as the memorandum of understanding.

COMMISSIONER-DESIGNATE BERRY. So, you are in the process of implementing. You are not at the point where you can say that is fully implemented?

MS. STEWART. No. I don't think we will ever be able to say it is fully implemented. I think it is going to be an ongoing process. I hope it will be an ongoing process that will continue indefinitely.

COMMISSIONER-DESIGNATE BERRY. In the case in the Ohio District Court where you stipulated you would send a survey to OMB by the end of this month, are you going to make that deadline?

MS. STEWART. Absolutely.

COMMISSIONER-DESIGNATE BERRY. In the hospital closings about to take place in New York City, has OCR worked out a mechanism to ensure that reasons for the closing do not involve discrimination in the first instance and then to see to it that there is nondiscriminatory access where patients are served even if hospitals are closed? What is the decisionmaking process to insure that discriminatory effects are taken into account?

MS. STEWART. The New York hospital review is still ongoing. We have conducted one pretest to test the validity of our census instrument. We plan to take a census of all of the hospitals in the system to determine whether or not the closing of the facilities in question will have a discriminatory impact upon minorities.

After the census is taken or at the same time we are concurrently investigating the alternative health care services in the area to determine whether or not the closing of these facilities would have a deleterious effect upon minorities.

COMMISSIONER-DESIGNATE BERRY. If it would have a deleterious effect, would OCR see to it that the hospitals don't close?

MS. STEWART. I would certainly hope so.

COMMISSIONER-DESIGNATE BERRY. Are there plans in the works for any suits or matters of that kind against State agencies between now and November 1980 that would cause OCR to directly cut off funds for discrimination?

MS. STEWART. We have investigations ongoing in several hospital cases—several almost ripe to be forwarded for enforcement. We have also directed our investigators to refer cases for enforcement when there becomes a problem of access to information.

We have had several cases, aproximately eight cases last month, referred for enforcement. I cannot tell whether they are school cases or hospital cases. So, we do intend to provide vigorous enforcement in this area.

CHAIRMAN FLEMMING. Mr. Saltzman.

COMMISSIONER SALTZMAN. How significant is the issue of health care availability and quality for moving forward the resolution of other critical civil rights issues like education, employment, and housing?

MS. STEWART. There appears to be direct correlation between the lack of access to health care for minorities and lack of health care to other federally funded services such as education and clinics and welfare services. Frequently when a minority community suffers cutbacks in services of one type, there is a ripple effect and other services are also cut back. This includes housing, education, and so forth.

COMMISSIONER SALTZMAN. Doesn't the availability of good health itself impact on the quality of education or the response to educational opportunity and housing and employment opportunity?

MS. STEWART. Well, in some areas, of course, the housing itself is a major health problem. The housing along with the lack of care, of health care services, would have a tremendous negative effect on the ability of the child to learn, from the point of view of the child's health and motivation and many other factors.

CHAIRMAN FLEMMING. Commissioner Freeman?

COMMISSIONER FREEMAN. Ms. Stewart, you cited several cases in which there have been findings of violation of Title VI. Does OCR, after such a finding, make the recommendation for the kind of enforcement such as termination? What is the procedure that you undertake at that time?

MS. STEWART. Unfortunately, under the statute, the main remedy that we have is cutoff of Federal funds. OCR is relunctant to cut off funds to hospitals because the very beneficiaries that we seek to assist would be further damaged. However, once a finding of discrimination is made, we undertake the attempt to achieve voluntary compliance. Most of our cases are, in fact, resolved through voluntary decisions.

We also have the ability to go into court for injunctive relief under certain circumstances. In many cases, especially in the handicapped area, our recipients are anxious to comply with the law. Frequently, they do not know they are in violation and seek our assistance in helping them to come into compliance. Even in the Title VI area, many of our recipients do want to comply with the law.

We are exploring ways now of enlarging our technical assistance branch. We had in the past been almost exclusively directed towards handicapped problems in the technical assistance area.

COMMISSIONER SALTZMAN. Ms. Ivie states a number of instances of widespread discrimination and said private people or *pro bono* organizations have litigated on behalf of those persons who have been denied the benefits. This seems to be an undue burden that is put on the private individual, when the agency that has the funds and has the resources and has the clout really ought to be doing more.

Would you comment on that?

MS. STEWART. I agree with you. I agree that we ought to be doing more. We ought to be continuously reassessing our resources so we can make determinations as to whether or not they are adequate to undertake these tasks. If they are not, we will seek additional funding in positions.

CHAIRMAN FLEMMING. I would like to pursue a couple of questions asked along the same line. Do I understand the response that you made to Commissioner Freeman's question to mean that it is the policy of OCR, the policy of the Department, not to utilize the sanction that the Congress has put into the law? Namely, cut off funds where there is a violation of Title VI?

MS. STEWART. No. I did not mean to give that impression. We do not have the authority not to do that once the process—

CHAIRMAN FLEMMING. How recently has that authority been used by the Department in connection with findings that there has been a violation of Title VI in connection with access to health services.

MS. STEWART. I cannot recall a case where that sanction has been used. I would like to research that issue and submit it at a later time. (See exhibit 2.)

CHAIRMAN FLEMMING. I would appreciate that very, very much. Let's say, personally, and I think my colleagues share this view, and in fact we have stated it in one of our reports in connection with application of Title VI in another area; namely, that we have the feeling it is very unfortunate when a Department decides not to use the sanctions that the Congress has put into the law to be used when there is a violation of, in this case, Title VI.

We recognize the reluctance persons have to use this particular type of sanction. But as Dr. Lee pointed out in his testimony this morning, it seems to me when a Department is reluctant to use this sanction, it should keep in front of it the number of persons who are being denied access, in this particular instance, to services because of a failure on the part of the Government to enforce vigorously the laws that Congress has passed.

We recognize some people may be able to suggest a better type of sanction. Some people have tried that from time to time. Over the years since 1964, there has been no serious effort made to replace this sanction with another sanction. Until another sanction is filed to replace this sanction, we feel that it is very important for the executive branch to use the authority that the Congress has given them.

It seems to us whenever there is a delay in the utilization of that authority, it is just a signal to everybody else. The effect is, look, we can go ahead and continue to violate the Civil Rights Act and nothing really is going to happen to us.

It is true you can go to court. You can get an order and so on. That takes much longer than administrative action should take. I appreciate the fact that administrative action has been taken. Let me ask this. Reference has been made in the testimony presented here to guidelines issued under Title VI in the area of the delivery of health services. What is the status of those guidelines at the present time?

MS. STEWART. We have several policies and guidelines which are being circulated with OCR at this time. One is a hospital closing policy. There are a number of other policies. We have a nursing home policy, for example. All in all, we have 11 policies which are in various stages of completion and should be published within the year.

CHAIRMAN FLEMMING. Have any guidelines been issued over the years in this particular area up to the present time?

MS. STEWART. In 1969, Mr. Chairman, there was a policy on health care and another policy on nursing homes, I believe. Those have been the only policies issued in this area.

CHAIRMAN FLEMMING. Are they still operative?

MS. STEWART. Yes, they are.

CHAIRMAN FLEMMING. You now have pending about 11 separate guidelines in this particular area. To your best judgment, it will take about a year for all of them to merge?

MS. STEWART. Within the year—less than a year.

CHAIRMAN FLEMMING. You mean within this calendar year? Do you feel that by December 1980 that they will all be out?

MS. STEWART. Yes, I do.

CHAIRMAN FLEMMING. That is the kind of objective that your office and the Department has in mind at the present time?

MS. STEWART. Yes. In fact, we are tracking those not only at OCR but the Department level to assure that those policies will in fact be published. I am reminded that we have deferred Federal funds in the New Orleans case.

I would like to point out the necessity for further sanctions as you have mentioned. Frequently, in a situation where there is a proposal to cut back or close a minority hospital, our major sanction of cutting off funds to that particular hospital could have the effect of destroying the main health care provider within a given community.

So, there is great need for additional sanctions which our office can administer.

CHAIRMAN FLEMMING. Does your office, does the Department contemplate making recommendations to the Congress for additional sanctions?

MS. STEWART. We have been asked for new legislative suggestions. Certainly that would be one of them.

CHAIRMAN FLEMMING. I recognize the fact that there are situations such as the one you described where additional sanctions could be utilized very effectively. But there are also situations where the existing sanctions could be utilized? Am I not correct?

MS. STEWART. That is correct.

CHAIRMAN FLEMMING. Just one other question. Reference has been made to the Hill-Burton institutions and the enforcement of the standards incorporated in the Hill-Burton law. This was related to a nursing home.

Do you have any figures indicating the number of nursing homes that are subject to Hill-Burton percentagewise?

MS. STEWART. No, but I can get that information submitted at a later time. (See exhibit 3.)

CHAIRMAN FLEMMING. Dr. Berry.

COMMISSIONER-DESIGNATE BERRY. Miss Stewart, I was pleased to have your clarification of your response about the funds cutoff when the Chairman asked it. I was surprised and astonished that a Federal official thinks that a law should not be enforced although it is on the books. I am happy that is not your view.

MS. STEWART. I am sorry I did not express it in a way that was more clear. We need all the instruments we can get, community or otherwise.

CHAIRMAN FLEMMING. Mr. Nunez.

MR. NUNEZ. I apologize for not being here for your presentation. We on the staff have worked long in your office for many years. I welcome the opportunity for working with you directly. Thank you for being with us.

CHAIRMAN FLEMMING. Thank you very, very much. We are now in recess until 1:30.

Afternoon Session, April 15, 1980

CHAIRMAN FLEMMING. I will ask the meeting to come to order. My colleague, Commissioner Saltzman, will preside during our afternoon session.

COMMISSIONER SALTZMAN. The early part of the session will deal with the present role in rural health care. Our presenter is George Lythcott. Dr. Lythcott will present his paper on "Health Care Administration in Rural America: The Federally Responsible Government." You have approximately 20 to 25 minutes.

Dr. Lythcott is presently the administrator of Health Services Administration (HSA) of the Department of Health and Human Services. Dr. Lythcott is also the Assistant Surgeon General and Associate Chief Medical Officer with the Public Health Service. HSA funds a variety of programs that provide health care to lower income people, Native Americans, Alaskan Natives, migrant workers, the aged, women, and children.

In addition to his government service, Dr. Lythcott is currently on the advisory committee for the national program to reduce infant deaths in isolated rural communities of the Robert Wood Johnson Foundation, Princeton, New Jersey.

He was appointed by President Carter in 1978 to serve as Alternate Delegate, U.S. Delegation, UNICEF. He is also a clinical professor of Pediatrics and Child Health, Howard University College of Medicine, Washington, D.C.

STATEMENT OF GEORGE I. LYTHCOTT, M.D., ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, ASSISTANT SURGEON GENERAL (USPHS), DEPARTMENT OF HEALTH AND HUMAN SERVICES

DR. LYTHCOTT. Thank you very much. Shall I proceed?

COMMISSIONER SALTZMAN. Yes.

DR. LYTHCOTT. I will introduce three members of my staff, three senior managers, who have asked to come with me. We would like to be as responsive as possible when there are questions from the audience. I am making certain I will provide the best answers.

My staff members are Emory Johnson, Director of the Bureau of Indian Health in my agency, and John Marshall, Deputy Director of the Bureau of Community Health Services. Jeff Hammon, Deputy Director for the Office of Planning, Evaluation, and Legislation, is in the building and will be in the room shortly. If questions come up that I cannot respond to, I will turn to them, if you will.

Distinguished members of this Commission, panelists, guests. Our written report is in your hands. What I have to say to you in person today deals with the problems still confronting us in delivering health care to rural America.

About 27 million rural citizens live in areas officially designated as areas of medical manpower shortage. These shortages exist because most doctors do not care to serve people who are poor and who live in awkward places. Part of the problem is that doctors are discriminating in where they choose to practice. But that is only part of the problem.

The more pervasive discrimination occurs between doctors in rural private practice and minorities who come to them for medical attention. It is visible in some places where an actual wall separates white and nonwhite patients in the waiting room.

It also manifests itself in the encounter between white doctor and black patient. Time is a vital ingredient in the quality of health care. Patients, particularly if they are poor and suffer language problems, need the doctor's time. They need to hear from the doctor why it is important to take the medicine or what side effects to watch for. They need advice about diet or habits that may harm them.

You have all heard about the Medicaid mills that diagnose, prescribe, and bill. The patients there may be getting the right kind of medicine but they are not getting the right kind of health care.

The clinical staffs who man our community health centers practice people medicine. They take time to see that the black mother understands. They take time to make sure her baby gets immunized. They take time to provide pap smears and screen for hypertension. They refer patients to the right facility if they need advanced treatment or diagnosis.

This is comprehensive care and all too often minorities don't get it outside of the clinics we operate. This is all the more tragic because they need more attention, not less, because poverty spawns diseases and disability. Poor diets, substandard housing, broken homes, and the sheer frustrations of life lived under these conditions create ill health.

Reality is not a happy experience when you are poor, black, and suffering the hundred insults of a society that fails to provide jobs, decent incomes, and the self-respect that comes with them. That is why minorities suffer a disproportionate share of what I call the diseases of despair—alcoholism, drug addiction, child beating, suicide, and homicide. Small wonder that black life expectancy is 7.5 years less than whites; that black newborns have a 50 percent higher death rate as measured by those who die in their first year of life; that studies show that when blacks see a doctor, they are quite a bit sicker than whites.

Despite these obvious deficits in health, minorities do not enjoy equal access to health care, even though they need more care. What is even worse for them, they do not even control the circumstances that conspire against them. Mississippi's population is at least 32 percent black. But not one black person sits on the State board of health and not one black is a member of the State hospital commission.

Yet, there can be little doubt that the Nation's overall health would be vastly improved if our minorities had an equal voice in the deployment of our health care resources. For example, the Surgeon General's Report, *Healthy People,* points out that America is well down the list in some major health indicators among the family of nations. Yet, if the health of minorities in America equalled that of the rest of our population, we would rank much higher on that list.

In that same report, the Surgeon General has set forth goals for 1990 of reduced mortality among infants, young people, and adults. Those goals would very nearly have been achieved now if America's minorities had the health care enjoyed by others.

Discrimination and poverty lie at the root of our Nation's health problems. That is abundantly clear. It is also clear, as this Commission knows, that discrimination is not going to disappear in America by wishing it away. There is no magic wand we can wave over the problem.

But we do have a potent instrument for attacking that problem—the Federal Government. With this instrument, we can introduce structural changes that will place in the hands of minorities the power to shape their own destiny in health care.

Minority peoples need to become a part of the decisionmaking apparatus in health care. Part of that apparatus are doctors and health care providers. There are all too few black, Hispanic, and Indian doctors today.

Likewise do we need to ensure that minority people are represented in the institutions that govern the healing arts professions—hospital boards, planning agencies, and professional groups. This will change the power relationships, and that is precisely the strategy pursued by the programs we administer through the Health Services Administration. It is, in fact, a strategy supported by the Federal laws governing these programs.

The law, for example, requires that half of the members of the governing boards that direct policy in each of the 903 community health centers we support must be representatives of the community being served. If a community is 80 percent black or Hispanic, its governing board will reflect that fact.

These centers enjoy a high degree of patient satisfaction and they are providing comprehensive care to the people of the communities they serve. By way of direct contrast, consider what has been happening with the wave of hospital closings and relocations in urban areas this past decade. In 3 years, 1975 through 1977, 231 urban hospitals have closed or relocated. These hospitals served surrounding areas that were heavily populated by minorities, chiefly blacks. But minorities are virtually invisible on the board of trustees in these hospitals.

The results speak for themselves. One study shows that the higher the proportion of blacks living around a hospital, the more likely it is the hospital will either close or relocate. Statistics tell that story: In neighborhoods with up to 25 percent blacks, only 14.2 percent of the hospitals closed between 1970 and 1977. But in neighborhoods that were 76 percent to 100 percent black, nearly 47 percent of the hospitals did a disappearing act.

Being black and without power means that the hospital in your community can close its doors and just go away. Imagine that happening in an affluent suburban community. Like it or not, hospitals operate on business principles and poor black families aren't good business because they can't pay. This means a higher pile of bad debts for the hospital and eventual flight.

This raises a question that we have yet to address in our dialogues. Is health care a business or is it a vital human service? And if it is the former, can it possibly do justice to its compassionate mission in our society?

I think that we must put a human face on the institutions that provide health care. The way to do that, I believe, is to make sure that minorities have a say about the operation of the institutions that provide health care to minority peoples. The poor and the forgotten must be able to shape their own destiny in health care. They must be fairly represented on the governance mechanisms—or those mechanisms cannot possibly respond to their needs.

Nations that do not have the varied ethnic makeup of ours need not consider solutions like this. Our Nation, which does, must. I see no other way that is fair, democratic, and in the interests of the Nation's health. If minorities have a say in their health care, then the resources needed to provide that care will tend to deploy where minorities live. Lacking that power, our minorities will continue to suffer chronic shortages of health manpower in the communities where they live.

If a national health insurance program offering open-door care to all were enacted tomorrow, it would not solve the problems of access that minorities face. National health insurance might well worsen their dilemma. Minorities would have a ticket to health care under national health insurance, but the resources would still be located where they could not get to them.

That's why it is so crucial we continue to expand the programs we administer—Community Health Centers, the National Health Service Corps, the Migrant Health Program, the Appalachian Program, the Indian Health Service.

On that account, we have had excellent support from President Carter. In the past 3 years, we have nearly doubled the number of

Community Health Centers and we have been able to increase substantially the field strength of the National Health Service Corps.

But medical schools need to do their part too. I believe they need to select and inspire more young men and women to seek careers that will serve minorities and underserved rural people. We have a shortage of medical students in minorities. Not every black or Hispanic physician will go forth to serve people of their minority, but I believe enough will to help ease shortages in rural areas and inner cities.

Despite this, the trend shows that there are a lower percentage of black medical students now than there were a few years ago. Actual numbers may be on the increase, but percentages are on the decline. In recent years, the percentage of black and other underrepresented minorities being admitted to medical schools has dropped. It never did reach the 12 percent goal by 1975 that was sought. If that trend keeps up, the doctor shortage will end in this decade for the majority of Americans, but it could very well remain in shortage for people who are black, Hispanic, or Native American.

I believe that medical schools have an obligation to train physicians for all America. It is a fundamental reason for their existence. They have a further obligation to assist in motivating medical students to serve in primary health care, where the needs of America's minorities are great.

At the very least, the medical school experience should not serve as an active discouragement to students who want to practice primary care medicine in underserved communities.

Yet, the evidence we have shows that this is exactly what has been happening. One study which followed the career preferences of medical students over several years found that only half the students who came into medical school wanting to practice primary care still wanted that after their fourth year, while hardly any who were originally interested in another field of medicine switched their interest to primary care. With influences like that at work, what chance do we have of creating enough physicians to serve in primary care in rural America?

This influence is at work even among the students whose tuition the Federal Government pays in return for periods of obligated service with the National Health Service Corps. For example, five medical schools today have a student body made up of more than 20 percent on Corps scholarships. Twelve medical schools have somewhere between 10 percent and 20 percent of their students on these scholarships.

Yet, these students are being educated in an environment that may be actively discouraging them from pursuing their Corps commitment beyond its obligated period. If so, we stand less of a chance that those future physicians will stay on in underserved areas. Yet that is the purpose of the legislation creating the National Health Service Corps. Congress wanted to create a mechanism that would attract physicians and other health care professionals to lifelong careers among the medically underserved.

Most medical schools are focused on the cure of disease today and upon biomedical research. This produces physicians in the subspecialities and it produces researchers, neither of whom find their workplace in ghettos, rural outbacks, and Indian reservations. Surely the places where we train tomorrow's doctors can open its selection process and its curriculum to accommodate young men and women who will serve in these places where they are so desperately needed.

Meanwhile, until we change the basic dynamics, we will continue to suffer shortages of doctors in rural America and in places where a preponderance of minority peoples live. This is an issue of pressing importance and one to which this Commission might address itself.

I would like to turn now to the health problems of another minority—Native Americans. There are about 777,000 Indians living on or near reservations in traditional Indian country, such as Oklahoma, where I once served.

Twenty-five years ago, the Indian Health Service (IHS) was a small program providing only acute care to the desperately ill. It has come a long way since then, both in terms of service and in sensitivity. A few decades ago, the IHS was administered like a colonial office—providing service to passive recipients of whatever care the Federal Government chose to provide.

All that has changed under the impetus of two laws enacted this past decade, the Indian Self-Determination Act and the Indian Health Care Improvement Act. These laws vest with the tribes of America the power to plan the direction, style, and delivery of health care provided to Indian peoples. This offers yet another example of how we must change the power relationships if we want to introduce real change rather than mere token gestures.

The status of Indian health has steadily improved over the years, but problems in Indian health still reflect that the overall caliber of health care must continue to improve. The death rate for Indians is still 1.1 times as high as the infant death rate for the general populace. The death rate for Indians as the result of alcoholism is about five and a half times as high. And many Indian homes still lack modern systems for solid waste disposal and an adequate supply of pure drinking water.

Financing problems also exist. The Indian Health Service has had trouble getting adequate reimbursement from Federal entitlement programs, even though it is entitled to receive monies from State Medicaid agencies for providing health services through its facilities to

Indians eligible for Medicaid. States have been unwilling to recognize Indian Health Service facilities for physician reimbursement. We are working now with the Health Care Financing Administration to correct this problem.

Typical of these problems is the refusal of the State of Arizona to pay for care provided to Indians served in the Arizona Preemie Program for high-risk premature infants. Arizona's position is that the cost of medical care provided to Indians is solely a Federal responsibility. We maintain that Indians have the same constitutional right of equal access to this program as other citizens of Arizona.

Because of this impasse, we have refused to reimburse providers of preemie services until Arizona agrees to pay its share of the cost. This matter may come to a head because the Department's Office for Civil Rights supports our position. It may issue a letter of findings to Arizona before long. In the meantime, the Public Health Service has agreed to ease providers' cash flow problems by paying 75 percent of their billed charges, pending a final outcome. This way, providers of care will be paid while the civil rights issue is pursued through legal channels.

Meanwhile, we still have a doctor shortage in the Indian Health Service. We believe that this shortage could be eased if more young people from the tribes are provided with special opportunities to become physicians or other health care professionals. More Indian doctors and nurses would then serve as models for Indian young people to consider becoming doctors themselves.

We also get complaints from some tribes about problems of cultural insensitivity to Indian customs and practices. Our response is to request the tribes to provide their own orientation for new doctors who arrive on the scene. Some do and some don't; in any case, this is the tribes' option. All we can do is to provide the resources for these sessions. In fact, most of the tribes' complaints to us center around the need to keep what doctors they have, regardless of their race.

The Indian Health Service provides environmental sanitation services that are assisting more and more Indian villages to acquire decent sanitation facilities and pure water. Our people work closely with tribal chiefs in the planning and design of these facilities. But there are environmental problems that lie beyond our jurisdiction.

No one thought, for example, to consult the Indian people living around the Prairie Island Nuclear Power Plant before that plant went into operation or was built. Federal authorities just gave a go-ahead, an action that would be unthinkable if the siting of a nuclear plant were being contemplated in an area populated by white citizens.

When an accidental venting of radioactive steam occurred last year, the Indian tribe wasn't even notified by State and local authorities.

Only when our Indian Health Service people learned of the problem were the Indian people notified. We then served as advocates for the Indians in trying to develop a responsible emergency plant that included the Indian community involved.

The same kind of heedless action was demonstrated in the case of Navajos hired to work in the uranium mines of Arizona and New Mexico. The knowledge that radiation exposure causes cancer is centuries old. Yet Navajo workers were sent to work these mines without proper safeguards, and as a result, some may die of lung cancer. Where were the Federal agencies responsible for the safety of uranium mines?

Tailings from these mines were deposited for 15 years around Indian dwelling places, without so much as a by-your-leave. In spite of urgent pleas by the staff of the Indian Health Service, the Federal agencies responsible took no action.

We are now investing money to stabilize these tailings and move people out of dwellings with high radiation counts. The major uranium tailing piles have been identified and cost estimates provided under provisions of the Uranium Mill Tailing Act. We still have additional samplings and studies to make in order to identify several small mining operations and fully evaluate any health hazards.

This concludes my remarks, but I cannot end this report to you without mentioning several laws that have an impact on rural underserved peoples and minorities.

One is the National Health Planning and Resources Development Act which aims at creating a network of health planning and resources development agencies at the regional and State levels. That law requires that no less than 25 percent of the allotments to the States for medical facilities projects be used for outpatient facilities to serve medically underserved people and that half those allotments be invested in medically underserved rural areas.

A second law with far-reaching potential for the rural underserved is the Rural Development Act of 1972. It requires that goals be established for rural development that include employment, income, housing, the quality of community services, and facilities. This law will have a decided impact on the health and quality of life for rural people, who are seriously affected by disease, inadequate shelter, bad water supplies, and substandard sewage systems.

It calls for strengthening primary and preventive care by integrating services in rural areas. By pulling together manpower, support services, facilities, and technical expertise at the local level, this law seeks to create an independent, self-sustaining capability in health care in rural areas.

The Health Services Administration and its far-flung facilities in rural areas—detailed to you in our written report—will have an important role to play in developing this capability. By making our resources work together and by joining them with an increasing level of State and local resources, we can make tangible progress in providing comprehensive and compassionate care to minorities and others living in underserved rural areas.

To many Americans, the health problems of minorities in rural America are invisible, but I have spent years of my life there and in the inner-city ghettos ministering to human need; and to me, these people are not invisible. The vivid memories of those years are with me each day, as I carry out my responsibilities as Director of the one agency created to alleviating their plight. The members of this Commission are in a position to give voice and visibility to that plight. You are the vested conscience of America and we look to you.

Poverty and discrimination in America will retreat when we change the structures that support and perpetuate it. Only the Federal Government is capable of changing those structures. That is why the recommendations you will make are so crucial, and why I conclude my remarks today by offering the members of this Commission my support and best wishes in the agenda before it. We have an unfinished agenda ahead of us in health care and you are at the cutting edge of it.

Thank you.

COMMISSIONER SALTZMAN. Mr. Belindo has been director of the National Indian Food and Nutrition Resource Center since 1979. This agency is responsible for ensuring effective implementation of Federal, State, and local food and nutrition programs for American Indians and Alaskan Natives.

Between 1976 and 1979, Mr. Belindo was executive director of the National Indian Health Board, Inc., responsible for coordinating functions related to health areas of Indian affairs, specifically programs, delivery systems, manpower, evaluation, health planning, and legislation. From 1973 to 1976, he served as national director of the Native American Legal Defense and Education Fund, Inc.

Mr. Belindo has also served as project consultant to the Institute for the Development of Indian Law and as a member of the Indian Rights Committee of the American Civil Liberties Union since 1973. He is a member of the Kiowa Tribe, from which he has received honorary awards.

Mr. Belindo received a B.S. degree in biology from Central State University in Edmond, Oklahoma, and has participated in the executive program of the School of Business Administration at the University of New Mexico.

Mr. Belindo, would you begin.

RESPONSE OF JOHN BELINDO, DIRECTOR, NATIONAL INDIAN FOOD AND NUTRITION RESOURCE CENTER

MR. BELINDO. Mr. Chairman and other members of the Civil Rights Commission and Dr. Lythcott, I want to thank you for this opportunity to respond to Dr. Lythcott's paper. First of all, I would like to clarify the issue of the American Indian population. This seems to be very critical to American Indians and Alaskan Native people. Presently, we have to base our population figures on the 1970 census. I believe there are some modifications with respect to those population figures as given in health plans which have been submitted by tribes to be acted on by Congress this year. We hear that the 1980 census will be an accurate, quantitative measurement of the Indian population of this country. But today the American Indian population is often discussed in terms of the following broad demographic groups: They are the reservation Indians, consisting of an estimated 400,000 American Indians who live on the areas commonly referred to as federally recognized reservations; the largest population of reservation Indians is located in Arizona; rural Indians, consisting of an estimated 300 American Indians who live near, but not on, the federally recognized reservations and in other rural areas; and urban Indians, consisting of an estimated 300,000 American Indians who live in or near various urban centers. The largest urban Indian populations are in Los Angeles, Tulsa, Oklahoma City, San Francisco, and Oakland.

When we discuss the rural health care delivery system or the Federal role in delivering rural health care medical services, I think this Commission has to see the recipients of those services in these three categories—either as reservation Indians or rural Indians or urban Indians.

I believe many of these initiatives which are a part of the Bureau of Community Health Services are those programs that relate most effectively to Indians. These are the National Health Service Corps and the Community Health Centers. Those two programs are impacting upon Indian populations across the country. The reason for this is that the Indian Health Service takes the position that they are a residual provider of health services to Indian people, whereas in many, many cases, Indians see the Indian Health Service as the primary provider of these crucial services.

I know that before the Indian Health Care Improvement Act was passed on September 30, 1976, the urban Indians were a totally forgotten segment of our Indian population. None of the federally sponsored programs were made available to the urban Indian population. Consequently, a lot of Indians were terribly disappointed by having to make the transition from a reservation or rural life style to an urban life style. Now, with the Indian Health Care Improvement Act, which makes monies available to urban Indians concerns, the health problems of urban Indians are beginning to surface as very critical issues.

I believe any time you discuss a rural health initiative, it must apply to the reservation Indians, as well as to the rural Indians. I think that there are other programs within the Bureau of Community Health Services that have relevance to Indian populations. I can get that information for this Commission through the Indian Health Service.

I think another important part of Dr. Lythcott's presentation is minorities, especially Indian minorities who have a very difficult time participating in the decisionmaking process. Participatory democracy has only come about for Indian people during the last 75 years. I will not take the time this afternoon to draw a historical perspective for this Commission. But Indians are just beginning to flex their muscles in terms of utilizing actions furnished by Congress to lay down methods of self-determination within the Indian community. Some of those instruments which Indian people are fortunate to have are the Indian Health Care Improvement Act, mentioned previously, and the Indian Self-Determination Act, which was passed 5 years ago. These two acts provide the leverage that Indian people require in assuming managerial responsibilities, not only for their health care programs, but other developmental activities which could raise the level of the individual within the community and, subsequently, the developmental level of the tribes within the various States.

So whereas, Indians have had a very difficult time in gaining access to participation of these programs, we do now have instruments furnished to us by Congress which make it somewhat easier.

Also, another aspect of Dr. Lythcott's paper, which I thought was very interesting: "Is health care a business or a vital human service?" I think that health care in the sense of the Indian care delivery system is a vital human service. We have experienced some problems in dealing with health systems agencies because of the tribe's own unique, planning processes. Indians feel that there should be a separate planning process apart from the health systems planning process that are utilized in the various States by HSAs.

We are hoping that if health systems agencies or a creation of statewide health systems planning mechanisms do arise, that Indian people will feel a part of that. We are not too sure about national health insurance. We feel if this country decides to develop and implement national health insurance legislation, we would strongly defend the ongoing Indian health care delivery system we have access to now.

Another interesting point of Dr. Lythcott's paper is the remarkable shortage of minority medical students. Two years ago, I was chairman of a study group that studied the feasibility of an American Indian School of Medicine provided under Title VI of the Indian Health Care Improvement Act. In that particular study, we found that Indian medical students or Indians desiring a medical education wanted their own separate institution because of cultural barriers, because of a feeling of isolation, and because of other medical institutions which were seemingly insensitive to the needs of Indian medical students.

We also felt that the Indian medical student is often largely forgotten. In my discussions with them, they felt that a separate institution would meet their needs. However, when this report was turned over to the Secretary of Health, Education, and Welfare, his recommendation to the United States Congress was that we come up with alternatives to an American Indian School of Medicine, rather than having Congress set aside appropriations for a separate institution.

Dr. Lythcott made references to the State of Arizona refusing to pay for a program because they felt it was a Federal responsibility. That is not an isolated case. There are other States reporting that attitude. We are also very aware of the acute environmental issues described by Dr. Lythcott, namely, the Prarie Island case and the nuclear waste contamination problems that the Navajos in New Mexico are having at this time.

I feel once again, in summary, when we examine rural health care delivery for Indians and Alaskan people, we have to usually go through reams and reams of various congressional acts applying to that delivery. Hopefully, with the cooperation of the Indian Health Service, tribal governments, and the Indian organizations, we can improve access to rural health care for American Indian people.

Thank you very much for this opportunity.

COMMISSIONER SALTZMAN. Thank you, sir.

Next is the respondent, Ernesto Iglesias. Mr. Iglesias has served as the deputy director of the Rural Health Division in the California Department of Health Services since May 1979. He is responsible for planning, organizing, and directing the activities of that division, including the development, implementation, and maintenance of primary care and public health care services for individuals in rural areas of California.

Prior to becoming deputy director of the Rural Health Division, Mr. Iglesias served in a number of positions related to the administration of health care services, including 10 years of work in rural mountain communities of New Mexico.

During the past 10 years, Mr. Iglesias has been a consultant for private and community nonprofit organizations' clinics in rural areas. He also has given lectures for the following organizations: University of California, San Francisco Medical School, Community Clinics; University of California, San Francisco, School of Nursing, Community Clinics, Health System Agencies; California Mini-Corps, Rural Health in California; Migrant Education-Health component, Coordination of Rural Health Services; Chicano Health Institute of Students, Professors and Alumni, Rural Health and Politics, Tax Initiatives (impact on Raza health programs).

Mr. Iglesias.

RESPONSE OF ERNESTO IGLESIAS, DEPUTY DIRECTOR, RURAL HEALTH DIVISION, STATE OF CALIFORNIA, DEPARTMENT OF HEALTH SERVICES

MR. IGLESIAS. Distinguished Commissioners and guests, I have a feeling that the Commission planned this audience to be sparsely populated to reflect the rural areas. A few in number, but high in quality for sure.

I want to thank you for allowing me to share my thoughts and concerns about the quality of health care in rural areas. I prefer to discuss the specific issues raised by the Commission within the context of Community Health Clinics. I believe it is necessary to take into account at least the following points when responding to the issue of whether the scope of services afforded by the primary care provider is sufficient to assure both a full range of preventive and treatment services.

A major dilemma for rural clinics is the historical scarcity of funds and health professionals, as has been eloquently stated by Dr. Lythcott. The major population shifts from urban to rural areas in the seventies places more of a strain on the rural health resources currently existing. Because of the population shift, efforts are being made by all governmental levels to channel more resources into rural communities.

We must put more of our energies into coordinating these efforts to make the resources and avoid duplication. There is an increase in the number of individuals attracted to rural areas to live alternative life styles. Also, more people are retiring in rural communities who must depend on resources that may not be sufficient for their needs.

Public health departments are also a victim of scarcity of resources. They have difficulty in meeting the increased demand for services while experiencing more of an economic pinch. Not only are urban hospitals closing, but so are rural hospitals. It is essential for Federal, State, and local agencies to refine methodologies used in determining underserved areas. For example, in rural areas, there is a disproportionate number of retired physicians. While they have retired from practice in urban areas, they decide to open up a practice and have office hours 2 days a week in a rural community. When people go around counting physician ratios to population, those 2-day-a-week physicians are included. What that does, as you can guess, is it presents a distorted picture of physicians to population ratio. That is a serious situation. What happens is that it has a negative impact on the decisionmaking process to allocate resources, which results in a form of discrimination.

There is also an increase in the number of individuals attracted to rural areas who, for reasons other than the desire to be in quiet areas, want to experiment with the different ways of living, as I indicated earlier.

The consequences of that is their styles of life are not in conformity to the "accepted mode of living." This puts a strain on the Public Health Departments because the sanitarians can't go in and claim that the tent is unsafe and a hazard to the health and welfare of the individuals, because they are on private property.

Another factor of health care services requiring attention is the very critical issue of acceptability. You often hear other criteria, such as scarcity of physicians, facilities, and availability, but acceptability is very critical for individuals who happen to be American Indians or Hispanics, especially farm workers.

In general, I believe it is safe to say community clinics, through the efforts of Federal, State, and local governments, have made an improvement in the health status of rural residents. If these clinics are not actually doing it, they have the potential and intent to provide services which assure both a full range of preventive and treatment services in rural communities. Much work, however, remains to be done in assisting clinics, as well as public health departments, to improve on this issue raised by the Commission.

I think we also have to look at the overall improvement of community health and socioeconomic status of individuals living in rural areas. We cannot look at health in a vacuum. These clinics assist in drawing attention to health and safety hazards in a community and contribute to their resolution.

Another issue raised by the Commission is whether the system follows a protocol of their efficacy and safety. From a rural community clinic perspective, it is important to consider the evolutionary process clinics go through and the state of the art of quality health care evaluation.

Dr. Lythcott mentioned earlier, or asked the question, is health service a business or is it a service? Unfortunately, funding agencies too often, without thinking about it, come up with ways of treating clinics as a business. In meetings, you often hear reference made, "I don't know if that is a good investment. We are spending too much money there, and we are not getting our money's worth." Certainly one can understand that, but that kind of talk leads to another barrier to understanding the evolution of clinics. That is, the insistence of some funding sources on treating clinics in the linear planning mode, which you really cannot do in health care. Funding agencies—both public and private clinics must meet minimum standards of quality and productivity.

In addition, clinics are required to employ staff qualified to provide the services. We have to admit that funding agencies are struggling with the conflict between productivity and the demand of quality. Some providers interpret quality to mean one patient per hour. That, of course, equals not a very cost effective way of providing services.

A brief description of the evolutionary process of clinics is what I wish to present now. The planning and development phase is really a critical part of the community development. This phase usually includes organizing the community, writing the proposal, obtaining funds, and, a very important part, board training.

The implementation phase is just as important as the planning and development phase. It is at this point when the clinic experiences its growing pains and learns how to respond to both the funding requirements and demands of the patients.

The realities of obtaining qualified staff and keeping them must be dealt with at this stage of clinic development. In some rural areas, it is easy to attract them because maybe it is located next to lakes or ski resorts, but then the clinics cannot pay the $45,000 that some physicians would like to have. A salient reality clinics must deal with is the requirement funding agencies place on clinics. That is, self-sufficiency within a given period of time.

Because many clinics service low-income people, I, for one, contend that the self-sufficiency requirement is, at this point in the history of health services, unrealistic, with all due respect to my boss and other people who make these demands on clinics.

Another issue in the evolution of clinics is the state of the art of quality evaluation. The art is such that most clinics and funding agencies are not satisfied with the existing evaluation tools. A major barrier to development of this tool is the difficulty of quantifying qualitative outcomes. That is just a general overview of the rural health situation.

I would like at this point to focus on farm worker realities. Some points that I want to make are: There is a need to identify and conceptualize the principle policy forces which play a role in generating resources and in implementation of resources to farmer populations; service delivery styles and patterns must be adapted in order to expand primary care services to farm worker populations in existing target areas and to expand services to other target areas for farmers.

The impact of service overlaps from various departments must be realized. Available program resources can be optimized through the interagency agreements, as exemplified with the interagency agreement between health services at the Federal level and the Farmer's Home Business Administration.

In California, we are attempting the same thing. California is one of the few States, if not the only State, that is funding community clinics directly. We want to enter an agreement whereby community clinics can make the loan for facility development.

Historically speaking, a variety of factors have led to and reinforced the categorical and piece-meal approach to the problems of farm workers. The following combinations are the primary elements of the policy enforcement of farm workers which have dictated the piece-meal allocation of resources.

I think, without malice intended, many of the funding agencies do not take the following factors into account. That is, the historical factors. How did people get interested in farm workers? One of the underlying modus operandi, if you will, of thinking and looking at farm worker issues is the sympathy factors or, as some people call it, the missionary factor.

Since the mid-sixties, the visibility of the United Farm Workers Union and its struggles have served to thrust the plight of farm workers into the national limelight. This brought about a lot of liberal support. Very conscientious individuals have tried to help improve the plight of farm workers. Hence, the label of the missionary approach.

The inability of public policy makers to define farm workers as an occupational or sociocultural cluster is a critical factor and contributes to discrimination against farm workers. I wish to suggest that the Commissioners put a lot of emphasis in looking at farm workers, not as a minority, but as an occupational cluster. That is what we are trying to do in California.

The factors I have mentioned, or more often a combination of factors I have mentioned, have sponsored concepts regarding farm workers and their needs. I think it is important for all of us to begin to change the way that we look at things.

The challenges we face are enormous. One area is research. I think it is important to note that too often when we hear statistics such as farm workers' life expectancy is 49 years of age, that the American Indian suicide rate is four times the national average, especially among young males, you don't see that too often. What do they mean?

I think we have to really develop a method of addressing what those things mean. Suicide is a real strong statement to make. Young males?

Four times the national average? That is pretty heavy duty, as people are prone to say in some areas.

I want to thank you all for allowing me this opportunity. I wish all of us good luck in this horrendous task in addressing these problems.

COMMISSIONER SALTZMAN. Thank you.

Next we have Dr. Aaron Shirley. Dr. Aaron Shirley has been the project director for the Jackson-Hinds Comprehensive Health Center since 1970. The community health center serves 22,000 residents of the city of Jackson, Mississippi, and rural Hinds County.

Dr. Shirley has been involved with rural health care since the late 1960s. In 1967–1968, he was the director of the Mississippi Action for Progress, which provided health and education services to 6,000 children in rural Mississippi. From 1968 to 1969, he was a clinical pediatrician for Tufts Delta Health Center, which was a comprehensive rural health project serving 28,000 people in the Mississippi Delta area. Dr. Shirley continues to serve on a number of committees and advisory boards concerned with health care, including: chairperson of Health Task Force, Southern Regional Council; Advisory Board of the Rural Practice Project, Robert Wood Johnson Foundation; National Health Insurance Advisory Committee, Department of Health, Education, and Welfare; Select Panel for Promotion of Child Health, Department of Health, Education, and Welfare.

In 1976 Dr. Shirley received the Charles Caldwell Award for Community Services, Jackson, Mississippi, and the Citizenship Award for Outstanding Health Service in 1970 from Omega Psi Phi Fraternity. Dr. Shirley received a B.S. from Tougaloo College in 1955 and his medical degree from Meharry Medical College in 1959.

Dr. Shirley, would you take the mike, please.

RESPONSE OF AARON SHIRLEY, PROJECT DIRECTOR, JACKSON-HINDS COMPREHENSIVE HEALTH CENTER, MISSISSIPPI

DR. SHIRLEY. Commissioner, Dr. Lythcott, and guests, I am indeed appreciative of the opportunity to come before you and present briefly my views on the problems of rural health delivery in our community. More specifically in a certain region, the South.

As a practicing physician in the State of Mississippi for the past 20 years, I have been keenly aware of too many of the problems of health care delivery in the rural South. I would speak specifically of this region.

Large numbers of people in this area have historically been denied access into the traditional medical services system. This fact makes the Health Services Administration's programs described by Dr. Lythcott even more important. Poverty, race, rural residence, and hostile environmental conditions have proven to be very strong and powerful barriers.

Over 10 million people, 20 percent of all of those living in the 11-State South, have incomes below the Federal poverty level. Twenty percent of the population is nonwhite. In Mississippi it is 37 percent. In four deep South States, half of the people live in rural areas. In five States, over a third. In nine States, the percentage of dwellings lacking some or all plumbing facilities is twice the national average. Each of these factors is interrelated, and the combination of these barriers has had a definite impact on the health levels within the region.

This is especially true of minorities and the poor. Some leading indicators of health status reveal that rural southerners have poorer health levels than other citizens and therefore a greater need for a wider range of health services. Infant mortality rates in the South are much higher than other areas of the country. General death rates are 22 percent higher—65 percent for infant mortality among blacks, higher than among whites. General mortality rates are higher with the greater incidence of poverty.

The rural South has greater incidence of accidental deaths, more disability, and more chronic conditions than do citizens of other regions. Clearly, the Health Services Administration programs serving rural Americans are alleviating many of the barriers inherent in the Nation's health delivery system. These programs have proven effective against the barriers of poverty and morality, where they have been implemented in accordance with appropriate Federal regulations and guidelines.

However, the barrier of race is still the single most influential factor affecting access and, ultimately, health status among blacks in my region. The discriminatory practices among private health providers, particularly in the most rural areas, such as separate waiting rooms and different office hours, are common. Black patients also receive poor quality care from some rural providers. We have had elderly patients come to us for the first time where they had been previously receiving their care from private white physicians. They had been surprised when we asked them to undress in order that we can give them a physical examination. This is especially important since black consumers have few, if any, options among medical care providers in many rural settings.

Discrimination is not restricted to the private sector. In addition to the blatant example cited above, there is more subtle, but equally damaging, discriminatory programs among public supported programs designed to provide services to the poor. If left unchecked, it will destroy the effectiveness of the Health Services Administration program.

These programs involved in health planning and financing could hold the key to continued existence and effectiveness in community health centers. As stated by Dr. Lythcott, the State Health Planning and Developing Agencies (SHPDAs) play a major role in designating areas medically unserved and thus eligible for community health centers and funding.

The nature of these should reflect the makeup of the State. There are serious faults which allow an all-white SHPDA to exist where the population is 40 percent black, especially where blacks represent this population and are affected by rising health care costs and maldistribution of health care providers. It is not a secret that where discrimination begins on boards and commissions, discrimination will follow in program development and allocation of resources.

The Mississippi SHPDA has been living proof of this. Discriminatory practices in agencies dealing primarily with financing is also a great barrier. A case in point is the distribution of the Mississippi Medicaid dollar. When we look at the distribution of the Mississippi Medicaid dollar, we find something very interesting. It is a fact. The potential problems to be caused are tremendous. Whereas whites comprise only 25 percent of Medicaid recipients in the State of Mississippi, they receive 50.2 percent of the Medicaid dollar. That is $3 for every $1 for blacks. As medical care costs have increased and restrictions placed on Medicaid expenditures, areas in which services are cut are those areas primarily of benefit to blacks.

In the case of Medicaid, that is physician services, dental services, prescription drugs, and outpatient care. When we take into account the limited resources of the rural program in the South, we can see the adverse impact of this attitude on the part of Medicaid. Half of all poor children in the Nation are covered by Medicaid. In Alabama, Arkansas, Louisiana, Mississippi, South Carolina, and Texas only 1 poor child in 10 receives Medicaid benefits.

Since rural health initiative programs have limited funding and rely primarily on Medicaid for third-party revenues, any cutback for reimbursement for medical services, prescription drugs, eliminates the ability to service those poor persons in our region. That means no service for 9 out of 10 poor persons needing it.

In order to make the Nation's system respond to the health needs of all southerners, widespread changes must be made in health planning. These must be in constructive health care planning and financing. The delivery of health care services has been mentioned by Dr. Lythcott. In view of his statement and his own experience, I recommend that the following components should be mandatory with any attempt for delivery of health services in rural areas.

First, rural health planning should be especially concerned with environment health and preventive medicine. It is not at all clear that the private medical profession can or whether it would provide the leadership for environment health intervention for the poor.

The strengthening of the board of directors would ensure that medical practitioners would be considered with environment health problems, substandard housing, inadequate waste disposal, and the like. Community outreach programs and transportation and improved access to medical care—these services cost money.

Since it is desirable to provide environmental, as well as services for health care, these services should be borne by the public. Expenditures make the medical costs of medical care higher than the case that if only traditional medical care is provided, these prove cost-effective in the long run.

An essential component is comprehensive ambulatory care. Special attention should be given to meeting the dental care and mental health needs of rural people. Rural areas have a higher population of elderly people and incidence of chronic conditions and confining to bed is greater in the rural South than in other areas.

Emphasis on home health services which provide qualified nursing care to homebound elderly is important in this area. Attention to the nutritional needs of rural southerners, particularly children, should be a part of the health system participation in the Federal program and nutrition, consequently, should be encouraged.

Because of low educational levels, many men in rural areas are unfamiliar with health habits. Visual aids should be a part of this.

Finally, the problem, reputation of user, including planning, financing, resources, allocation, and policymaking, must be assured at the Federal level. Responsible Federal authorities must act swiftly and decisively when it is determined that the full rights of minorities are being denied.

Thank you for this opportunity to present my views on the problems of rural health in our southern region of this country.

Discussion

COMMISSIONER SALTZMAN. Thank you, Dr. Shirley. Thank you to each of you who responded to Dr. Lythcott. I am going to ask my colleagues at this point to present their questions. We will start with Mrs. Ramirez.

COMMISSIONER-DESIGNATE RAMIREZ. I was interested, Dr. Shirley, in how a program like the Head Start Program, which delivers health services to children in Mississippi, whether it was receiving the support of agencies which are supposed to provide health services to poor children and to the degree that it was to your satisfaction.

Dr. Shirley. The Head Start children are receiving full support from those agencies where those agencies are in place. However, in many areas in Mississippi, there are no publicly funded facilities for a direct delivery of health care. In this instance, the Head Start Program relies on the private sector. It is there where problems exist. Many private physicians will not participate in the Head Start Program by providing health service.

Commissioner-Designate Ramirez. Is that because of the race issue involved or the payment?

Dr. Shirley. Primarily the race and the mechanism of payment. Most of the Head Start children are on Medicaid. Head Start programs cannot spend Head Start dollars for health services for children who are on Medicaid. Only one physician in three will participate in the Medicaid program.

Commissioner-Designate Ramirez. You are saying one private physician will participate in Mississippi out of the three?

Dr. Shirley. Yes.

Dr. Lythcott. That is about the national average.

Commissioner Saltzman. Dr. Flemming.

Chairman Flemming. Dr. Lythcott, we appreciate very much the presentation you made. You identified important issues. You have had a good deal of experience with Title VI as it relates to the delivery of health services, not only in the rural areas, but the Nation in general. I was wondering whether you would share with this Commission some of your observations relative to the way in which Title VI has been used in connection with the observations that you have been able to make.

You did refer to the fact that you felt that guidelines on Title VI were somewhat deficient in that they ignored the staffing problem. We received testimony this morning to the effect that no guidelines have been issued on Title VI since 1969. We were told there are 11 sets of guidelines now in the process of being considered within the Department at various points and that the expectation or the hope is that they will be issued at least as proposed guidelines or regulations by the end of the year.

As you can appreciate, the Commission is very much interested in Title VI. We have been very much concerned about the effect of Title VI in connection with the delivery of health service. We would be delighted to get your observations.

Dr. Lythcott. I am not as familiar as I might be with Title VI. I have read it. I made the statement that it seemed to me to be the vehicle that might indicate what kinds of relationship should exist between boards of public institutions that receive Medicaid/Medicare funding and the communities they serve.

I am going to do what a good quarterback does. I am going to throw the ball to my tight end or wide receiver and ask John Marshall to respond to that. As Deputy Director of the Community Health Services, I think he might have a more basic understanding of the relationship of Title VI responsibilities and so forth.

MR. MARSHALL: I think one of the problems that causes us some difficulty in this area is that Title VI, basically, operates as it is structured and implemented, to provide a remedy when discrimination has been demonstrated. There are so many areas where that becomes the active issue, not enough attention can be given under the title to serving as a preventive thing.

I think that as a functional thing is probably easy to understand. The number of areas in which discriminatory patterns can occur is so broad, if you attempted to anticipate each in the statute, you would have a statute running on forever and probably be unenforceable, given its details.

It would be found to have contradictions. Title VI does not explicitly anticipate all areas where there can be discrimination. The kinds of things we are dealing with, and Dr. Lythcott made reference to in the statement, are situations where not because there is any deliberate intention to deprive people of representation or participation in setting a policy but because that is the way it has happened.

Unless somebody comes out and attempts to demonstrate there has been an overt and deliberate pattern, nothing much happens. So, what we are handicapped by is the lack of an affirmative action part that anticipates in these areas.

CHAIRMAN FLEMMING. You feel that if there was vigorous enforcement of Title VI that, in and of itself, would begin to serve as a preventive factor as far as discrimination is concerned?

Let me be specific. You do have responsibilities as far as the community health centers are concerned. In connection with community health centers, have there been charges in connection with operation of any of that of a violation of Title VI denial of access to services on the basis of race? If such charges have been filed, have they been pursued? If they have been pursued and the charges have been substantiated, has any effort been made to take action against the community health clinic that engaged in the discriminatory practice?

DR. LYTHCOTT. Let me begin responding. I have been here 2-1/2 years and while I don't claim to know every detail of this kind of activity, litigation if you will, that occurs in every agency and bureau, I would feel comfortable in saying that in my tenure here such instances have not occurred. I could not see how it could occur when one considers that our clinics are built on the basis of community desire.

First of all, there is a need and desire by the community. Not only do they support these centers, but actually manage them. Most of the persons who run our clinics are consumers. We pride ourselves on the fact that nobody is turned away. It is certainly unlikely they are turned away on the basis of race or because of dollars.

I can answer in a negative way to your question, but I would ask one of my colleagues to speak to that also.

MR. JOHNSON. We have never had that formal action. There have been allegations that border on it, but they, in each perhaps three or four cases that I can recall, were situations where it was a factional dispute within a governing board and one partner to that faction says there is a civil rights issue here and that is why there is an unresolved issue. They were not validated by the facts.

CHAIRMAN FLEMMING. We received testimony earlier today to the effect that studies showed that overall, and not referring just to community health clinics, there is a serious gap between minorities and white persons in terms of access to health services. Minorities do not have access to health services in proportion to their representative parts in the population or in proportion to their need.

You are saying as far as the community health centers are concerned that situation does not prevail. Minorities do have the kind of access to which they are entitled under the Constitution and under the laws?

DR. LYTHCOTT. I think we have taken a bit out of context what we have said. We are first to agree that the relative access to minorities and other minorities is a wide disgrace. What we say is, where we exist—community health centers and other outlets—there is no discrimination. We will be the first to agree that there are many areas where there is no place for the local consumer to go. In that instance, I would have to say people are being deprived of access to health care. If there is a facility, nobody is turned down.

COMMISSIONER SALTZMAN. Does that include the undocumented worker?

DR. LYTHCOTT. It does. We do not see ourselves as having a role in deciding whether or not persons need to be served. We are there as humanitarians to people who show up at our front door.

CHAIRMAN FLEMMING. I would ask Dr. Shirley a question. As a part of your testimony, you were referring to the operation of community health clinics in Mississippi.

DR. SHIRLEY. I was not referring to the operation of the community health centers. The point I was making was: the discrimination that exists in other areas can very well jeopardize the community health center which does not discriminate in terms of planning and resource allocation, all-white commissions—that those determine whether a community health center can expand its services or erect a new building.

Mr. Iglesias. On the issue of discrimination in the clinics, too often what happens in rural areas is reference to secondary, tertiary care. Because many of the minorities cannot afford hospital care, they have difficulty accessing the kind of care that whites have available to them. That is a statement I think is important to make. We have to look at the continuity issue involved in health care.

Chairman Flemming. Dr. Lythcott, or your associates, have you set up any kind of control system designed to provide you with information as to the access of the minorities to the community health clinics?

Dr. Lythcott. Mr. Chairman, we have up-to-date data. Eighty-five percent of our users are black and 12 percent are Hispanic. So, it is a very small minority of neither black nor Hispanic users among our clinics as across the Nation. Those numbers vary somewhat from region to region. That is the overall picture.

Chairman Flemming. Is that part attributable to the way in which the community health clinics have been located? In other words, you have located them where the need is, as far as minority groups are concerned?

Dr. Lythcott. Yes. But I think most important is they have been initiated, if you will. Proposals have been written by minority groups to add to the support that we have given. That is, making sure they are in the right area so the appropriate clientele can come to the clinic.

Chairman Flemming. Another issue that has come up is the question of the closing of hospitals in the urban areas. Very, very often there is not only a tendency to close out hospitals in urban areas, but to close them out in areas within the urban areas where there is a fairly large population of minorities. Have you gotten into that issue at all in connection with your work?

Dr. Lythcott. Only peripherally, Mr. Chairman. We are involved in ambulatory care, not really hospital patients. However, any time one gets into the issue of closing hospitals in an urban area, he does by emphasis, perhaps, relate to the ambulatory care left in that area. If you remove a constant source of ambulatory hospital care, those units left which are ambulatory must deal with what is left.

So, we have not a simple interest, but an enthusiastic interest in what happens to this problem of hospital closures. How can we pick up the slack, for example, if a number of these hospitals close? We have no control over that. We are involved in committees within HEW that are involved with this question. We have a deep and abiding interest in the whole issue of urban hospital closings.

CHAIRMAN FLEMMING. Have you been involved in any discussions where measures that might be taken by the Federal Government have been under consideration to slow it down?

DR. LYTHCOTT. I have not personally been involved. There is a dialogue going on now. Had I known there was a question, I could have spoken to the Under Secretary to get details on this.

John, do you know about this?

MR. JOHNSON. The Department established a committee dealing with inner-city hospitals in particular for the immediate moment, with plans to look into other hospital areas that threaten to close. We have been involved in several situations in urban areas in New York, Detroit, to make certain that there is an ability to absorb, in the existing community health centers, the outpatient populations being served and the emergency room populations being served. These are brought into the primary care system, into the clinics sponsored by the Health Services Administration.

There have been frequent requests made to use these funds to liquidate the operating deficits generated and accumulated by the hospitals, and the Department has resisted that on the grounds that that would dismantle an important capacity building activity in order to provide a temporary solution. Unless you change a lot of other things, those hospitals will go on accumulating those debts, not easily resolvable.

CHAIRMAN FLEMMING. Going back to the question of the gap that exists in the country as far as access to health services between minorities and white population, I gather from what you have said and the evidence you have just presented that you feel that one of the most effective ways of dealing with this gap is further expansion of the community health center program.

DR. LYTHCOTT. How much time do you have to listen to me?

CHAIRMAN FLEMMING. I appreciate that is a wide open invitation.

DR. LYTHCOTT. I agree. My position and the agency's position is this: Until a better mechanism comes along, the community health centers, rural initiatives, and similar types of programs are the answer to the problems of providing access to health care for the poor.

We talked about the minority and majority. The common denominator is the poor. If you are white and poor, you are in the same bag.

CHAIRMAN FLEMMING. Do you have any figures on the number or the percentage of older persons being served by these clinics?

DR. LYTHCOTT. John, do you have a figure?

MR. MARSHALL. The figure is, over 65, about 11 and 13 percent of users. Users are heavily weighted towards younger people. Older people come in a distant second, and middle-aged between 25 and 50, it becomes a distant third in terms of users.

CHAIRMAN FLEMMING. I will make this comment. Your records are much better than the community mental health clinics. This Commission held hearings some time ago in which we took testimony on mental health clinics in relation to the service or lack of service to older persons. There are comparable percentage figures around 3 or 4 percent.

DR. LYTHCOTT. That is not by accident. We have a deep and abiding interest in what happens to the elderly. We have an agreement with the Administration on Aging. Their demonstration projects show what we can do in our community health centers with the special expertise and skills that can be developed with the Administration on Aging money. That figure is 10 to 13 percent. We hope it goes up rather than down. Most of us see the problems of the aging as paramount to our country within the next 10 years.

CHAIRMAN FLEMMING. Thank you very much. I was aware of that agreement. I think it is a very constructive step in the right direction.

COMMISSIONER SALTZMAN. Dr. Berry.

COMMISSIONER-DESIGNATE BERRY. I have a number of questions. Although I did read your report, I was not here. You describe a community health center program that works and serves people without discrimination. Yet, we seem to have a major problem with people not being that adequately served. Is the main problem a budgetary one and that there are not enough centers?

DR. LYTHCOTT. Dr. Berry, that is a good way to put it. There are simply not enough resources. If you take the 27 million people living in underserved areas in the rural parts of our country, I would say we are probably not serving more at this time than 12 to 16 percent. Is that about right, John?

MR. MARSHALL. Yes.

COMMISSIONER-DESIGNATE BERRY. Some centers, I am told, have problems with the agency telling them their patient load is not high enough. Is there a formula for how much you get paid, based on how many patients you have? If that is the case and not enough people are being served, how effective is the outreach effort in letting the minority and poor know these programs are available?

DR. LYTHCOTT. Would you respond, Mr. Marshall?

MR. MARSHALL. We require the projects achieve a certain level of productivity. We set those as goals and as general factors in determining how much money goes to the regions and how the regional offices use the money in determining how much money individual projects get. We require the projects to have outreach and to have transportation. But in all honesty, I would have to say, when you give a local governing board the responsibility for deciding within the broad latitude of the statutes how they want to spend the money and where they want to place the major kinds of resources that they have, it is very hard for that governing board when they have lots of people who are showing up at the door in a certain age group or population category demanding services.

It is hard to say we are going to turn those away and reach out and get people who don't come in. We have tried to establish a number of criteria in addition to productivity that will push the project and push the governing boards in the direction of emphasizing preventive services and comprehensive services. Those clinical indicators, as we call them, do emphasize a number of people that they are providing hypertension control for and doing that kind of screening. They emphasize the number of agreements that they have with other agencies or other service delivery institutions in their service area that can provide secondary, tertiary care that is most appropriate for the older population. We have required, for example, that they look at pulmonary diseases. We require that they be involved in home health where there is capacity for them to do that.

So we do try to put emphasis on that. But you cannot have that directiveness from Washington with respect to specific problems and populations and have true local governments. We walk a tight line on that.

COMMISSIONER-DESIGNATE BERRY. When you were asked whether there was discrimination in services provided at the center, part of your response was there had been allegations or occasional allegations referring to a governing board, but that situation did not actually turn out to be one of discrimination. I am familiar with the report provided for Dr. Lythcott in August or September called *Sources of Information on Consumer Preferences and Satisfaction.*

I noticed in your newsletter that a task force is supposed to be working on that. When I read the report, many of the issues relating to consumers of your programs who were largely minority consumers seemed to be based on a great deal of dissatisfaction in terms of representation on boards, representative of them, and the services being provided.

Could you tell me now or provide for the record, how far along you are in implementing that report? When do you think you will have it implemented?

DR. LYTHCOTT. I will provide you details for the record. (See exhibit 4.) I can only give you a squash response now.

We have a task force in operation for about 2-1/2 or 3 months. They are looking into the whole area. During the summer, I had a consultant to come in and review the whole agency for me. It took 2 to 3 months. On the basis of his recommendation, I set up a task force.

The task force has not given me the direction I should go, but I suspect they keep in contact with the consumer and decentralization throughout the Nation and broad systems and central office, and individual consumer facilities involvement in this.

I have been a champion of consumer rights for many years. I was in New York at Columbia University at the time when it was unpopular to relate the establishment to its community. It has been one of the important things as far as I am concerned in making services to the poor and relationships particularly. I can assure you we will pursue the recommendation of that task force and integrate it into the larger task force that the President has put together in the whole area of consumerism.

COMMISSIONER-DESIGNATE BERRY. On your grant monitoring process, could you explain to me how in monitoring the grants you ensure procedurally that discrimination is not being practiced in the services that are provided? Is that a normal part of the monitoring process, and how is it done?

DR. LYTHCOTT. Most of it is done through the regional office. That is a whole series of issues that are involved there. I would like to ask John to tell you how we monitor and guard against discrimination in the selection of grantees. The answer is yes.

MR. MARSHALL. The question has to do not so much with discrimination in the selection of grantees as it does on whether or not there may be discrimination in terms of the services that are offered.

COMMISSIONER-DESIGNATE BERRY. In both. If it is too detailed, you can provide it for the record.

MR. MARSHALL. I think I can summarize.

In terms of the selection of grantees, we do not follow the process of many Government agencies by advertising in the *Commerce Business Daily* and waiting for proposals to come in and selecting those that are technically the best. We have applied to medical services and rated those counties by degree of medical service. We are giving to the medically underserved areas. We go beyond that and limit the funding in the two more underserved portals. Perhaps that is sometimes alleged to be discriminatory against the others, but we feel when you do it on a rational basis of going out and selecting, if there is some rational basis for doing that, that relates to demonstrated need, that can be defensible.

We then attempted to work within the community to put together a coalition of representative organizations that can form the governing board, form the public corporation that would be the grantee. When the grantee gets in trouble because there is mismanagement or not otherwise effectively performing, we are sometimes required to terminate that grant. I cannot think of a situation where we absolutely closed the doors and walked away. We try to find an alternate organization within the community. That usually involves forming one.

Sometimes we keep an organization alive long after we should have by many standards because we don't have a safety net to slide under the organization. That is part of the process. We require our governing boards in their bylaws to have a formalized grievance procedure. When a grievance is filed with the governing board, they have the first step responsibility for resolving that grievance. That also triggers a copy of it to the regional office so the regional office can monitor the process for taking care of that grievance.

COMMISSIONER-DESIGNATE BERRY. You have a normal monitoring process where you look at centers? One question you look at is how well they serve people and whether they are discriminating?

MR. MARSHALL. Right. That is another part of the answer. Our projects as part of their application are required to provide a health services plan that shows that they have looked at the population characteristics in the service area and made assessment of the need of that service area, of that population.

We require them to maintain a medical record system that allows us to sample and audit, to look at their routine reports, to see the extent to which they are penetrating that target population.

That really is the essence of that compliance. We don't have any ability, any system for going out and systematically interviewing in the community to find out whether or not people feel that they are not being served.

DR. LYTHCOTT. Until he made that statement, we were not being responsive to you. What I want out of this committee is that kind of advice and counsel as to how best to do that. We want to do that. We are not doing that.

COMMISSIONER-DESIGNATE BERRY. The last question.

Dr. Shirley referred to an all-white board in Mississippi, which, as I understand it, is a State planning board. He also, in response to Chairman Flemming, said the problem was not with the community health center, but all the other boards and resources they have to deal with. Where you have the all-white board and 40 percent of the people in Mississippi are black, what does your agency do about that and do you work with the Office for Civil Rights to see that these things don't happen?

DR. LYTHCOTT. The Department is working in that case. There have been interfaces between the Secretary and persons in Mississippi. It is under active litigation. I think it inappropriate for me to go further. We at the local agency kick it up to Civil Rights and the lawyers. We keep reminding them about the problem if they don't take care of it. But they are taking care of that.

CHAIRMAN FLEMMING. So the record is clear, this board, what is the name of the board?

DR. SHIRLEY. You have two problems in Mississippi. You have the State Health Planning and Development Agency which is SHPDA.

CHAIRMAN FLEMMING. They are funding from where?

DR. LYTHCOTT. Health Resources Administration.

CHAIRMAN FLEMMING. Is it that board to which you were referring?

DR. SHIRLEY. That is one plus another one.

CHAIRMAN FLEMMING. Let's stay with that one plus another. What is the composition of that board?

DR. SHIRLEY. That board until 2 days ago, and I don't know where we stand now, for one year and a half that board was a seven-person, all-white board. It was developing health planning and resource allocations for the State of Mississippi.

CHAIRMAN FLEMMING. You said that was a situation up to 2 days ago. Something happened?

DR. SHIRLEY. After a year and a half of screaming and yelling and kicking and protesting and letter-writing and telegram-writing, the Governor, 2 days ago, said that he was appointing two persons to that board.

CHAIRMAN FLEMMING. It is still a seven-person board?

DR. SHIRLEY. Yes.

CHAIRMAN FLEMMING. Two are going to be relieved or resigned and two are going to go on?

DR. SHIRLEY. The only two whites on the board stepped down and—

DR. LYTHCOTT. The only two whites who supported your principals stepped down?

DR. SHIRLEY. Right.

CHAIRMAN FLEMMING. The other board?

DR. SHIRLEY. That is the board of health, which operates a number of federally funded programs. That is an issue that we raised 2 years ago.

CHAIRMAN FLEMMING. That is all white?

DR. SHIRLEY. It has 1 black out of 14, 9 white physicians, not one black physician. The white medical association exercises sole authority as to which of the nine physicians would serve on that board. That has been our frustration and dilemma for 2 years. We protested this and nothing happened. We, with our limited resources, carried it to court. When we got in court, nothing happened beyond that, because the people who could pull the strings said we could not do anything because it was under litigation. That is the agency that provides services to a patient population which is 83 percent black, through the State board of health. It has little receptivity to black input. There is not a black provider representative on the board.

COMMISSIONER-DESIGNATE BERRY. That is why I asked what his agency did, because Dr. Shirley said they had to go to court.

CHAIRMAN FLEMMING. That is what I am very, very much interested in. I think we ought to get the record as clear as we can.

The Department did not move in on this on its own initiative. You went to court, and that was the thrust of your comment. There is a matter pending in court. Consequently, you don't feel free to comment on it at this time?

DR. LYTHCOTT. More importantly, we do not have a rôle or authority to do anything about that from where we sit, as we have the level of the program.

CHAIRMAN FLEMMING. Are you in Federal or State?

DR. SHIRLEY. Federal.

CHAIRMAN FLEMMING. What relief are you asking?

DR. SHIRLEY. We are asking that the State medical association which has the appointing authority, which has the sole appointing authority, that that authority be taken away and full authority be given to the Governor without having to rely on a private agency which is not accountable to anyone. The State medical association has historically been oppposed to community health centers. It has been one of the greatest stumbling blocks and barriers to the kinds of programs aimed at getting at the problems of the poor and minorities.

CHAIRMAN FLEMMING. The court proceeding has taken place under Title VI under the Civil Rights Act?

DR. SHIRLEY. Yes.

VICE CHAIRMAN HORN. Let me ask this question. You say the Federal Government did not do anything in that situation in terms of policy or change. But do we have an affirmative action requirement with regard to the makeup of the advisory committees that are dispensing advice as far as the proper allocation of Federal funds?

DR. LYTHCOTT. You raised it to a level above the agency head. I can tell you why we do not have authority over the States on the regular programmatic basis. I am sure the Office for Civil Rights has authority as to what followed. It is information that I cannot give you because I do not know.

VICE CHAIRMAN HORN. I would like the staff to ask what is the Federal policy in terms of affirmative action on advisory committees that advise on the dispensing of Federal monies or a portion of the Federal monies in the State. That, to me, would be the question as to the makeup and composition of an advisory board.

Is there an affirmative action requirement?

CHAIRMAN FLEMMING. In addition to that request, I would like to have the staff get from HEW a complete statement on this particular case. This is so we have in our files a memorandum which brings us up to date on this case. (See exhibit 5.)

COMMISSIONER-DESIGNATE BERRY. In addition to the memorandum of understanding between OCR and PHS, there are at least two memoranda of understanding whereby they will coordinate the grant monitoring process with the OCR process, so that when there are violations, they will be called to the attention of OCR. So we can have better enforcement, I would like to see those memoranda when they are available.

CHAIRMAN FLEMMING. We will request those be obtained and be made a part of the record at this point. (See exhibits 6 and 7.)

I have one other question. You made an interesting comment, Dr. Shirley, relative to Medicaid, relating to the entire State. Am I correct?

DR. SHIRLEY. Right.

CHAIRMAN FLEMMING. What were they, again, your figures?

DR. SHIRLEY. $3 and $1.

CHAIRMAN FLEMMING. You had a percentage of whites against—

DR. SHIRLEY. Twenty-five percent of the total Medicaid recipients are white. That 25 percent of recipients is receiving 50.2 percent of the dollar.

CHAIRMAN FLEMMING. Here, again, I would like that portion of the testimony excerpted. I would like a letter to go to the Secretary of Health, Education, and Welfare and ask her to obtain from her associates a statement relative to that situation. Particularly, I am interested in learning whether in the judgment of the Department they have to permit something like that to continue or whether there is some remedial action that can be taken. (See exhibit 5.)

COMMISSIONER SALTZMAN. Dr. Berry has a further question.

COMMISSIONER-DESIGNATE BERRY. I have a question about Indians. From reading your paper, there is a big problem with nonreservation Indians being served in Indian Health Service. I would like to ask you or Mr. Belindo if that is correct. If so, what is HEW doing about the problem of Indians being sent away from private health care facilities? Is my statement correct, and what is HEW doing?

MR. BELINDO. I believe Indian Health Service facilities are open to non-Indians with the understanding that the Indian health facility will receive reimbursement for services that are provided by the Indian Health Service.

DR. LYTHCOTT. Yes, but I don't believe that was the question Dr. Berry was asking.

COMMISSIONER-DESIGNATE BERRY. Is it the case of local health providers? If that is true, what happened to the Indians if they deny service? Is that correct or not correct?

DR. LYTHCOTT. That is not a common occurrence. We cited the Indian in Arizona. That is in litigation. It has taken a long time. Dr. Johnson of Indian Health Service may want to give you more detail on discriminatory practices with respect to Indians.

DR. JOHNSON. I think, Dr. Berry, there is no question that some private providers or some community providers of service, county hospitals, for example, may very well fail to provide services to Indian people who arrive at their door and see that they get sent down the street to the Indian facilities. I think it is not easy to ferret those out. The Secretary is personally aware of this problem in one particular area. I believe that they are looking very, very quickly and carefully at this. Our role in this, as you mentioned in the agreement, is to attempt to identify instances in which there appear to be occurrences. We are not an investigatory agency. If it appears to us something is happening like that, our role is to advise the Office for Civil Rights. It is their responsibility to investigate this to whatever end is required.

COMMISSIONER SALTZMAN. I would like to thank you all for this most helpful testimony that you presented to us. We appreciate your presence and cooperation this afternoon. We thank you very much.

CHAIRMAN FLEMMING. Our next session is the Federal Role in Urban Health Care Delivery.

Dr. Foley is Administrator of the Health Resources Administration, Department of Health and Human Services. He was appointed to this position in 1977. As Administrator he directs the agency which supports the nationwide system of State and local health planning agencies; provides support to improve the supply, distribution, use, and quality of health personnel; and provides financial and technical assistance for conversion and compliance of health facilities.

Prior to assuming leadership of the Health Resources Administration, Dr. Foley had served as executive director of the Colorado State Department of Social Services, which included responsibility for a variety of human service programs, including Medicaid, food stamps, and veterans' affairs, as well as programs for older people and mentally retarded individuals. He has also served as Deputy Director and Planning Chief, Office of Program Development and Analysis for the National Institute of Mental Health; and director of Manpower Training and Labor Relations at Milwaukee Technical College.

Dr. Foley holds a B.A. from St. Johns College, an M.A. from Marquette University, an M.S. in urban affairs from the University of Wisconsin, Milwaukee, and a Ph.D. in political science from Harvard University.

We are pleased to welcome you and look forward to your presentation.

STATEMENT OF HENRY A. FOLEY, PH.D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

DR. FOLEY. Thank you.

The Health Resources Administration is charged with assisting in the development of both the personnel and physical resources needed for the delivery of health care services and with supporting a nationwide health planning system. The agency does not provide or support the provision of health services. None of the programs is directly targeted at urban areas, but many have aspects which relate to the concern of the U.S. Commission on Civil Rights for ensuring adequate health care in urban areas. This paper will discuss issues relating to availability of appropriately trained health personnel; the financial viability of health facilities; and planning for a health system which contains cost and provides an appropriate mix of services and institutions, as they pertain to urban areas.

Those responsible for policy development and program management within HRA have themselves focused to a greater extent on access questions over the past 2 years. This led to the development and publication in 1979 of a booklet titled *Promoting Equal Access to Health Careers and Health Care.* It states HRA's commitment to a goal which includes: assuring equal opportunity for access to health careers; alleviating specialty and geographic maldistribution of health professionals; assuring equal opportunity for access to health facilities; assuring equal access to available health resources at a reasonable cost for all groups, including minorities and the handicapped; and providing leadership and staff support to accomplish this goal.

We are in the process of refining and further developing this access strategy and, at the same time, tying it to specific program objectives. Carried out over a period of time, this will assist us in targeting access issues in the operation of all of our programs. Though the access question is broader than urban health, many of the racial and ethnic minorities, the elderly, and the poor, reside in urban areas and would be affected.

The Health Planning and Resources Development Act of 1974 (P.L. 93-641, amended by P.L. 96-79 in 1979) lists among its 17 priorities for health planning the provision of primary care services for medically underserved populations and the promotion of activities to achieve needed improvements in the quality of health services. Under the act, health service areas are established across the country. These are served by 204 Health Systems Agencies and 57 State Health Planning and Development Agencies. A health service area is defined as a geographic region appropriate for effective planning and is generally required to include between 500,000 and 3 million people. Each standard metropolitan statistical area is to be entirely within the boundaries of one health service area except for interstate SMSAs in which each Governor of the affected States, together with the Secretary, has determined otherwise.

Thus, most major cities comprise one health service area, perhaps with the inclusion of surrounding suburban areas. Some cities, such as New York and Los Angeles, far exceed the 3 million mark and utilize subarea councils to facilitate the involvement of larger number of residents in the planning process. As health service areas are to include at least one center for the provision of highly specialized services to the extent practicable, many of them contain at least a medium-sized city. Large urban HSAs have been defined as those serving (1) all or a major portion of one or more SMSAs with a population of 500,000 or more, and (2) an area with a total population of at least 1 million. Of the 204 HSAs in the country, 57 fit this definition.

Each Health Systems Agency is required to have a governing body which includes 51 to 60 percent consumers who are not providers of health care and who are broadly representative of the health service area, including individuals representing the principal social, economic, linguistic, handicapped, and racial populations and geographic areas of the health service area. All committees, special task forces, and subarea councils of HSAs must also meet these requirements. The Health Systems Agencies are responsible for the production plan; for providing technical assistance to entities attempting to develop needed services; and for reviewing proposed capital expenditures and changes in health services. They also review and approve or disapprove proposed uses of Federal funds under the Public Health Service Act; the Community Mental Health Centers Act; the Drug Abuse Prevention, Treatment, and Rehabilitation Act; and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, which fund the development, expansion, or support of health resources. They must also perform appropriateness reviews; that is, they review all institutional and home health services in the area at least every 5 years and make recommendations to the State agency regarding their appropriateness. This appropriateness review may, but is not required to, result in institution specific findings; otherwise, it results in findings as to the appropriateness of specific services in the health services area.

The Health Systems Agencies do not have regulatory powers but submit their recommendations to the State Health Planning and Development Agencies, which are part of the State government and do have regulatory authority. The State agencies are responsible for developing State Health Plans and for approving or disapproving the obligations of capital expenditures within the State, the offering of new institutional health services, and the acquisition of major medical equipment. This process results in the issuance or denial of certificates of need. The State agency must consider the recommendations of the HSA, but is not bound by them. Projects not awarded a certificate of need by the State may not be developed. The State also considers HSA recommendations on appropriateness and makes its own review. In some States, there is a movement to link this activity to delicensure or decertification of beds or facilities found not to be needed. This is not a Federal requirement. In performing the various reviews, HSAs and SHPDAs must employ criteria based on factors spelled out in the act or in regulations. A number of these factors specifically relate to access and are discussed below.

The SHPDA is advised by a Statewide Health Coordinating Council appointed by the Governor of the State and including representatives of each HSA in the State. Not less than half the SHCC members are to be consumers of health care, and it must include individuals who represent rural and urban medically underserved populations if such populations exist in the State. The SHCC does not have to meet the broadly representative requirements of the HSA governing bodies.

The purpose of the HSA activities is to:

1. Improve the health of residents of a health service area.
2. Increase accessibility, acceptability, continuity, and quality of health care services.
3. Restrain increases in the cost of providing health care services.
4. Prevent unnecessary duplication of health resources.
5. Preserve and improve competition in the health service area.

The Health Systems Plans, which set the framework for all of the other activities, are to be detailed statements of goals describing a healthful environment primarily with regard to health care equipment and to health services provided by health care institutions, other providers of health care, and other health resources and health systems in the area. Plans are to be responsive to the unique needs and resources to the area, and are to take into account the National Guidelines For Health Planning which the Secretary must issue as well as to the priorities cited in the act.

The presence on the governing bodies of the planning agencies of representatives of all major population groups in the community and the effective functioning of these consumer members is essential to assuring that that health systems plan, the annual implementation plans, and actions taken in accordance with them reflect community sentiment and address community needs. It is obvious to all that in a time of fiscal constraint and rising health care costs, not all desired facilities and services will be available. It is critical that all population groups have a voice in the resource allocation decisions and priority setting which must occur, and that local control over the health system be enhanced.

The planning agencies have been the target of criticism about the composition of the governing bodies in terms of representativeness of the consumer members. The Congress has stated clearly that the broadly representative requirement is not meant to be a quota system. Determining and enforcing compliance in those agencies which do not appear to meet the intent of the law has not been a simple matter.

Even more complex a problem is the effectiveness of consumer representation when actual board composition appears to be well-balanced and inclusive. Those population groups who have the most difficulty in obtaining adequate health care services are also at a disadvantage in participating in the functioning of an HSA and in influencing its actions.

The average board member donates an estimated 10 or more hours of volunteer time per month. Board members must read complicated technical documents, understand the implications of the issues, and articulate a position. They must be able to attend meetings which may conflict with personal work schedules. Those at the lower end of the economic scale are least likely to have employers who will give release time for such activities. In addition, consumer members are often more intimidated by professional provider members of the governing body and feel unable to challenge their views or opinions.

HRA and the Bureau of Health Planning have undertaken the development of a comprehensive strategy to enhance the effectiveness of citizen participation. This will include the designation of staff in the HSAs to provide assistance to the board members as required by the new statute, training for staff and board members, and development and distribution of more and better informational and training materials.

We also have begun an effort to strengthen our relationships with a number of the national organizations which represent the interests of ethnic and racial minorities, the handicapped, the elderly, and women and to seek their advice on increasing the effectiveness of citizen participation. We recognize as clearly as any of these groups that a seat on the governing body is only the beginning in ensuring access to the decisionmaking process.

The Bureau of Health Planning also has taken a leadership role with the Health Systems Agencies in directing attention to certain health system issues through the distribution of policy guidance and information, and through the issuance of regulations. For example, the April 1979 regulations regarding certificate of need advised State agencies that they must give special consideration to (a) the health related needs of medically underserved groups; and, in particular, members of groups which have traditionally experienced difficulties in obtaining equal access to health services, such as minorities, women, and the handicapped; and (b) the contribution of the proposal being reviewed in meeting those needs. Within the past year, guidance has been sent on Section 504 of the Rehabilitation Act of 1973, having to do with handicapped individuals, achieving equal access to health care, and problems of the chronically ill in obtaining needed services.

The 1979 amendments allow up to 5 percent of the funds appropriated for Health Systems Agencies to be used to assist those facing extraordinary costs. The Bureau of Health Planning will make $1.7 million available this year for fully designated HSAs which serve (1) interstate areas, (2) large geographic areas, (3) large medically underserved populations, where 25 percent of the residents or 250,000 people reside in designated medically underserved areas. Twenty-three urban HSAs will receive additional funds under category 3.

A number of HSAs can point with pride to real accomplishments in ensuring access to health care in urban areas. An HSA can stimulate positive developments even though it does not provide direct service. Individual HSAs have taken the initiative by getting hospitals to agree voluntarily to provide uncompensated care; stimulating the development of clinics to meet the needs of the poor, the elderly, and migrant workers; promoting the availability of home health services; and assuring access in the face of closure.

In a random survey of 100 agencies' plans, 57 percent contained goals and objectives dealing with urban health problems. These goals include: improving emergency medical services, increasing services in OB/GYN and pediatrics for non-English speaking populations, expanding social and medical outreach services, increasing access for ambulatory care, increasing primary care services, upgrading crisis intervention services, reducing rodent infestation and substandard housing, prevention of preschool child lead poisoning, expansion of urban hospital staff complements, increasing accessibility to general hospital services, provision of transportation to health and social services, increasing availability of home health and social services, day care centers for the elderly, greater coordination among urban providers, expanding urban area dental care availability, increasing community sewer systems, establishment of drug abuse prevention programs, detection and treatment programs, and assuring adequate recreational facilities in urban areas.

In addition, approximately 75 percent of our sample 141 plans have access, discrimination, and services to minorities goals. These include: initiating screening and nutrition programs for disadvantaged populations; reducing infant mortality rates for black populations; transportation for the disabled; increasing the number of bilingual health professionals; increasing access to health care for migrant workers; assuring access to rehabilitation services; expansion of consumer education to poor black and elderly populations; and improvement of housing conditions.

Several urban areas have undertaken major projects in determining the need for accessibility to health care. For example, the New York City HSA completed a study on short-stay hospital care. That study recommends denial of new hospital construction in areas already oversupplied, along with steps to prevent facilities from closing or relocating and thus reducing access to the underserved population of that city.

The Chicago Health Planning Agency is coordinating major efforts in prevention of lead poisoning as well as the development of a new facility to serve the residents of the southern portion of the city, who are for the most part presently underserved and economically disadvantaged. The District of Columbia Health Planning Agency is coordinating a major effort designed to reduce infant mortality in the District.

In the performance of their many functions, both HSAs and the SHPDAs take actions which may have civil rights implications for various populations. They may also review applications for certificate of need from certain facilities which some members of the community feel have not complied with civil rights requirements. The HSAs, most of which are private, nonprofit corporations, cannot perform a civil rights monitoring or compliance function. While the Office for Civil Rights has the responsibility of enforcing Title VI of the Civil Rights Act, HSAs can, of course, alert OCR to possible violations. HSAs do not have the authority or capability to conduct Title VI investigations, and an attempt to do so would threaten the availability of the data they need from the health facilities for health planning purposes as well as their ability to develop a broad-based acceptance of health planning activities.

HRA has responsibility for providing guidance to the health planning agencies on the access requirements of Title XV of the PHS Act, which is the health planning program's authorizing legislation. As discussed above, it has done this through provisions in the regulations governing certificate of need reviews, as well as those for reviews of existing institutional health services for appropriateness also discussed above, and those for review and approval by HSAs of proposed uses of Federal funds. The Bureau of Health Planning is working toward a policy issuance which will bring together the various policies and guidelines on access contained in various regulations and guidelines.

As stated earlier, the health planning program is directed at containing costs while improving access to quality care. Some see those three objectives as contradictory and therefore unobtainable. It is true that certain tensions are inherent in the program, given this multiple mission. However, just as inflation is generally most harmful to those in lower economic classes in which the target groups are proportionately overrepresented, the extraordinary inflation in the health care sector has hit hardest at those who are dependent on public or subsidized services. Inpatient care in acute care hospitals is the most costly method of delivering health care, and often not the most appropriate. A number of studies have shown that an excess capacity of acute care hospital beds greatly raises the costs of care. The National Guidelines for Health Planning propose a standard of four beds per 1,000 population as adequate for the provision of needed services. Many major cities far exceed this number.

In thinking about access, quality, and cost containment, one has to think about reducing the number of excess acute beds while promoting the development of an appropriate mix of ambulatory services, nursing home beds, and other resources suited to the health care needs of the population. Although many see the reduction of beds as reducing access for target groups, the runaway inflation in the current system is bound to exceed the capacity of State and local government and the Federal Government to pay the costs. This will result in financial failure for some hospitals, and an unplanned and uncoordinated curtailment of services. We take the position that changes are going to occur in urban areas, and that it is preferable to plan for appropriate reductions and development of alternatives rather than just let those institutions which are financially weakest go under, since many of them are truly serving the disadvantaged.

In recognition of the problems of many hospitals in the country, Nathan Stark, Under Secretary of HEW, has convened a Task Force on Financially Troubled Hospitals and testified before the Congress on this subject in February of this year. The Department is concerned about hospitals, particularly those which serve the poor, that are reported to be experiencing financial difficulties. Characteristically, these hospitals are in medically underserved areas and serve as the principal source of ambulatory care for individuals who have no or inadequate health insurance coverage. Among those most seriously affected are publicly owned and operated hospitals.

Perhaps the most serious problem some hospitals face is uncollected revenues due to inadequate health insurance protection for many of the patients they serve. It is currently estimated that 22 million people, most of whom are poor, have no health insurance at all. Another 20 million individuals have inadequate coverage. Compounding this problem is the growing and uncertain number of undocumented aliens, perhaps as many as 5 million. Most are indigent, have no health insurance, and, in emergencies, seek care from local community hospitals. Furthermore, much health insurance provides poor coverage for ambulatory services. Such coverage deficiencies reduce incentives for physicians to treat patients in their offices, thereby shifting the burden of care to hospital outpatient departments.

The National Council on Health Planning and Development, at its March 1980 meeting, passed a resolution stating, in part, that the core problem of much institutional financial instability is financially troubled people. It then called for comprehensive health insurance for Americans not covered, and for Medicare and Medicaid modifications to share reasonable payment for free care and bad debts.

Hospital operating costs also are increasing at high rates due to inflation, rapidly advancing medical technologies, excess hospital beds, and ineffectual institutional planning. Many inner-city hospitals are burdened by aging or obsolete physical plants which are costly to operate. Furthermore, some hospitals have a history of bad management manifested by poor accounting practices, inadequate collections operations, lack of leadership, and an inability to operate under conditions that promote effective personnel management and efficient staffing patterns.

Limited public financing and reimbursement limitations by other third-party payers are placing a further strain on some hospital budgets. Local funding for some urban public-general hospitals is becoming increasingly constrained as a result of diminishing local tax bases. In addition, States and municipalities are pursuing general policies of fiscal austerity, and are limiting expenditures and curtailing services.

The perverse incentives built into the reimbursement practices of third-party payers further exacerbate the financial problems of hospitals. Low Medicaid physician reimbursement rates in some States and a shortage of office-based physicians in many inner-city areas limit local patients' ability to obtain care in nonhospital ambulatory care settings. Consequently, hospital outpatient departments and emergency rooms frequently must provide primary care to patients who more appropriately and cost-effectively should receive that care in physicians' offices. Moreover, some State Medicaid programs severely limit reimbursements for hospital outpatient services, thereby further exacerbating the financial pressures on certain hospitals.

The Department is attempting to develop an appropriate strategy for addressing the problems of financially troubled hospitals. However, as the Under Secretary stated in his testimony before Congress on the subject, we must be concerned about both access and delivery system reform. Institutions which serve as the primary sources of care in underserved areas must be kept viable, or acceptable alternatives must be developed. The assumption should not be made that all hospitals in financial trouble should necessarily be saved, or even supported with their present missions, modes of operation, and governance. Federal policies should encourage significant restructuring of local health delivery systems in order to produce institutions with a promise of future viability. Such restructuring must take account of the total health resources of the area, and should emphasize the appropriate use of ambulatory care, as opposed to institutional treatment modalities.

The Department is examining a number of ways to assist financially troubled hospitals, such as revising reimbursement formulas under Medicare and Medicaid, and various other categorical programs. This paper will focus on programs administered through the Health Resources Administration.

The one authority under which direct financial assistance is provided to hospitals is Section 1610 of the Public Health Service Act, which allows the Secretary to make grants to institutions for construction and modernization to correct safety hazards and noncompliance with State or Federal codes that could lead to loss of licensure or accreditation. An institution must be unable to obtain other financing in order to qualify.

Of projects obligated since the start of this program in 1974, 54 percent of the funds, or $21,085,590, have gone to urban facilities, including 10 hospitals, one public health center, and a number of nursing homes. Of the remaining funds appropriated under this authority, we anticipate awarding 76 percent, or $7,669,959, in urban areas to assist seven hospitals, one public health center and some nursing homes. There have been no new monies appropriated for this program since 1977, however, and there is no request in the President's current budget.

In the main, hospitals must borrow funds for capital improvement. HRA administers, through an interagency agreement, the Department of Housing and Urban Development's guaranteed loan program under the Federal Housing Administration, Section 242. We attempt to determine financial feasibility and conformance with health planning guidelines. Projects to develop excess services or bed capacity or those found to be unneeded by the health planning agencies are not approved.

The financial feasibility requirement means that these guaranteed loans are not available to financially troubled hospitals. Current high interest rates are resulting in large increases of as much as $50 per patient day attributable to debt service. Those increases will both increase costs to public and private third-party payers and price some people out of being able to afford coverage. This will increase the demand for indigent care, often in institutions which provide at or near the maximum level they can carry. This burden can serve as an inducement for the hospital to turn patients away, referring them to public institutions. In many urban areas, these institutions themselves are being less adequately supported by municipal governments and State Medicaid programs than they have been in the past, and are less able to provide uncompensated care.

The Hill-Burton Act of 1946 authorized the Secretary to require assisted institutions to (1) make their services available to all persons residing in the facility's area (the community services assurance); and (2) provide a reasonable volume of uncompensated services to persons unable to pay (the uncompensated care assurance). The community service obligation specified that Hill-Burton assisted facilities were not to discriminate on the basis of race, creed, or color.

Provisions for regulating the act and enforcement of the assurances have been extremely varied since its inception. In 1975, P.L. 93-641 replaced the Title VI program of assistance with Title XVI and made several changes in the assurances program. These included (1) facilities receiving aid under Title XVI would now be obligated for an unlimited period of time; (2) the facilities aided under Title VI and XVI would file periodic compliance reports; (3) the joint State-Federal monitoring and enforcement process was ended, and the Secretary of HEW was given the sole responsibility, although States may participate on a voluntary basis; and (4) individuals could file complaints with the Secretary charging noncompliance by a facility. Proposed regulations were issued in October 1978 to which over 1,000 comments were received. Two days of public hearings were held in December 1978, and the final rule was published in May 1979.

Title VI assisted facilities have an obligation limited to 20 years from the date when they received Federal assistance, while those assisted under Title XVI are obligated for an unlimited period of time. Facilities must provide uncompensated care equal to 3 percent of operating costs, less Medicare/Medicaid reimbursements, or 10 percent of the amount of the assistance, whichever is less. In FY 1980 we estimate that 5,392 obligated facilities are to provide $435 million worth of uncompensated care. This figure will be adjusted annually for inflation in future years. The community service assistance has no expiration.

Since the publication of the final regulations we have held three meetings with the States and four public meetings in various parts of the country to explain its implementation. We have developed a providers' guide, an assessment manual, a complaint investigation manual, and a reporting form for institutions. We have mailed 14,000 provider manuals to 7,000 institutions, and have notified each facility of its assistance amount. We also have distributed 87,000 signs, in both English and Spanish, to be posted by obligated facilities to inform the public about the assurance program. All activity related to Federal implementation and monitoring of this program must be carried out by 27 staff members in the central office and 10 employees in the HEW regional offices. The law provides authority to develop memoranda of understanding with the States to carry out this responsibility, but we are not able to provide any financial assistance to States for this purpose. Although the Justice Department may investigate an alleged violation, there are no penalties for noncompliance above having to provide the obligated amount of care.

The Hill-Burton program, affecting over 5,000 institutions, is a tool for assuring access to care for all members of the community and for removing barriers based on discrimination or inability to pay. The program also holds the potential, in some cities, for providing relief to public hospitals. By enforcing the obligation of some private institutions to provide uncompensated care, we may cut into the practice of referring medically indigent patients to public facilities. However, it is also true that in some institutions with large numbers of Medicare and Medicaid patients from whom reimbursement, except for Medicaid in a few States, does not include reasonable costs of delivering uncompensated care, the Hill-Burton requirements may heighten financial difficulties. The same may be true in some States with rate setting commissions which will not allow hospitals to set rates high enough to cover the costs to the institutions of uncompensated care.

As stated above, it is our view that not all financially troubled institutions should be preserved, but that there should be a restructuring of the health care and long-term care services. A number of major cities exceed the guideline figures of four beds per 1,000 population, and are currently considered to have excess acute care beds. For example, Chicago has about five beds/1,000; Philadelphia, 4.6/1,000; and Cleveland 5.1/1,000.

It is generally agreed that the presence of excess beds contributes to overutilization, and that even those beds which are not utilized or staffed generate significant costs for an institution. The costs of excess beds have stimulated an interest in bed reduction programs. The cost savings will vary, often related to whether a few beds, a unit, a wing, or a whole facility is to be closed. Unnecessary duplication, tertiary care, and high technology services also is costly in terms of capital investment and staffing. In addition, evidence exists that health outcomes are better in specialized units and services which are operated relatively near capacity than in those which are inadequately utilized.

Several States have already begun or are considering programs to reduce excess capacity, partly because of concern about rising Medicaid costs. The State of Michigan is planning to reduce hospital beds by 10 percent, or 3,800 beds. A unique Coalition on Health Care Costs, comprised of the big four automakers, United Auto Workers, Blue Cross/Blue Shield, and the legislative and executive branches of State government, made this legislative mandate possible.

Until the Public Health Service Act was amended by the Health Planning and Resources Development Amendments of 1979 (P.L. 96–79), there was no Federal requirement that State certificate of need programs cover reductions or decreases in the bed capacity of a health care facility. The amended act, however, requires that a State certificate of need program provide for the review and determination of need for any capital expenditure which "substantially changes the bed capacity of the facility with respect to which the expenditure is made." The Department has interpreted "substantial changes" as those which increase or decrease the total number of beds or distributes beds among various categories, or relocates beds from one physical facility or site to another by 10 beds or 10 percent.

Although all of the standard criteria required for certificate of need reviews must be applied in reviewing bed reductions, certain criteria which relate to the health needs of underserved groups are particularly pertinent. State Health Planning and Development Agencies and Health Systems Agencies are required, both in developing their health plans and in conducting certificate of need reviews, to consider the extent to which the health needs of low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups are being met and will be met by proposals under review.

I wrote a letter to all HSAs and SHPDAs in November 1979 expressing concern about possible effects of closure and conversion on access. I stated that HRA policy was the HSAs should require that alternative services be in place prior to a closure and that they should have made a commitment to providing services to those who had previously utilized the facility or service to be closed. I also stated that retraining and relocation programs for displaced workers, when needed, were essential for HSA approval. This letter was prompted by a concern that alternative services were often still in the planning stage at the time of a proposed conversion or discontinuance, and that hospitals in the vicinity which, on the basis of occupancy rate, had the capacity to provide replacement services were not always willing to do so. This was especially true when those affected were minorities or disadvantaged. Furthermore, it seemed apparent that unskilled and semiskilled hospital workers, often women and minorities, were those least likely to find other employment. With retraining, they would be useful resources providing needed services in long term care facilities, ambulatory settings, and home health services.

Apart from requiring review under State certificate of need programs for capacity reduction, the Department is proposing to provide financial assistance for conversion and discontinuance with the objective of better balancing the levels and types of service available and containing costs.

The Health Care Financing Administration is considering reimbursement for costs attributable to reduction of patient care capacity in hospitals. The proposal would permit reimbursement for certain costs incurred by hospitals participating under Medicare and Medicaid that reduce patient care capacity. The proposed regulation also specifies the conditions that must be met by a hospital to receive reimbursement. The purpose of the regulation is to achieve savings by encouraging hospitals to reduce unneeded and costly patient care capacity.

Proper health planning, coordinated by the local Health Systems Agency and the SHPDA, should prevent closure of needed services, as well as encouraging elimination of excess capacity. Any reviews conducted by the SHPDA for reimbursement will also address a number of civil rights concerns relating to access to health care. The Office for Civil Rights is preparing policy guidance regarding enforcement of the nondiscrimination requirements of Title VI of the Civil Rights Act for use by the HEW regional offices and by hospitals planning closures.

In addition, the 1979 amendments to Title XVI included a new authority for actual grants to hospitals for conversion and discontinuance of services. This would be a voluntary program to reduce excess hospital capacity and convert the unneeded beds to needed health uses. It would be a program of last resort of funding, and could assist financially troubled hospitals to retire outstanding debt as a prelude to closure. This program would also stress protection of access for the poor and minorities.

The statute requires that the Secretary of the Department of Labor issue regulations regarding the fair and equitable treatment of employees, and to certify that employees are fairly and equitably treated prior to HRA funding of an applicant. Funds could be made available for retraining and relocation, and could also be awarded to

SHPDAs for excess hospital capacity reduction projects. The HEW Office for Civil Rights is closely involved in the development of regulations for this new authority, which is, as yet, unfunded. Authorizations are for $30 million in 1980, increasing to $50 million in 1981, and $75 million in 1982.

Not much is known about the effects of capacity reduction, so we consider such a program as a demonstration to be closely monitored and evaluated. HRA has recently published a monograph in the Health Planning Series titled *Conversion and Other Policy Options to Reduce Excess Hospital Capacity,* which presents 17 case studies and examines some of the issues.

We recognize that hospitals in urban areas are often the sole source of health care for surrounding communities. However, a well-planned reduction of acute beds, together with reasonable access to an appropriate mix of alternative services, should help us realize the objective of providing adequate services while containing costs and improving the financial health of the remaining institutions. An example of the type of change we would like to see occurring would be reduction of a 600-bed hospital in an area exceeding the four beds per 1,000 guideline, which has few ambulatory and emergency services, to a 300-bed hospital with more ambulatory and emergency services, and with long term care, mental health, alcoholism, or drug abuse units. It has been estimated that this type of program could "save" $3 in health care expenditures for every $1 spent on discontinuance of excess capacity.

Along with the heavy focus on the total health system and the availability of facilities, we must also recognize the importance of health personnel to urban health care delivery. For some time, the administration has recognized that the critical issue is not the total numbers of graduates in the various health professions, but serious geographic and specialty maldistribution. We have tended to train too many physicians who end up practicing specialized medicine rather than providing primary care services. In addition, physicians and other health professionals tend to practice in more affluent urban areas, suburbs, and medium-sized towns rather than in the inner cities or remote areas. In many States, low Medicaid reimbursement rates for office visits serve as a disincentive to opening a practice in a poor neighborhood.

Prior to passage of the Health Professions Educational Assistance Act of 1976, most shortage area designations were in rural areas. This was because the criteria for shortage were based primarily on practitioner-to-population ratios applied to county data, and most urban counties did not qualify. However, the HPEA Act of 1976 specifically mandated designation of urban as well as rural areas, and designation of population groups as well as geographic areas. In addition, that legislation required that indicators of health status and of access to health services be considered along with practitioner-to-population ratios.

To implement these legislative provisions, HRA developed revised criteria for determining shortages of health manpower. These criteria allowed for designation of urban neighborhoods and population groups such as medically indigent and Spanish-speaking populations with health manpower shortages within metropolitan counties which, on the whole, had adequate supplies of health manpower. As a result of our application of these criteria, approximately 25 percent of the currently designated primary care health manpower shortage areas, including designated population groups, are in metropolitan areas. Moreover, the population residing in these areas represents 50 percent of the total population of all primary care health manpower shortage areas.

The designation of a health manpower shortage area can allow the community to receive certain assistance, such as the discretionary funding to urban HSAs serving areas with a significant problem discussed above. The designation of a medically underserved area also makes the area eligible for the placement of a physician or other health care provider through the National Health Service Corps. The Community Health Centers and Urban Clinics programs administered by the Health Services Administration also provide direct services to these areas.

It is currently the intent of the administration to eliminate general institutional support for health professions schools, and to concentrate on funding targeted programs aimed at meeting identified needs. These needs will generally fall into the two categories of correcting geographic maldistribution and increasing the proportion of primary care practitioners.

One of the most important programs for placing physicians in shortage areas is the National Health Service Corps Scholarship Program and the National Health Service Corps. Medical students who are committed to entering a primary care field such as family practice, general pediatrics, or general internal medicine, as well as psychiatry are supported through the scholarship program. In return, following a deferment for residency training, they must agree to serve, where placed, in a shortage area on the basis of a year of service for each year of support. Currently there are 1,070 scholarship recipients fulfilling their service obligation, and 8,988 individuals in awardee or deferment status. A major objective of the program is to have a number of practitioners remain in the area following the time of obligated service. There are some who think that the stresses of practice in certain inner-city areas are such that it is more realistic to think in terms of part-time, inner-city practice for physicians, and greater utilization of physician extenders. A limited number of other health professionals also are supported through the scholarship program. Many of the other health professionals have been recruited directly into the corps to work at the corps site.

For the past 20 years, large numbers of foreign medical graduates have entered this country for graduate medical education, filling significant numbers of residency positions. A disproportionate number of these slots have been in those hospitals less attractive to U.S. medical graduates. From both a quality of health care perspective and a foreign policy "brain drain" point of view, the influx of FMGs was viewed as an undesirable situation.

Title VI of the Health Professions Educational Assistance Act of 1976, Public Law 94–484, as further amended by Public Law 95–83, contained several amendments to the Immigration and Nationality Act that significantly affect the process by which FMGs are allowed to enter the United States as immigrants or exchange visitors, and limits the time for remaining in the country.

In order to enter the United States to participate as an exchange visitor or in a graduate training program, a foreign medical graduate must have passed the visa qualifying examination or obtained a waiver of the requirement under the Substantial Disruption Waiver Provision discussed below. The number of FMGs entering the country through either avenue has been dropping sharply as indicated by the total number of exchange visas under the Educational Commission on Foreign Medical Graduates sponsorship: in 1975, 7,507; 1977, 5,310; 1979, 2,578.

In the graduate medical education programs conducted in hospitals, the high reliance on FMGs had become a serious issue. The FMGs filled 29 percent of graduate medical education positions in the United States and 28 percent of the first-year positions in 1974–75. By 1978 these figures had begun to reflect a downward trend, and FMGs represented 15.4 percent of all residents in graduate medical education programs.

If entering FMGs were evenly distributing themselves by location, by specialty, and by type of hospital, the impact of the recent Immigration and Nationality Act amendments would be minimal. However, it was clear from data collected by the American Medical Association in 1977, that the reliance on FMGs to fill house staff positions was concentrated in certain types of hospitals, geographic areas, and specialties. For example, 73 percent of the FMG-filled residency positions were located in nine States: New York, New Jersey, Illinois, Delaware, District of Columbia, Maryland, Michigan, Ohio, and Pennsylvania, even though only 35 percent of the U.S. population resided in the same States.

Several of the large metropolitan areas, especially in the Northeast and North Central regions, showed high proportions of FMGs in residency positions. FMGs filled substantial proportions of the total number of residency positions in the following metropolitan areas: Baltimore, 40 percent; Chicago, 46.6 percent; Cleveland, 36.6 percent; Detroit, 37.4 percent; New York City, 42.1 percent; and Philadelphia, 30.6 percent.

In addition, a large proportion of hospitals in several major metropolitan areas had more than one-half of their residency positions filled by FMGs: Baltimore, 56 percent; Chicago, 70 percent; Cleveland, 75 percent; Detroit, 44 percent; New York City, 52 percent; and St. Louis, 54 percent.

Because of the expected severe reduction in the number of alien physicians entering the United States annually as a result of the amendments to the law, Congress provided for waivers of two of these requirements on a case-by-case basis. The waiver clause, which extends through December 31, 1980, can be granted if a graduate medical education program can demonstrate that application of these requirements would result in a "substantial disruption" of health services. The substantial disruption waiver was developed to provide programs and institutions traditionally placing significant reliance on alien physicians, a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, programs and institutions are expected to develop alternative provider resources and to attract primarily graduates of U.S. medical schools. If substantial disruption waivers fail to meet the manpower needs of particular programs or institutions, the waiver mechanism provides for an appeal process in which additional waivers can be requested.

A Federal Substantial Disruption Waiver Appeal Board has been established to consider appeals from those programs and institutions. The Waiver Appeal Board functions in an advisory capacity to the International Communications Agency, the agency responsible for administering the exchange-visitor program for alien physicians. The waiver mechanism has been in operation since May 1978. Information collected since the program became operational supports the early predictions on the geographic location of hospitals which would be most severely affected by the reduction in FMGs. Hospitals in some cities have been much more aggressive and successful in reducing their dependence on FMGs than those in other urban areas. For example, of 64 applications for 185 positions considered during calendar years 1978 and 1979, 52 were from public and private nonprofit hospitals in the

Northeast and Central Northeast regions for 171 of these 185 positions. Large cities also were heavily represented in the applicant pool. For example, 38 of the applications were from urban centers, while 18 were from medium-sized cities, and 8 were from small cities and/or rural areas.

The statistics on the specialty programs, however, are not as consistent as was expected. While neurosurgery, psychiatry, anesthesiology, pathology, and other specialties which rely heavily on FMGs are reflected in the applicant pool, the primary care specialties of pediatrics, internal medicine, and surgery also represent large numbers of training programs. This may reflect the heavy utilization of the waiver mechanism by hospitals in large urban centers which provide extensive primary care services, as well as acute in-patient services. It is estimated that as much as 75 percent of outpatient services in the New York metropolitan area is provided by FMGs. It is likely that a limited extension of the waiver authority past the December expiration date will have to be considered by the Congress, especially for the greater New York City metropolitan area.

Physician extenders, a term which encompasses both nurse practitioners and physician assistants, are another source of health personnel, particularly in organized care settings such as urban clinics. A number of studies have shown that physician assistants and nurse practitioners perform those functions for which they are trained equally as well as physicians. The degree of supervision under which they must practice varies from State to State, depending on the medical practice acts as well as the various Medicaid reimbursement rules. Medicare Part B reimburses only for the services of a nurse practitioner incident to a physician's professional service. The fact that a nurse practitioner may cost more out-of-pocket for the patient reduces utilization, even if the overall cost is less.

A study in 1979 indicated that 23 percent of nurse practitioners were practicing in inner-city areas and that 60 percent of nurse practitioners were employed in ambulatory clinical practices such as community based clinics, with an additional 10 percent employed by health departments or home health agencies. Since 1972, 7,600 physician assistants have been graduated from federally assisted programs. The number of females in the profession, which was once dominated by former military personnel, has increased markedly, but minority representation has not. The Federal grant program has required deployment of students to health manpower shortage areas, and studies have shown that graduates do tend to locate in both urban and rural shortage areas. Although data are not available on the impact of PAs on the populations of interest to the Commission, studies indicate that PAs have definitely had an impact on accessibility to care where access was previously minimal.

The Area Health Education Centers program is aimed at training physicians and other health care providers with a primary care orientation, and requires that a significant portion of the training take place in a rural or urban site remote from the health science center. This program hopes to interest developing health professionals in practicing in such locations, while also providing important professional linkages for existing practitioners in that area.

Although the predominant number of AHEC projects, originally 11 and now 21, were oriented toward rural areas, 3 have been rural-urban and 4 have been totally urban in nature. The AHEC program, begun in 1972, was developed along lines recommended by the Carnegie Commission. Its goals are to improve access to health care services in underserved areas by providing decentralized training, education, and experience; increasing primary care training; and encouraging more efficient utilization of health care personnel. The program is continually being evaluated, most recently by the Carnegie Council, as well as the Department in a report to Congress, and has shown some positive results, both in stimulating new practitioners to locate in underserved areas and in making it more professionally rewarding for those who are already there to remain.

In talking about health professions, we have used the term, "primary care." We are concerned that increasing numbers of physicians have gone into the specialties and subspecialties, while the greatest need is for the primary care practitioner, who is the physician one sees first, and who is capable of treating 90 percent of our ailments (according to the Institute of Medicine) and who refers patients to specialists as appropriate.

A primary care practice is not hospital based, and often is not as well reimbursed by third-party payers. In addition, it is less prestigious in academic health science centers than surgical specialties and those which are more closely tied to the research community. However, meeting the health needs of the disadvantaged will require primary care physicians. In targeting support for medical education, HRA is providing funding for primary care residencies in general internal medicine, general pediatrics and family practice, and family medicine curriculum development. For these projects, a preference for funding is given to applications which propose a substantial portion of the training program in health manpower shortage areas (Section 332) or in a federally funded AHEC. Many of these are in urban settings. Support also has been provided for the development of geriatrics and nutrition curricula in medical education. It is our position that geriatrics ought to be incorporated into all medical education rather than becoming another subspecialty. We also have provided support for projects such as interdisciplinary team training for hospice care.

There is concern in all parts of the country about the high vacancy rates for nurses in hospitals. In 1977 there were 1,401,633 nurses in the Nation; some 423,400 of them were not employed in the nursing field. The various nursing education programs graduated 77,874 new students in 1978. We are currently attempting to better understand the factors affecting the high dropout rate, such as salary, scheduling, burnout, and career mobility opportunities. It is more logical for us to study such factors than to produce more and more graduates to compensate for the numbers of nurses leaving the profession. We intend to have the Institute of Medicine of the National Academy of Sciences carry out a study over the next 2 years on issues relating to nursing education and retention.

Apart from generalized support of nursing education, we have been supporting programs aimed at furthering identified priorities. These projects include nurse practitioner programs focusing on women's health and on geriatrics. Other projects address the needs of women in childbearing and childrearing. Although such programs are organized along disciplinary lines or focus on subject areas as in nursing research, it is easy to see their relevance to the health care of target populations in urban areas.

It is unclear in the present fiscal situation what funds that have been available for undifferentiated support of health professions schools will be redirected into targeted priority activities. With the decreasing level of Federal support for health professions students, the role of the States is increasingly significant, both in terms of financial resources and potential service obligations. A number of States also are imposing service requirements on health profession students who have attended State-supported schools or on those who have received State financial assistance. We are increasing our monitoring of State activities in this area, and are attempting to coordinate service obligations for students.

The Commission has asked us to discuss the quality of health care received by target population groups. We do not, however, participate in the actual monitoring of the quality of health services delivered.

The principal health professions programs administered by this agency which relate to quality are those in curriculum development and continuing education development. We also have played a strong role, in conjunction with various health professional associations, in supporting the development of credentialing standards for these personnel.

Within the Health Resources Administration, the Office of Health Resources Opportunity directs the Health Careers Opportunity Program, which funds projects aimed at the identification, recruitment, and retention of minorities and the disadvantaged into the health professions. We cannot provide direct data on the relevance of this program to urban health care for population groups of concern to the Commission, except to note a study published by OHRO titled "The Treatment Practices of Black Physicians," which states that in 1975, 87 percent of patient visits to black physicians were by nonblacks. One can infer that the training of more minority health professionals increases access for minorities. Currently, blacks constitute 5.7 percent of medical students; mainland Hispanics, 2.8 percent; and women, 25.3 percent. We have found that over the last 9 years, the average percent of minority students in the first year was 9.3 for those nonminority schools which received grants under this program, compared with 6.8 percent for schools which did not receive grants.

Although place of residence is not a determining factor for participation in HCOP programs, except for those directed at American Indians, a listing of HCOP grantees shows that 131 are urban centered out of a total of 151. It can be assumed that a significant number of the more than 10,000 youths served by these projects are from urban settings. The projects themselves range from general information and motivation at the secondary school level through identification and compensatory education. This program does not provide student assistance; however, approximately 640 students in FY 1979 were recipients of Exceptional Financial Need Scholarships for the first year of health professions education. These scholarships enable the student to determine how well-suited he or she may be to such an education before incurring a debt for tuition loans. The program is based on need and not racial or ethnic background.

It is, of course, obvious that urban health is influenced by much more than the availability of health care facilities, services, and personnel. Adequate food, housing, education, a healthful environment, and a health promoting lifestyle are critical elements. Even within the realm of actual health services, we need better coordination between financing and reimbursement practices and programs which deliver health services or which promote the development of health resources. Building a structure for the planning and implementing of a rationally organized health care system and training professionals to provide needed services is an important part of a broader approach to problems relating to urban health.

I am ready to respond to questions.

Commissioner Saltzman. Of course. Your entire paper will be included.

We will come to the respondents at this point. I will introduce all three at one time. First is Marilyn G. Rose.

Ms. Rose has been an attorney with the Center for Law and Social Policy in Washington, D.C., since 1974. In this position, she has engaged in major law reform activities in the health area, directed towards increasing access for the poor and minorities into the health system. Ms. Rose was actively involved in the first case brought to enforce the obligation of hospitals built with Hill-Burton monies. The successful resolution of that case resulted in issuance of regulations by HEW and in attempts to effect compliance by New Orleans hospitals with Title VI of the Civil Rights Act of 1964.

Among her major cases is one challenging HEW for its failure to enforce nondiscriminatory site selection for hospital relocation. As a result of the case, HEW instituted changes in its procedures for reviewing civil rights impact of hospital planning applications.

Ms. Rose has testified before congressional committees and, since 1972, has held the position of chairperson of the Health Task Force, Leadership Conference on Civil Rights. She has also given numerous lectures and seminars on aspects of health law at law schools and schools of public health, as well as legal training sessions.

Ms. Rose graduated from Brandeis University *summa cum laude,* with distinction in political science, and graduated from Harvard Law School *cum laude.*

She will be followed by Janice M. Robinson. Janice M. Robinson has served as executive director, National Association of Community Health Centers (NACHC) since November 1979. NACHC is a primary advocate for ambulatory health care delivery programs in the United States.

Prior to becoming director of the NACHC, she served as executive director of the William Fitts Ryan Community Health Center in New York City from 1972 to 1979. In addition, she was also a member of the Ambulatory Care Standards Task Force, Region II, Department of Health, Education, and Welfare (DHEW); the Urban Health Policy Task Force, Bureau of Community Health Services, DHEW; and the National Minority Health Consortium. She also testified before the House Appropriations Committee regarding Neighborhood Health Center Programs and their proposed budgets in 1977 and 1979.

Ms. Robinson has presented many papers to professional health organizations, including "Health Services of Medically Indigent in An Urban Setting," presented at the National Health Council in Philadelphia, 1976; and "Community Health Centers: An Experience in Cost Containment," presented at the New York Academy of Medicine, Annual Health Conference, 1979.

During the period 1973 to 1978, she was a guest lecturer and lecturer at Cornell University, New York University, Hunter College, and Manhattan College on health areas such as community health centers, community participation, alternative models of ambulatory care, and planning for health services.

Ms. Robinson received her B.S. degree from University of Bridgeport School of Nursing and her M.S. degree in nursing from New York University.

Dr. Wing is our third respondent. Dr. Wing is currently assistant professor of health law with a joint appointment in the School of Law in the School of Public Health at the University of North Carolina. Dr. Wing was the deputy civil rights officer for the California State Department of Health. In that position he had responsibility for enforcement of Title VI of the 1964 Civil Rights Act and other laws relating to equality in health service delivery, both in departmental programs and in services delivered by contractors and licensees. He has also been affiliated with the National Health Law Program in the capacity of assistant director and, later, acting director.

Dr. Wing's current professional activities include appointment as legal counsel to the Institute of Medicine committee conducting a 6-month study on health services to minorities and the handicapped. He is also an elected member of the board of directors, National Health Law Program, as well as a consultant to the Legal Services Corporation.

Dr. Wing holds an A.A. from Foothill College, a B.A. from the University of California at Santa Cruz, the J.D. from Harvard Law School, and M.P.H. from the Harvard School of Public Health.

Ms. Rose.

RESPONSE OF MARILYN ROSE, ATTORNEY, CENTER FOR LAW AND SOCIAL POLICY

MS. ROSE. I would like to thank the Commission for the invitation to speak here today. I will try to limit my remarks, which is somewhat difficult because of my years of experience in this field.

Once upon a time I was a HEW civil rights lawyer. That was in 1966, during the desegregation of southern hospitals, when the decision was made on the White House level to use Medicare to desegregate those hospitals. After 18 months the blinds were pulled down on the window when we wanted to get beyond the issue of simple segregation. Since 1970 I have been in the private sector, first with the National Health Law Program, the federally funded legal service backup center, and then with the Center for Law and Social Policy, a privately-funded public interest law firm.

For the last 6 years I have been involved in probably the bulk of the civil rights and poverty law cases in the access area. Even though I know Dr. Foley personally and I believe that he is speaking with good faith, my experience is one of cynicism. I do not believe any of the promises which HEW makes in the statement. I do not believe the promises can be fulfilled by government as it is organized.

It is unfortunate that we are here 15 years after Title VI passed, and they have still yet to do what is authorized to be done by the Office for Civil Rights, HEW. In the early days of the program, the focus was to eliminate overt signs of discrimination. That took place and little more was done by HEW.

In 1970 I instituted, with New Orleans legal services attorneys, the first of the Hill-Burton lawsuits. I did not recognize at the time the size of the endeavor. Most Hill-Burton hospitals were violating their obligations. They had given 4 years of obligations to give compensated care, but no State agency or HEW did anything to enforce those obligations. It took court orders and Federal judges in cases brought by legal services offices to obtain the first substantive regulations in 1972, and those were limited to free service.

When we attempted to get HEW to recognize that Hill-Burton hospitals had obligations to serve Medicaid populations, we had to go for another court order. In 1974 we finally got the regulation on that subject. There was reference this morning to a recent case in Texas, but 7 years ago we had a Federal judge in Louisiana say that obligation existed.

The Office for Civil Rights in 1974, as a result of a consent agreement on the Title VI issue in the case, began an investigation of 18 hospitals in the New Orleans metropolitan area. However, we had to keep pressing HEW to get any action. In 1978, 4 years after the consent, HEW finally sent notices against three of the hospitals. I asked the Office for Civil Rights recently what they were going to do about the other hospitals. I am still awaiting an answer. The problem, I am told, is limited resources.

You heard this morning about a survey form the Office for Civil Rights is going to send out. It is a joint survey form. It is going to ask questions about both civil rights compliance and Hill-Burton compliance. It is a result of another case that started in 1974. In early 1975 we amended the 1974 complaint, adding allegations involving noncompliance with the new Health Planning Act, which became law on the 5th of January, 1975. This law is administered by people in Dr. Foley's bureau. That health planning law did not suggest that data be gathered, it mandated that the data be gathered. If you read the health committee hearings in 1974, we made complaints, the General Accounting Office made an investigation, and Senator Kennedy had an oversight hearing. The report of that hearing said one reason HEW did not know whether these assurances were lived up to was because HEW did not get data.

After many more stays of action and mountains of paper, in the summer of 1978 I got a consent agreement from HEW that HEW will issue new regulations, under the act signed into law in January 1975, and that HEW would develop information forms to comply with the requirements. In January 1980, a draft assurance reporting form was finally sent to the Office of Management and Budget for the free service part of the assurance. The civil rights part of the assurance is going to be combined with a survey from the Office for Civil Rights by the 30th of April of this year. This is 4-1/2 years after the statute was enacted.

In fact, the regulations which Dr. Foley alluded to, published in the *Federal Register* May 1979, were published after the original act would have disappeared except for a continuation. It is the problem of dealing with an agency understaffed. I think Dr. Foley's staff who work in the Hill-Burton area consists of 17 employees or maybe only 14 employees, enforcing assurances from 7,000 hospitals.

The question is, where is the commitment? There is another area talked about today, the closure of public hospitals and the relocation of private hospitals. The Commission alluded to it this morning. It was alluded to in Roma Stewart's testimony. Dr. Foley alluded to it also. It is very serious. Nothing had ever been done by HEW about relocation until we brought the original cases.

In Wilmington, Delaware, we brought the only case that tried to stop a hospital before relocation occurred. OCR was reluctantly dragged in to investigate and found that there was a problem with moving the hospital 8 miles outside the city, where 76 percent of the elderly and 88 percent of the minorities live. However, HEW found that a shuttle bus will take care of the discrimination. We fought that in court. We had been fighting it for 3-1/2 years. We were initially denied our private right of action, but the third circuit reversed. (Incidentally, HEW at first took the position that we were not entitled to a private right of action, but changed its denial in the third circuit, to be consistent with the position the Solicitor General was taking on Title IX cases before the Supreme Court.) We had a 5-week trial finally in 1979. We suspect we may have to appeal to the third circuit again.

HEW has not helped us there. They have not helped in any of the cases, although they could say that when you get Federal monies, $25 million of Medicaid or Medicare money a year, if you want to continue to get this money, you have to stay where the poor folks are, where high risk populations are. You have a minority population in Delaware. Thirteen percent of the population of New Castle County is minority. But 45 percent of the premature nursery days are minority. These are the high risk premature babies. Yet, the whole obstetrical services want to move out to the suburbs. The problem is the health planning operation looks at it as this is good health care and that they have no responsibility to look at it. The civil rights people say we cannot stop anybody if they want to go. This is the kind of problem that we have with HEW.

In fact, soon after we instituted the Wilmington Medical Center case, I took depositions of the people in the Office for Civil Rights and they never heard of the HEW planning responsibilities of Dr. Foley's agency of HEW. Some regulations were issued a couple of weeks ago that are pretty good on paper. What are they really going to mean in fact? What is really going to happen? Dr. Shirley testified about the State planning agencies, the SHPDA; he talked about an agency which is HEW, through Dr. Foley's operation. It is composed of people who are a part of the white establishment. That is what has happened. That was what happened in Delaware. The establishment decided what it wanted. HEW will not combine its Office for Civil Rights and planning responsibilities to say no. They say, "Maybe if you make a few corrections," which we find meaningless.

We have had this same problem in free service and community service programs of Hill-Burton, and the civil rights program; they are all part of the same package. Dr. Foley's program used a word a while ago in relationship with OCR coordination and I think he said strong relationship with OCR. I don't know what kind of a strong relationship there is. Let me give you an example of current lack of such relationships. The reporting form was sent to the Office of Management and Budget to be approved by OMB before being sent to the hospitals. After it went over there, some 30 letters were sent to community groups to the Office of Management and Budget, pointing out these differences in the question asked in community service regulations. There was no data asked about them. You cannot tell how they were going to be enforced. The person in the Office of Management and Budget who reviewed the forms was impressed by the issue raised in these 30 letters. He went over to HRA armed with questions he thought they should add to the assurance form.

HRA said, "We don't want to use that data, so, it should not be put into the form." The interesting thing is that HRA had signed an interagency agreement with the Office for Civil Rights, and the Office for Civil Rights was going to administer this community service assurance. The Office for Civil Rights wanted this information. However, nobody told the Office for Civil Rights that this meeting was taking place and the Office of Management and Budget did not know the coordination agreement had been made and the responsibility was over at the Office for Civil Rights. He should have been talking to them, but nobody told OMB.

The Health Resources Administration did not contact anyone. It took a couple of people outside HEW, like me, calling back and forth between HRA, OCR, and OMB and acting as a liaison between different factions of Government. When I thought the Office for Civil Rights contacted HRA and nothing was happening, I decided to call Dr. Foley myself, directly. It was already out of his agency, out of his jurisdiction, and he knew nothing about it. It is a fascinating story of what happens in bureaucracy. Well-meaning people buried in various places.

I am very cynical because of events which these stories relate of what we are going to get government to do. Federal money is in every one of these agencies, and Title VI rights go with it. Title VI money goes to the State health planning agency when it does its function. So it has to respond to civil rights. It goes to health service agencies and hospitals and to the entire health apparatus. The reason is they can't function without it. But, 15 years after Title VI, little has been done by HEW. All the litigation has been done in the outside market, by my program, in the National Health Law Program, and by a dozen or two or three dozen legal service lawyers who work with us and who have gotten HEW to be responsive.

It does not mean there are not people within the agency who would like to be able to do these things. However, it seems to be an absolute impossibility to get them to function without court orders. These court orders come very expensive.

One other point, and maybe this is a good lead in to Ms. Robinson who heard one of my clients. About 5 years ago, we sued Dr. Foley's predecessor, because in 1970 Congress amended the law to give a priority for the outpatient construction monies to go to projects in poverty areas to serve poverty residents. The money was—to use a term—"ripped off." We have gone through years of litigation. We got interpretation after interpretation. If a hospital is located in the poverty area, its emergency room can get the money even though they have deposit requirements and the poor people could not get served. In our review of the files during discovery, we found money was transferred illegally for inpatient functions.

The simple fact is, it has taken lots of effort and lots of time of outside people. The question is, when is HEW going to get its act together?

COMMISSIONER SALTZMAN. Thank you.

I might say, Dr. Foley, that after all of our respondents, you will have a few moments to respond.

RESPONSE OF JANICE ROBINSON, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Ms. ROBINSON. Mr. Chairman and members of the Commission, I appreciate the opportunity to speak to you this afternoon. I will respond to the presentation by speaking about the Community Health Center movement in this country, and the people it serves.

The program was begun in 1967 under OEO. There were initially 164 health centers funded through this means throughout the United States. They were set up primarily to meet the needs of the poor and minorities in this country. They were set up as alternatives to hospital outpatient departments and emergency rooms.

As I said, they were originally funded by OEO; however, by 1973 all programs were transferred to DHEW. There was originally no charge to the individual patients that were considered medically indigent for the service they received. Eligibility requirements were based upon family income and limited to the poverty level or below.

Once the program was transferred to DHEW, a sliding fee scale was mandated for all centers based upon income and family size. This created somewhat of a problem for a number of patients who could often ill afford the minimum charge, though they may have been ineligible for Medicaid. They were either unemployed or inadequately employed and therefore had no health insurance.

The centers were funded under Section 314E of the Public Health Service Act, initially, but P.L. 94–63 established them as a recognized entity that should be authorized for appropriation by the Federal Government. Originally, they were demonstration projects for the poor. However, once under the administration of HEW, health centers were to serve the entire community, regardless of income. P.L. 94–63 mandated specific primary services to be provided. First, provision of physician services, diagnostic and treatment services, preventive health services, including eye and ear examinations, perinatal care, child care, family planning services, emergency medical services, transportation as required for adequate care, preventive dental services, and pharmaceutical services. The centers may provide supplemental services, but the problem is, often there are not adequate resources for the center to provide the services. These include rehabilitation, mental health service, therapeutic radiological services, health education environmental services, as well as promoting and facilitating optimum use of primary health services.

All of that is fine, except there are not enough dollars to do it. The grants given to these programs from HEW are for subsidizing the care of the medically indigent, that is, those ineligible for Medicaid. Reimbursement for Medicaid patients comes from individual State health departments basically. Medicaid reimbursement is generally less than cost. There are a few States, New York and California in particular, where there is an attempt to provide reimbursement at an inclusive rate as opposed to a fee-for-service basis. For most of the rest of the country, health centers are not treated as institutional providers but are reimbursed solely at a rate for an individual physician. Health centers are treated as individual private practitioners. Since health centers must rely upon third parties, for sometimes as much as 50 percent of its budget, the impact can be devastating. An additional factor which impacts upon the economics of health centers is unemployment. The inner cities of this country have some of the highest rates of unemployment. I was formerly the director of a health center. Unemployment in the community there reached 20 percent in 1976. Concurrent with this, the State reduced the level of eligibility for Medicaid recipients, as well as reducing the number of services that they would cover (all to "save" money). These acts reduced the center's ability to provide services to the poor.

Hospitals, which have greater financial resources, managed to have the effects of the State's actions on them muted. While a cap (maximum level of reimbursement) was placed upon independent out-of-patient hospital facilities—health centers fall under this category—they removed the cap for hospital outpatient departments. Those same hospitals, particularly voluntary hospitals, have had the ability to turn away people who cannot pay, and most often they are directed to health centers, who may not turn away anyone because of inability to pay.

Voluntary hospitals in New York City increased the cost of individual patient's visits to the outpatient department. In fact, most voluntary hospitals, and I will use the example of New York City, have stated that unless a patient can pay the fee when they walk in the door, they will not be served in the outpatient department. The minimum fee in most hospitals at this point is $10 to $15 for a clinic visit. Many of the medically indigent who utilize health centers can ill afford a $3 fee, let alone afford $10 or $15.

There is a built-in inequity between hospitals and community health centers. Compounding the problem has been the fact that grants to community health centers have remained stable, if not reduced, for the past 3 consecutive years despite double-digit inflation, rising unemployment which has increased the volume of demand placed upon community health centers. Despite this reality there has been a proposal for recision in 1980 dollars for community health centers. There is continuing concern, and it was addressed in Dr. Foley's paper, regarding the trend of hospitals to close in inner cities, or to reduce in size, or to relocate to the suburbs. Once again, the Federal

Government is attempting to find ways to put dollars into the same institutions that have consistently rejected the poor and minorities in this country in terms of delivering service, while penalizing those entities that consistently have served the poor and minorities. Ms. Rose has already discussed the Hill-Burton problem. Under that program, only a few health centers received any money. None was received to develop facilities, many of which are in poor physical shape, and some of which are out of compliance with the State code. They are out of compliance because there has been no money made available for health centers to correct these deficiencies. Recently HEW entered into an interagency agreement with Farmer's Home Loan Program that provides loans for rural health centers. The Rural Health Clinic Act provided clinic support to communities which need the support and allows for an urban demonstration. There has been no urban demonstration, nor has there been any parallel program to allow for dollars for plant modernization or replacement for urban centers.

Despite all the problems, health centers have in fact helped community government. Fifty-one percent of the board of directors of the community health centers are made up of actual users of service, the poor and minorities. They in fact, by law, are responsible for approval of all budgets, approval of services to be provided, the hours of services to be provided, the hiring of the chief executive officer, as well as all personnel policies. Under P.L. 94–63, the board of directors has legal and judiciary responsibility for the health centers. Health centers have been able to show they can reduce hospitalization between 34 and 50 percent. Health centers have provided jobs for minorities, and have provided access to the jobs in administration, and to professional jobs, when the doors have been closed in other areas. They have in fact reduced their administrative cost by 12 percent. Despite these accomplishments, they do not receive the same notoriety as hospitals who fought against cost containment and have not matched the same rate of productivity or reduction in administrative cost.

The average cost per encounter for a health center is approximately $32. For a Medicaid patient, the same service is $55. The annualized cost per year for all services for a patient in a health center is $96. For Medicaid patients the cost is $155 annually. I think these figures speak for themselves in terms of the effectiveness of these programs. It has been shown through studies that they provide equal, if not better, quality services in ambulatory care.

A particular area of concern that I have is that of manpower. One of the things that is generated from Dr. Foley's department are the regulations concerning designation of health manpower service areas. The criteria, as they are listed in urban areas, generally mitigate against health centers being able to be qualified as health manpower shortage areas (HMSA). The criteria set-up is based on population, percentage of poverty and elderly, and infant mortality rates within the population, as well as the ratio of primary care physicians to population. In the inner city, the population is heterogeneous. The poor get lost when you average out numbers. When one counts physicians, one is counting doctors who are teaching at hospitals, private physicians who often refuse to serve Medicaid and Medicare patients, and physicians who have retired. (You are dealing with a home address rather than a practice address.) There is less manpower available for the inner-city poor and minority. Being designated an HMSA is essential to eligibility for National Health Service Corps physicians. Once eligible, many inner-city health centers would like to be able to have minority physicians, as most inner-city patients of health centers are minorities. However, they are few. I would make recommendations concerning that. First that there be emphasis upon recruitment of students from the inner city who are minorities and give priority to students who show a commitment to practice in a medically underserved, inner-city area upon completion of their studies. Second, experience, field experience, begins while in medical school. Connect them with community health centers which are federally funded projects and can be coordinated between Public Health Service BCHS [Bureau of Community Health Services] as well as HRA.

COMMISSIONER SALTZMAN. Thank you.

Dr. Wing.

RESPONSE OF KENNETH WING, ASSISTANT PROFESSOR, SCHOOL OF LAW AND SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA

DR. WING. The chief advantage of speaking last is you can fashion your remarks by people who go before you. The major disadvantage is many of the things you prepare to say have been said. I am down to five or six major points, both the response to Dr. Foley's paper and things he said earlier.

I would like to get to them and address those points to Dr. Foley and hear his response to some things Marilyn has raised. I will introduce my first point with a little bit of personal history.

In 1975 the State of California Department of Health established a civil rights office very much along the lines of the office of HEW. I am primarily interested in health rights of the poor. It was a job, the assistant director of something, which included the enforcement of Hill-Burton with free service obligation and the health facilities and responsibilities facing the program for the State in the area of Title VI in health service.

Since I was interested in Hill-Burton, I took the position thinking whatever exactly an enforcement program would be, it would be an exciting opportunity. As it turned out to be, it sounded like a bit of new leadership. We had a newly created office and mandate. Our department's plan of action included a mandate to fund innovative programs. We were going to redirect resources to serve those people who had not been served before. We were going to influence health plans and certificates of need in California and to enforce Title VI, which meant a variety of things in my mind.

Also, investigating complaints of discrimination and trying to determine where our enforcement actions should be directed. I worked there for 2 years. I must say I learned a great deal about Title VI as well as Hill-Burton. I learned a number of things which were disturbing.

To begin with, despite the job description and what our mandate to do had been, it turns out that the techniques for investigating civil rights complaints in a health care setting really did not exist. Simple data gathering techniques have never been developed. The basic standard for deciding what is discrimination and what is not discrimination and the data for deciding disparity in treatment does not exist.

We found out, despite the repeated rhetoric of State and Federal Government, the responsibilities of various State and Federal certification of Medicaid and licensing health facilities have never been sorted out.

Beneath the assurances made by State agencies to HEW and funded facilities to both the State and Federal Government and policy statements issued in the usual introductory materials, the principle of nondiscrimination in delivery of health services and particularly government funded health services has never really been accepted.

There is no real commitment to ensure equity. It is very, very clear at the same time from that evidence, from the few complaints you get and are able to investigate, there is gross disparity in the number of dollars spent and the terms of services rendered.

My first comment that I had when reading Dr. Foley's paper had to do with a strong sense of deja vu. The principles, and certainly a lot of them, were questions we had heard before. If you go back and read the various reports by officers in HEW in '68, '67, following the implementation of the Civil Rights Act and first go around of the Medicaid and Medicare, you find similar discussions. Now, we found there is a problem.

There is a newer one. We have new offices. We are going to focus on what we think are the problems. Progress is going to be made. If you look at the reports for the Civil Rights Commission, it is the 1974 report which is probably a summary of the 1973 data. You find HEW and States made similar representations. Yes, there are problems in the past, but we have a variety of new programs. Things are going to be better. Certainly, we heard that in 1975 in California, and both of us at State and Federal levels were saying that.

The question is whether you can go beyond acknowledging the problem. It seems to be dangerous to acknowledge the problem and underplaying it and say marginal adjustments in existing programs can make substantial progress. It implies the willingness is there to make those marginal adjustments. I find it difficult to believe the willingness or marginal adjustments exist. The civil rights enforcement efforts in education regarding health and welfare programs have always been marked with substantial problems within HEW, between the regional office and the central office and HEW and the State agencies.

From the observations that Marilyn makes, from the observations that you will find from local and State levels, and observations you get from people involved in the day-to-day enforcement activities of HEW, it is clear those internal struggles are still there.

Another observation I would like to make in terms of Dr. Foley's paper and things we have heard today is, I think it is dangerous to emphasize or to ascribe primary responsibility for race discrimination for health services to economic factors. There is no doubt the fact that people who are poor, people who have no insurance, people who don't have cash although they have a set of problems in gaining access to health care does impact on minorities in health care.

But, if you look at the data, I did not hear Dr. Aday this morning, but I have before and I read the draft of the book she is going to publish, the facts bear that out.

If you look at some of the complaints that have been investigated and carried out, if you look at the complaints documented in the U.S. Office of Civil Rights in 1974, there is more than that going on here than race discrimination. National rising health insurance which probably is unrealistic by emphasizing what we need are increases in Medicaid or Medicare reimbursement is only to talk to a part of the problem. Those are all necessary, but they are all minimal sorts of adjustments we have to make to move towards ending economic discrimination.

There is still clearly, although undocumented in any finite way and though it is hard to quantify into specific numbers of people, overt and covert race discrimination going on in health services. In terms of identifying basic problems for government agencies and enforcing civil rights laws, it must be emphasized that the basic problems must be reviewed as discrimination in the mainstream.

The focus has to be on primary care, nursing homes and hospital care. Of course, the representatives of various counsels and boards of directors of HSAs should be representative of the population they serve. That should go without saying. Of course, Public Health Service, from everything from rat control to identifying lead poisoning programs, should and could lead towards equalizing health delivery. The problem for HEW and OCR at this time in terms of this newer civil rights enforcement in health care has to focus on medical care, nursing homes, physician care, and hospital care.

I also think, in responding particularly to something Dr. Foley said, it would be a gross error in terms of law and in terms of practical problems of administration to define the relationship between individual programs throughout HEW and OCR where the programs assist the civil rights efforts. It seems as a matter of law and practice that the responsibility lies with the program. Administratively, that may be carried out by the Office for Civil Rights. But, historically, the division of loyalty to the civil rights objectives in terms of work has been one of the problems within HEW.

I would think from the very beginning it should be emphasized the program personnel carry a responsibility for enforcing civil rights laws, very much as the objectives of the health plans legislation starts out by saying one primary goal of the program is to ensure those of uncertain passive services in the future.

Discussion

COMMISSIONER SALTZMAN. Thank you.

Dr. Foley, would you like to respond for a moment or two? You can submit a written statement if you would like it to be added to your paper.

DR. FOLEY. I would like an opportunity to respond.

I think the panelists raised important and critical concerns. I would like to address some of them and not rationalize over what I think they factually have described.

I think oftentimes leadership in any large bureaucracy or organization requires outside pressure, be it a business or pressure when a Marilyn Rose will call me and tell me there is a problem within my agency and department.

The fact is, when it occurred, we did get it straightened out. That data will be collected. The staff has also been informed that collection of such data is necessary for this program.

The other aspect is, there has been an identification of lack of resources which I would not deny. This is, however, not the time when administrators in Washington would win their case for added resources. I think that is clear to everyone. There is no question that you cannot run an adequate Title VI enforcement responsibility with a staff of 17 people in your central office who also have the responsibility of monitoring over $2-1/2 billion of loans in those hospitals.

My staff aide says there are 27 people plus 10. We are not talking about a significantly large number of people. In order to assure free care is provided in those hospitals that have responsibility, we are targeting the resources we have. We are involved in a key investigation into one of the major metropolitan areas of this country, targeting hospitals with free care obligations. We move people off of their work in order to effect that. We have had that in plan and process for over 2-1/2 months.

Secondly, I would particularly like to address Dr. Robinson's concerns. I don't think there is any question that reimbursement for the kinds of facilities that you represent and which provide needed primary care services needs to be determined more carefully. That, currently, is not the responsibility of the Health Resources Administration, but I assume I am not here just as a spokesman for HRA.

At some time, we are going to have to link reimbursement with administration policy on health and health service programs. Otherwise, we will continue to have programs inadequately funded to provide needed primary care.

I think this second aspect raised by yourself in terms of the health manpower shortage area designation criteria mitigating against urban areas, the Commission should be aware those criteria are under review for each health service area on a yearly basis and will take cognizance of what you appropriately pointed out.

We have moved the National Health Service Corps scholarship program much more to the recruitment of minorities and other people who will serve in specific areas. At Meharry Medical School, over a third of the students are on National Health Service Corps scholarships. The problems are, we have high private medical education fees in the country which makes it very difficult for students to afford tuition. A greater proportion of nonmajority students are forced to use these scholarships because they find no alternative ways of funding.

I agree with Dr. Wing basically, standards and criteria have not existed for a long time. That is precisely what we are trying to work out. It is a difficult task.

Frankly, the way judgments are made on whether or not populations are described again in the last 4 or 5 years has been on the basis of demographic outcomes, statistical outcomes of the population in those areas. For example, infant mortality in certain areas and things of that kind. That is different in a criteria for judgment of how long to avoid discrimination, avoid negative outcomes, that we have seen in some parts of this country.

The question of the reality of the commitment. I don't think there is any question about the commitment of the Federal Government to fulfill the law. I think what is appropriately addressed is whether the resources are sufficient to do the task, as well as whether or not we have the appropriate techniques to be sure that the local communities really compare their responsibility and to make the pressure felt on those hospitals and facilities that do discriminate against certain populations.

If you look at the health systems agencies, they now represent the largest consumer representative body in HEW programs. Over 50,000 volunteers are involved. What they must do is look at how effective this specific hospital or clinic or any other health facility has been in providing services to those populations. Those are built into the performance criteria we put on all HSAs and SHPDAs. In the periodic grant cycle, we look at that in assessing their performance.

Last year we did not continue funding in some cases. We have defunded a health systems agency in a major urban area. We have put conditions on certain HSAs and SHPDAs when they did not meet those conditions. You talked about Mississippi. I put conditions on the State and the Governor with the concurrence of the Secretary of HEW. They have met a part of that condition.

It is an interesting legalism that we get into. The broadly representative factor applies in the law to consumers, not to providers. It is an interesting decision made by the Congress. I think that ought to be reevaluated. We make sure the consumer is widely representative, but the providers are not.

The program at this point does not have the authority to investigate, in a legal sense, the Title VI compliance issues. The second item which ought to be clarified is—I find it strange that any of us would consider that the economic factors now are not extremely serious for urban hospitals. I am aware, through my official responsibilities, of 22 urban hospitals that are facing and fighting financial closure. I think that is the tip of the iceberg. There are serious economic problems for these hospitals. They ought to be addressed.

COMMISSIONER SALTZMAN. Dr. Flemming.

CHAIRMAN FLEMMING. I would like to refer to one part of your statement, Dr. Foley. You have really referred to it again in connection with your comments just a few minutes ago. It is headed "Civil Rights Implications." It recognized the fact that. . ."in the performance of their many functions, both HSAs and SHPDAs take actions which may have civil rights implications for various populations. They may also review applications for certificate of need from certain facilities which some members of the community feel have not complied with civil rights requirements. The HSAs, most of which are private, nonprofit corporations, cannot perform a civil rights monitoring or compliance function. While the Office for Civil Rights has the responsibility of enforcing Title VI of the Civil Rights Act, HSAs can, of course, alert OCR to possible violations. HSAs do not have the authority or capability to conduct Title VI investigations and an attempt to do so would threaten the availability of the data they need from the health facilities for health planning purposes as well as their ability to develop a broad based acceptance of health planning activities."

I am not addressing myself at the moment to the relative legal responsibilities of OCR and program unit. I recognize OCR was set up in such a way that a program unit can draw conclusions to the effect that because OCR has been set up in a particular way the primary responsibility rests with OCR. I take issue with that form of organization within any department or agency. I believe we are not going to make progress in this area unless it is clear that programming has the primary responsibility for the enforcement of Title VI.

I think one reason why we are in difficulty 15 years after the passage of the 1964 act is the fact that that has not been made clear. We are in it. We have reasonably good legislation. We are in implementation stages as far as civil rights is concerned.

The comment that I would like to make particularly clear was this. You say an attempt to do so would threaten the availability of the data they need from the health facilities for health planning. I recognize the fact when a program unit or either a Federal program unit or one financed by a Title VI fund moves into implementation of Title VI, it disturbs the status quo and steps on toes. It becomes unpopular in certain quarters. That does create some administrative responsibility. It seems to me that this is one of the prices that has to be paid if we are really going to implement Title VI.

I wonder if it is this consideration that has led us to a position in connection with fair housing. For example, the law was passed in 1968, and we are just now beginning to take a look at proposed regulations over a period of 12 years.

In connection with Title VI and HEW, as we commented on a bit before, here we are in 1980. We are told that by the end of the year we may have the opportunity of looking at 11 sets of guidelines. They will be added to a couple of sets that were issued back in 1969. To me, this reflects a lack of commitment on the part of program people. I am not personalizing this at all. It is an institutional problem. It is a problem of making our system work in such a way we really can implement Title VI in a meaningful and effective way. For example, it seems to me the HSAs should not be let off the hook entirely as far as Title VI is concerned. They should be involved. They are getting Federal funds. They have an obligation to live up to Title VI.

DR. FOLEY. I agree with you on that. I have not said in my testimony that they should not meet Title VI.

CHAIRMAN FLEMMING. No. Your judgment—most of which are private nonprofit corporations that cannot perform a civil rights monitoring or compliance function. That was your point.

Here again, I am not getting into an argument as to what the setup of OCR is. It is the latter part of your program. Even though they had the right to do it, if they did do it, it would interfere with their effective functioning from a programming point of view.

VICE CHAIRMAN HORN. Excuse me. I don't get that they have the right to do it. "HSAs do not have the authority or capability to conduct Title VI investigations. An attempt to do so threatens the availability of data." So, you don't have authority.

DR. FOLEY. They have not the right to do so. If they were arms of government, extensions of the State or Federal Government, I think by our regulations we could require them to investigate.

CHAIRMAN FLEMMING. If they are recipients of Federal funds under Title VI, what are their obligations to meet the Title VI requirements to be sure in their own practices they do not discriminate?

COMMISSIONER FREEMAN. I would like to ask, Mr. Chairman, that a copy of the contract or grant document be provided. (See exhibit 8.) I take issue with the statement that is made. I believe this is so important that we ought to direct a communication to the Secretary for a definitive response.

If program people take the position that they do not require compliance with the civil rights provision while they can, at the same time, comply with other provisions, this is a system which is responsible for the problem in which we find ourselves.

COMMISSIONER SALTZMAN. Could you provide us with that?

DR. FOLEY. Yes. I want to be clear. I am not saying that these private sector, nonprofit organizations do not have to meet compliance under Title VI. They clearly do. They do not have the authority, however, to investigate as a legal arm such as the Office for Civil Rights or General Counsel of HEW.

VICE CHAIRMAN HORN. Has any staff agency within HEW asked that they have the authority? Have there been staff papers exploring the feasibility of such authority, if granted, so they could investigate the recipients of funds under their jurisdiction?

DR. FOLEY. There have been papers prepared in Public Health Service in terms of whether or not the program agency can, in fact, have third-party organizations do so. We could provide that to you. There has been disagreement on that.

VICE CHAIRMAN HORN. I would like to have those documents put into the record at this point.

CHAIRMAN FLEMMING. Without objection, that will be done. (See exhibit 9.)

COMMISSIONER FREEMAN. Pursuant with the letter to the Secretary, Mr. Chairman.

CHAIRMAN FLEMMING. Yes.

COMMISSIONER SALTZMAN. The Staff Director is here with us.

COMMISSIONER FREEMAN. My legal opinion would be different. I would disagree with that. I am sure HEW has better lawyers than that.

DR. FOLEY. In my experience, I have given you the current situation.

Dr. Flemming, you addressed the second part to regulations. It is not a question of program people not wanting to issue the regulations or do the job. They have, at my agency, done so over the last 3 years. We have issued over 50 sets of regulations, including for this area. Oftentimes, clearly, as you know as well as I, the decision about why a regulation is issued or not is a political decision made at the highest level of the Department or administration, often taking into account the views of the Congress.

It was quite helpful that a month and a half after I came into office, there were three people under Court order. They were the former Under Secretary, the General Counsel, and myself. Either we got those regulations issued or we would go and spend time in the Nashville jail. While I like country music, not in those circumstances. While I may be hard on some of my program people, this is not the time. I would say it is true of most departments of the Federal Government that the decision on many regulations is a political decision.

CHAIRMAN FLEMMING. I certainly accept the statement you just made. When I use program people, I was thinking of top people in political positions. They clearly should be held responsible for failure to get out the kind of guidelines and regulations we are talking about. Whatever the reasons, it is discouraging in both Title VI and VIII. I know a great many program people who are deeply concerned about this, as you have indicated.

MS. ROSE. May I make a response for Dr. Wing and myself?

We would make an offer to present our view. We agree with Commissioner Freeman. There is a legal responsibility. It is not necessarily as narrowly defined as the investigation of the Title VI, but the whole health planning process is supposed to go into the review and assessment of need. If an HSA is ignoring the needs of minorities and the poor and the elderly and the handicapped and giving approvals, as happened in Louisiana, giving approval to hospitals being taken to trial for failure to serve the minorities in those communities and agencies given approval for expansion, it is violating the health planning laws.

COMMISSIONER SALTZMAN. I would suggest that if you would like to make an additional statement, and I know Dr. Wing was cut off a little, we would be happy to enter additional statements into the record. We are getting to closing time.

We have another meeting to go to.

Chairman Flemming, are you done?

CHAIRMAN FLEMMING. Yes.

VICE CHAIRMAN HORN. Dr. Foley, I was interested in your comment that 5 million undocumented aliens lacked health care services. What thought was given by the Health Resources Administration as to how one might appropriately deal with the need for health care for undocumented aliens who perhaps number from 3 to 12 million people in this country?

DR. FOLEY. We have supported the Surgeon General's recommendations to the Secretary and the President to expand the number of community health centers of this country for that population as well as others. We have been working within the Department and with the Health Care Financing Administration on various possible amendments to Section 328, the Health Services Administration authority, and the waiver provision. Other avenues are being explored. I serve on the Under Secretary's task force, just recently coming into existence, which is looking at financially troubled hospitals, and these serve undocumented aliens, particularly in New York, Los Angeles, and some parts of Florida. I would not say we have any particular solutions at this time except to maximize the waiver authority under the Health Services Administration.

I have no funded authority now in my program areas which could assist directly on the problem.

VICE CHAIRMAN HORN. What I want is the charges to service in federally subsidized programs. Do they vary? Is there no charge for undocumented aliens or are they treated the same as citizens or what?

DR. FOLEY. They are treated the same as citizens.

VICE CHAIRMAN HORN. That could mean a sliding fee for services on a needs basis?

DR. FOLEY. Yes. And pay on local implementation. You would have more stringent enforcement and each test and circumstances not so strictly enforced. The difficulty that Dr. Robinson identified is, if that continues too long some centers will have financial difficulty. By using the sliding scale for some problems, these people are able to have some health care services.

VICE CHAIRMAN HORN. Are there areas where there is a feeling that changes are needed in the law in order to handle this population, or is it simply a matter of adequate funding under existing programs since apparently, as you say, the undocumented aliens are treated the same as citizens?

DR. FOLEY. Mr. Horn, there was consideration in the past. The Under Secretary testified before Congress that we are going to try to come up with alternatives other than the existing authorities.

VICE CHAIRMAN HORN. Pursuing a question the Chairman raised concerning the OCR relationships with the program agencies, how adequate do you find the daily formal and informal administrative relationships between OCR and the program areas for which you are responsible? In your answer, I would appreciate having you link up the planning function in HEW as well as the civil rights function with your program analysis and needs. Are civil rights considerations taken into account in prospective resource allocation requests from your program agency? Or are "program planning" and "civil rights" passing each other in the dark on the Atlantic Ocean?

DR. FOLEY. Not quite. I am a relatively simple man in some regards. As an administrator, I am impressed by both formal and informal communications. The formal and informal depend upon the leadership of offices, not just agency level but within bureaus and divisions. You have to get the right individual. Sometimes we have that with OCR and sometimes we have not.

The second thing is that location is strategic for communication, to say the obvious. The Health Resources Administration is 8 miles out of town. Out of sight, out of mind. We have managed in this city to so decentralize, we have HCFA [Health Care Financing Administration] 60 miles up the road. We have Dr. Lythcott's program 20 miles up the road. You have the central office down here. I find that so much of the problems develop simply because people have not been close enough to walk across the street and talk to each other. That needs to be greatly improved. We need to figure out our logistics problem.

I think the second aspect is that civil rights and access concerns must be addressed within the framework of internal and programmic resource allocation. We have a plan for the full agency. It was developed over the past year involving all bureaus and offices and divisions below them. Each bureau chief and office chief is required to achieve specific accomplishments and build that effect into projections for resources over the year, particularly the zero based budget and processes beyond that.

If we are going to push for access in health professions areas or planning or various activities in health facilities, we are going to have to build in a specific approach for each programmatic leader within each administration. We would be glad to forward that plan.

VICE CHAIRMAN HORN: I gather, then, that in your written formal planning process, civil rights considerations—at least from the standpoint of increasing services each year to a targeted minority population—are to some extent taken into account as part of the basic program review of the delivery of service?

DR. FOLEY. To some extent, but not in terms of how many more services do we want for a specific population in specific parts of the country. We encourage SHPDAs and HSAs to do that in State and local plans, but we have not any quotas.

VICE CHAIRMAN HORN. It seems to me it would be important to know who is receiving the services now. What is their demographic makeup and the area makeup in demographic terms and how might the targeting of those services be improved?

DR. FOLEY. I think that is extremely reasonable. This is the first year we have completed such information. We have now a hint of what the demography looks like for health in every part of the United States and the islands. We are analyzing those health plans which build that and trying to let the Department use the data to make choices about where they are going to put Federal resources. Federal placement has not matched the actual need. We told the HSAs, you must tell us the outcome and what are the services needed just as in an urban planning document.

VICE CHAIRMAN HORN. It was stated that the Hill-Burton funds don't go to fund the health centers. Is that a matter of law or the scarcity of resources?

DR. FOLEY. It is the second. There was a strong bias in the program prior to this administration to fund urban hospitals and outpatient departments of hospitals. There is the authority, and appropriately identified, to allow for the funding of clinics and renovation. However, the funds have not been available for over 3-1/2 years.

VICE CHAIRMAN HORN. Funds available for what, Hill-Burton generally?

DR. FOLEY. For full development in terms of renovation and expansion of clinics.

VICE CHAIRMAN HORN. How about funds available under Hill-Burton to hospitals?

DR. FOLEY. Basically, that has been stopped.

VICE CHAIRMAN HORN. How much is available under Hill-Burton?

DR. FOLEY. Nothing. We have two aspects. We have responsibility for free care and community service assurances and the second is responsibility for Hill-Burton loans.

VICE CHAIRMAN HORN. None of that money can be recycled?

DR. FOLEY. No.

VICE CHAIRMAN HORN. Is there any attempt within any portion of the administration to seek additional budgetary authority? Is this an administrative decision or a congressional decision?

DR. FOLEY. It is clearly an administrative decision not to seek more money in this area at this time. It has been accepted by Congress in the last couple of years.

VICE CHAIRMAN HORN. We have had a discussion not only concerning the outreach of services to minorities but also the question of getting minorities involved in the health care system. I note in the recent administration request to Congress for cuts in the 1980 budget, that a recision of $77.4 million out of $100 million has been sought in nurse training.

What is the best thinking at the administrative level of HEW as to the validity of this recision and the need for funding for health care personnel, particularly with regard to the need that the minority community should be funded to gain access to these professions, hopefully in the delivery of services?

DR. FOLEY. Let me start at the last point and work backwards. I think that is the key to administration decisions. One criterion is the impact on future and current programs on recruitment and retention of health professionals. Therefore, the administration has upped the funding of certain programs, particularly the disadvantaged assistance programming which promotes retention.

It is also continuing National Health Service Corps scholarship programs and is moving towards special projects which can target the funding to move that towards minority objectives.

Existing programs, which did serve useful purposes, have provided indiscriminate funding to the various health professional schools, which were not necessarily meeting the expectations suggested by Congress, and this, or the previous administration.

If we had our fiscal druthers and financial druthers and could go for a tradeoff, we would fund special projects to meet the needs of the urban centers, but the administration does not have that option. It wants to cut programs in the field that are no longer effective or increase it in the area of nursing, disadvantaged assistance, National Health Service Corps, and primary care medicine programs.

There has been that kind of budget discussion and tradeoff. There has not been budget balancing except in the larger national sense.

VICE CHAIRMAN HORN. As one who lives in an urban area, it seems to me that such a policy is against access for minorities to nurse training, and, regardless of whether the nurse is minority or not, the fact is there is a need for nurses in the inner-city hospitals, especially on the night shift.

Is there any way to redirect that nurse training program to provide incentives to meet what seems to be clearly those needs, in terms of minority access to profession, and thus serving the needs of inner-city urban communities? Could the loan be waived if one worked in an urban environment?

DR. FOLEY. We have discussed that as an option. There is a favorable attitude towards that if we can come up with funds for the loans. We have taken the position that the problems of vacancies, which are real in the urban centers and other hospitals in this country, need to be resolved at the local level in terms of salaries, incentives for nurses. Of the 1,495,000 nurses, we have 495,000 who have left nursing. There is a high attrition rate, partly because of work and partly because of salary. We are sure that Federal funding in the way we have done it in the past does not resolve the basic problems for the hospitals or for the nursing profession. We have challenged them and have moved ourselves to look at that carefully. We do see we have doubled the number of nurses in the last decade and a half. We have created a new class of LPNs, that were not there in the 1960s, of over a half a million. Yet, we see the vacancy rate going up faster than the population increases. We think that should be clearly addressed and not with a Band-aid approach, which I think the current programs do.

But that does not mean that over a time we could not come up with an appropriate approach. Certainly, we need to recruit minorities into the profession and retain them in hospitals and long term care facilities.

VICE CHAIRMAN HORN. Thank you very much. I appreciate your answers to these questions.

COMMISSIONER SALTZMAN. Mr. Nunez.

MR. NUNEZ. Dr. Foley, You have a full-time staff of approximately 1,200 people? Is that correct?

DR. FOLEY. 1,197.

MR. NUNEZ. We have been talking about the need to increase the percentage of minorities in the health services out in the field. What are the statistics for your administration at the present time, particularly in the area of professional categories?

DR. FOLEY. We can send that (see exhibit 10) and this relates to the earlier question of Mr. Horn. We have a specific work plan for each hiring official in the organization. They are making excellent progress. We have one of the best track records in the Public Health Service. We need improvement, but I am glad to share that with you.

Where I find a lack is in the recruitment and retention of Hispanics. I have hiring in the performance criteria of each senior executive who reports to me. Unless they can show they have gone out and looked for a competent Hispanic or black, you don't fill the position. You get much prompter action than if you let the system grind on by itself.

MR. NUNEZ. Would you not hazard a guess to minorities in your organization?

DR. FOLEY. The percentage of minorities is very high. It is probably well over 35 percent. It probably is much higher now. The professional ranks need some strengthening. We have two strong priorities. One is the recruitment of women into those positions and the other is recruitment of minorities. I had to balance both.

MR. NUNEZ. You are talking about out of the 1,100, approximately?

DR. FOLEY. It is extremely high for my agency and extremely high for GS 11s and 13s. What needs more representation are the 13s through 15s and the senior executives. We have a woman at the head of the Bureau of Health Facilities and a deputy director in the Bureau of Health Planning. Basically, our minority leadership is very good. It is very mixed leadership.

MR. NUNEZ. Thank you very much. It has been very interesting. We appreciate the contribution of each of you.

Dr. Flemming?

CHAIRMAN FLEMMING. May I just say we are grateful to you for spending this time with us and helping us look at some of these issues we feel are very, very important.

The consultation will be in recess until 9:30 tomorrow morning.

Morning Session, April 16, 1980

CHAIRMAN FLEMMING. I am requesting my colleague, Commissioner Freeman, to preside during the morning session. Commissioner Freeman.

COMMISSIONER FREEMAN. This morning the focus will be on legislative initiatives. We will ask the presenters and respondents to come forward at this time. Dr. Karen Davis, John Holloman, Laurence Branch and Marcia Greenberger. Is Dr. Karen Davis here? John Holloman?

DR. HOLLOMAN. That I am.

COMMISSIONER FREEMAN. Laurence Branch?

We understand that Dr. Davis is on her way. Respondents are here, ready and willing and able.

DR. HOLLOMAN. Ready and willing.

COMMISSIONER FREEMAN. Dr. Davis?

DR. DAVIS. Yes.

CHAIRMAN FLEMMING. All right. The meeting will come to order, please.

COMMISSIONER FREEMAN. This morning we will focus on legislative initiatives. The presenter is Dr. Karen Davis. Dr. Davis is currently Deputy Assistant Secretary for Planning and Evaulation/Health at the Department of Health, Education, and Welfare, soon to be called the Department of Health and Human Services. She is responsible for the development of the administration's major health legislation proposals, including the national health plan, hospital cost containment, child health assessment plan, and the rural clinic act. She also serves as principal advisor to the Secretary of Health, Education, and Welfare on health policy issues.

Prior to going to HEW in 1977, Dr. Davis was a senior fellow at Brookings Institution in Washington, D.C. Other professional experiences include the following: member, Health Advisory Panel, Office of Technology Assessment; member, U.S. Department of Health, Education, and Welfare, Health Care Technology Study Section; associate editor, *The Milbank Memorial Fund Quarterly, Health and Society.*

Among her publications are the following: *Health and the War on Poverty: A Ten Year Appraisal; National Health Insurance: Benefits, Costs, and Consequences;* "A Decade of Policy Developments in Providing Health Care to Low-Income Families," in *A Decade of Anti-Poverty Policy Achievements, Failures, and Lessons;* and "The Distribution of Medicare and Medicaid Benefits to the Elderly," paper presented at the American Economic Association meetings, December 20, 1974.

Dr. Davis has a B.A. in mathematics and economics and a Ph.D. in economics from Rice University.

Dr. Davis, you will have 25 minutes to make your presentation and then I will introduce the respondents after your presentation.

STATEMENT OF KAREN DAVIS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

DR. DAVIS. Thank you, Commissioner. Fellow Commissioners and guests. I am pleased to be here today to discuss problems in access to health services experienced by members of minority groups and Federal legislative proposals designed to improve access to care.

Although we have made great strides in improving health status and access to care of minority groups, disparities persist. The infant mortality rate among black infants is still twice that of white infants. Life expectancy among black males is 8 years below that of white males. More than one out of every three black women does not receive timely prenatal care. Only 35 percent of the minority population receives regular dental care, compared to 51 percent of the white population.

Black children see a physician on an average of 2.9 times per year. The rate for white children is 4.3 visits. Minority patients are twice as likely to receive care in hospital emergency rooms and outpatient departments, rather than private physicians' offices as are white patients.

The Federal Government supports a variety of programs designed to improve access to health services for disadvantaged Americans. In 1979 Federal health care costs represented $62 billion or 12.7 percent of the Federal budget, a substantial commitment.

Federal programs represent two basic strategies. The service delivery programs, largely administered by the Public Health Service, provide direct health care services to disadvantaged citizens—80 percent of the 5 million Community Health Center users are members of minority groups. The maternal and infant care and children and youth centers operated under Title V of the Social Security Act are all located in economically depressed areas. The Indian Health Service supports facilities and personnel serving 770,000 American Indians.

The Department's financing programs are third-party payment programs which reimburse for services provided largely in the private sector. Medicaid is designed to improve financial access to health care to the poor. Over $12.4 billion in Federal Medicaid expenditures supported basic acute health care services for over 21.3 million poor in 1979. The Medicare program pays for health care received by the aged and disabled. In 1979 Medicare spent $28.2 billion in care provided to over 23 million beneficiaries.

Yet, despite these efforts, serious gaps exist in providing access to care for the poor and disadvantaged. Among these are, first of all, lack of health insurance coverage—22 million Americans have no insurance protection. Another 20 million citizens have very inadequate health insurance coverage for even basic health care services. An additional 41 million Americans, or 83 million Americans in total, have inadequate protection against the cost of major illness.

The lack of insurance coverage falls heavily on minority citizens. For example, while 8.5 percent of all white individuals are without insurance coverage, over 14 percent of blacks and other minorities have no insurance protection. In large part, the concern is tied to employment and income under current programs. Minorities comprise 25 percent of all poor people, yet, 20 percent of public financing program beneficiaries—Medicare and Medicaid—are minorities.

Discrepancies exist in the use of services among minorities, even among those covered by public financing programs. Minority Medicare beneficiaries use hospital, skilled nursing homes, and physician services at lower rates than white Medicare patients. Utilization of Medicaid funded services is 10 percent higher for whites than minorities, except for nursing home and intermediate care where utilization rates for whites are 4-1/2 to 5-1/2 times higher for whites than for minorities.

Medicaid per capita expenditures for whites are roughly 10 percent higher than for minorities. Utilization rates for Medicare covered services are higher for whites than for others. This is especially dramatic in skilled nursing facilities where the utilization rates for whites are 63 percent higher than the rates for minorities.

The administration has developed a number of legislative proposals designed to improve access to health care services. Major efforts geared toward improved financing of health services include the President's National Health Plan and the Child Health Assurance program.

We also have specific areas of public service delivery programs which we believe will be covered by other parts of our program. Other major administration proposals now being considered to improve the delivery of health services include the Mental Health Systems Act and the expansion of the National Health Service Corps under the Health Professions Education Assistance Amendments. In addition, community and migrant health centers, which are highly targeted on minorities and the poor, will be expanded from the level of 5 million users to serve nearly 6 million persons in fiscal year 1981.

Of all administration proposals, the National Health Plan has the greatest potential for increasing the financial access to health service for minority citizens. Our current legislative proposal represents Phase I of a broader, comprehensive, universal national health insurance proposal. Improving the financing of care for minorities is a high priority and a major focus of this plan.

The following provisions are of special importance for improving coverage for members of minority groups. The National Health Plan creates Health Care, a new Federal umbrella insurance program that will provide comprehensive coverage to our most vulnerable citizens, including the poor, the aged, and the disabled.

Currently-mandated Medicaid beneficiaries and all individuals with income below the Health Care standard, which is currently at 55 percent of the Federal poverty level, will be automatically eligible for fully subsidized coverage. Poor individuals who do not immediately qualify for Health Care can become eligible for fully subsidized coverage if major medical expenses reduce their income below the Health Care standard.

The National Health Plan requires employers to offer insurance to all full-time workers, those working at least 25 hours per week for 10 weeks, and their families. No policy could require out-of-pocket expenses on the part of the family of more than $2,500 per year. No worker would have to pay more than 25 percent of the premium cost.

Individuals not eligible automatically under Health Care or the employer mandate can purchase coverage from Health Care at a nationally community-rated premium with no waiting period and no exclusions for preexisting conditions. Benefits are the same comprehensive services provided Health Care enrollees, subject to a $2,500 deductible.

The National Health Plan will have a substantial impact in responding to the special needs of minorities. National Health Plan expands coverage for poor minority citizens with incomes below or slightly above the health care standard. Medicaid currently covers 21.3 million poor, of whom 33 percent or 6.6 million are members of minority groups. Medicare now covers 23 million elderly Americans, of whom 7.5 percent or 1.4 million are minorities.

Under the National Health Plan an additional 12 million poor, including 4 million minorities, are expected to become eligible for subsidized care. Many of these individuals are now excluded from coverage under Medicare because they are in two-parent families, are childless couples, or are single. The National Health Plan will also protect many low-income minority members who do not qualify for Medicaid because their incomes are slightly above very restrictive State Medicaid standards.

The National Health Plan will improve coverage for workers, their spouses, and families. The requirement that employers offer insurance to all full-time workers is of particular importance to employees of marginal or low wage industries, who typically lack any insurance. For many workers now insured through employer contracts, this scope of benefits will be improved through coverage of physician services and home health benefits.

The National Health Plan establishes a structure to assist individuals with special problems who are unable to obtain adequate coverage in the private market. This option to "buy into" health care should be of special benefit to groups with sizable minority representation such as individuals who work intermittently and in hazardous occupations—private insurance plans are customarily reluctant to protect these individuals—those in poor health or who have a history of serious medical problems in the past, preexisting conditions, who find it difficult to obtain insurance in the private sector.

The National Health Plan alters Medicaid and Medicare and significantly improves coverage for health care beneficiaries. Health Care provides unlimited hospital and physician services. Many States have placed specific limits on these vital services under Medicaid. Also, low-income Health Care enrollees will not be subject to cost sharing requirements now imposed on certain Medicare beneficiaries.

Most importantly, the National Health Plan removes the financial barriers to prenatal and delivery services and total preventive care and treatment for infants during the first year of life. Medicaid now fails to cover many women who live in two-parent families or are pregnant for the first time. Current employer contracts have traditionally placed limits on prenatal delivery care and rarely cover preventive, well-baby services.

The administration's plan would provide comprehensive coverage for all mothers, pregnant mothers, and infants through the first year of life, either under Health Care or under mandated employment care. There would be no financial barriers in the form of restrictive or co-insurance for receipt of these services.

The administration's National Health Plan has been introduced in both the House and the Senate. The House has held joint hearings between the Ways and Means Health Committee and the Commerce Health Subcommittee. The Senate Finance Committee has been continually marking up the bill from last summer through the present time. Currently they have completed all of the work of the National Health Plan as of mid-March and are expected to resume in late April for low-income provisions on the plan. This is to be particularly crucial and particularly important for minorities.

I'd also like to refer to the administration's Child Health Assurance Program, referred to as the "CHAP" proposal. The CHAP is designed to expand Medicaid services to low-income children and pregnant women prior to implementation of the National Health Plan.

Millions of children and pregnant women lack adequate insurance coverage for preventive treatment services. Medicaid covers only 11 million children. Yet, only 3 million of those receive regular preventive checkups. Thirty percent of those children who were screened under Medicaid and found to need treatment do not receive follow-up care.

The administration's CHAP proposal would extend Medicaid coverage to all children up to the age of 18 in families with incomes below 55 percent of the poverty line, or below the State's standard, whichever is higher, and to pregnant women meeting these standards. Two million children and 100,000 pregnant women would be made newly eligible.

CHAP also expands the scope of mandatory services for all children and ties increases in Federal matching money to improved State performances with respect to screening, treatment of conditions discovered in screening, and continuous care.

The House of Representatives has passed a very generous version of CHAP. The Senate Finance Committee has voted out a somewhat more restrictive plan, both in the number of individuals who would be covered and the scope of benefits. We are hopeful that that legislation will be passed by the Senate this year and enacted into law.

Although the finance programs are extremely important in assuring children access to health care services, there are almost no areas to be addressed to assure equal access to health care services for all. For example, we now know that some providers, especially in the South, maintain separate waiting rooms and separate hours for black patients. Some hospitals have refused to treat minority patients even in emergencies because many patients failed to have adequate finance resources. Minority patients have been refused treatment by private providers who refer them to public facilities even in emergencies.

Minorities still may be excluded by inadequate representation in decisionmaking bodies. Minority members are typically underrepresented on such bodies as hospital governing boards. In some cases, minority representation on local, federally supported health planning agencies has been by State action.

These and many other problems in the health delivery care system are essential to be passed if we are to continue our progress forward, assuring that all individuals have adequate access to health care services.

Thank you.

COMMISSIONER FREEMAN. Thank you. The first respondent is Dr. John L. S. Holloman. Dr. Holloman is currently a staff member of the U.S. Congress Ways and Means Committee, Subcommittee on Health.

Prior to joining the subcommittee staff, he served as professor of Health Administration at the School of Public Health at the University of North Carolina at Chapel Hill from 1977 to 1978; president of the New York City Health and Hospital Corporation from 1974 to 1977; medical director of the Health Insurance Plan, Automated Multiphasic Health Testing Center, New York City from 1970 to 1972.

Dr. Holloman was one of the founders of the Committee for National Health Insurance and continues to serve on its executive committee. His other organizational affiliations include the National Medical Association, the American Medical Association, and the Institute of Medicine of the National Academy of Science.

Dr. Holloman received his bachelors degree from Virginia Union University and earned his medical degree from the University of Michigan in 1943. Following an internship at Harlem Hospital, New York City, 2 years in the U.S. Army Medical Corps, and postgraduate training in internal medicine, he engaged in the private practice of medicine from 1948 to 1974.

Dr. Holloman?

RESPONSE OF JOHN HOLLOMAN, STAFF MEMBER, HOUSE WAYS AND MEANS COMMITTEE SUBCOMMITTEE ON HEALTH

DR. HOLLOMAN. Thank you. I think this is probably the first time I have ever lost my voice, particularly in a situation that I found challenging. I am certainly impressed by the litany of statistics which documents a problem that some of us have lived through over the years. I am always distressed when I find that there are limited solutions available to solve our race problem. Ways in which we could have saved some of the victims of the racial discrimination and some of the victims of a destructive and exploitive economic system that puts a lesser value on the lives of those who happen to be poor.

As we look at the legislative prospects for relief, we are aware of financial limitations, which would, to me, suggest that we as a Nation have decided in advance that we can spend only so much on health; we limit the value we place on the lives of the citizens of our country. By limiting health care we limit the access to life, liberty, and the pursuit of happiness for such a large segment of our population that we have made a calculated economic decision, which I think perpetuates some of the racist problems that we have in this country since the first blacks arrived in 1619. We have seen many problems in health care and the leadership of health at many levels which need to be corrected.

I am reminded of the president of the American Medical Association, who in 1869 suggested for all the world that blacks were incapable of becoming physicians. I remember the efforts of organized medicine and of the American public to contain the advances of minorities because of the fear that there may not be enough health care to go around. And as I watch the current efforts to limit the production of physicians because there may, at some point in the not-too-distant future, be too many physicians concentrated in our more affluent areas, I am appalled. I think that some of the problems that we face are enumerated when we refer to medically underserved areas. And yet we have watched an unarrested, unabated trend for the destruction of institutions, the removal of providers and facilities from those areas which have already been designated as medically underserved. We do not have an acceptable national health policy.

This would suggest that our Government is powerless or that our Nation does not have the will to correct these injustices. I don't believe either is the case, and I would expect that like other nations our Government will begin to take a strong leadership in the direction of correction. As I listened to Dr. Karen Davis, I was impressed by the legislative proposals, and I would not miss this opportunity to add one or two of my own—to suggest that we could perhaps bring about some significant differences in our legislative and administrative efforts to correct some of the problems of discrimination that exist.

I am reminded that as recently as 1979, June, that there was a White House symposium—a black provider health task force concerned primarily with hypertension. Why do I mention hypertension? I mention hypertension because it is probably the number one killer among blacks in America today, in the rather critical age group from 35 to 54. The instance of hypertension is about 60 percent greater in blacks than it is in the rest of the population, and death and disability at that particular critical age is a destructive force in the black community—destroying the role models and destroying families and destroying the potential black leadership in so many of our communities, which, as I mentioned a moment ago, are less affluent and are becoming increasingly underserved, rather than the reverse.

As I look at some of the other activities that are associated with the creation of a greater problem, I look at my own city, New York. And I look at the very counterproductive activities of the mayor of the city of New York as he proposes to eliminate the financial support of hospitals which serve large minority populations in that region of the city which has already been demonstrated to be medically underserved and to have probably the greatest incidence of illness of any community of its size in New York.

As I look nationally, I see a trend through destruction of the public general hospital. The destruction of the public general hospital is associated directly with the medically underserving area expansion. A study done by Allan Sager of the Heller Institute at Brandeis University has shown that the likelihood of a community losing its hospital increases in direct proportion to the darkening of the complexion of the neighborhood. So, that as a neighborhood becomes dark, the neighborhood is more likely to lose its institutions.

It should be pointed out that it will be federally assisted and that the needed institutions will move from the inner-city area to a more affluent suburb. This trend needs to be immediately arrested. The cities, and there are almost 40 cities—some 18 of which have been studied over the past 40 years—have all followed the same pattern. The pattern is presently being repeated by the mayor of the city of New York. As a matter of fact, there is a court action involving the Office for Civil Rights of the Department of Health, Education, and Welfare. There is a requested action from the Department of Justice. We see the spectrum of the city of New York stonewalling, refusing to give the information that the Office for Civil Rights and Health, Education, and Welfare thinks is necessary, which, to my personal knowledge to date, has not done so, in spite of the fact that the plan has been impending for more than a year and that the institutions have been eroding.

The mayor and the city have refused to accept Federal aid from the Department of Health, Education, and Welfare, if that Federal aid includes building on the existing institutions that serve this underserved community. So much for that particular problem, although that problem has been repeated in varying degrees in other cities around the Nation.

We can look at the Homer G. Phillips Hospital in St. Louis, recently closed, an institution which was closed in a community which had a high minority population and which 80 percent of municipal hospital users of an entire city lived. More than 50 percent of the black physicians in this country have at least a part of their training given to them at the Homer G. Phillips Hospital and yet when an institution is selected for closure, it is that institution, while there remained, for whatever reasons, facilities in another part of the city where there were large numbers of voluntary and private institutions using public funds and taking care of needs of the more affluent and probably less medically needy population.

As we look at the impending national health care legislation, we—by the way—how much time do I have?

COMMISSIONER FREEMAN. You have 5 more minutes.

DR. HOLLOMAN. As we look at impending legislation, we recognize that there are a number of pieces of legislation that have been pending for a number of years. The history of Medicare and Medicaid is particularly interesting, because when Medicaid was originally enacted, as Title XIX of the Social Security Amendments of 1965, it was the intent of Congress to give the poor the same access to health services that the more affluent semiprivate patients then enjoyed.

To the consternation of too many other health providers, it represented a threat; it represented a potential loss of "teaching material"; it represented the loss of those second-class citizens on whom teaching had traditionally been done; it represented a potential loss within the countries of those individuals that were somehow less worthy and could be experimented upon. We have seen Medicaid, which was a concession to the "State's Righters" so that the States could control their own level of welfare and set their own contributions to health care. We have seen Medicaid changed into a program in which the contempt for the poor has grown and which there are any of a number of distortions in many of the States. Again I refer to some of the larger urban States. We have watched the situation in New York City, again associated with State action, disintegrate to such a point that nearly 97 percent of the physicians will refuse to treat or do not treat any significant number of Medicaid patients in their private offices. We see patients being driven instead to more costly hospital outpatient departments and inappropriately into the emergency rooms of the remaining inner-city hospitals. We see a conscious denial of human dignity.

I might add, that in New York City, 52 percent of the institution ambulatory care is given at the municipal hospitals, while the other 80-odd hospitals provide the rest. Very few of the 80-plus hospitals provide the levels of free care that are mandated by the Hill-Burton regulations, that are mandated by the Hill-Burton law.

We have watched the struggle of the Hill-Burton Hospital Construction Act. Hill-Burton was passed in 1946. The fight against the "separate but equal" clause consumed enormous amounts of time and energy. It was a struggle to eliminate the inequality of a separate basement ward in an old building from being considered at the Federal level the equal of a new semi-private room in a new facility, federally inspected.

We do have some major problems and we look forward to legislation. We do have some major problems while we try to decide who is going to be excluded and at what level. The Congress is going to decide who is not entitled to care. One of the things that we should strive for is to eliminate the barriers at the legislation, and as a staff member of the House Ways and Means Subcommittee on Health I will certainly try to encourage the full committee and the Congress to give the Department of Health and Human Services the necessary tools so that it will move in a direction that will not force dangerous, unwholesome, and unhealthy choices on people whose resources are marginal and thus can least afford to be without adequate health care.

COMMISSIONER FREEMAN. Thank you, Dr.Holloman. Our next respondent is Laurence G. Branch. Dr. Branch is currently assistant professor on prevention and social medicine and a member of the committee on geriatrics at Harvard Medical School. From 1975 to 1979, he was program director of the Center for Survey Research, affiliated with the University of Massachusetts and the Joint Center for Urban Studies of M.I.T. and Harvard University.

Dr. Branch has served on a number of committees related to the health care of older persons, including secretary of Elder Affairs Professional Advisory Committee, an elected council representative, gerontological health section, American Public Health Association.

His professional affiliations include American Psychological Association, American Association for the Advancement of Science, American Public Health Association, and Gerontological Society.

Dr. Branch has also written a number of articles concerning health care and older persons, including: "Understanding the Health and

Social Service Needs of People over Age 65," a Center for Survey Research monograph, and many others.

Dr. Branch received a B.A. from Marquette University, and M.A. and Ph.D. degrees from Loyola University of Chicago.

Dr. Branch.

RESPONSE OF LAURENCE G. BRANCH, ASSISTANT PROFESSOR, HARVARD MEDICAL SCHOOL

DR. BRANCH. Thank you for this opportunity to address the legislative initiatives currently undertaken by the Federal Government from the perspective of the access to health care for older people. I would like to start with a brief historical perspective.

I am sure that most of you are aware that of all the older people who have ever reached age 65, half are alive today. Most of you also realize that at the turn of the century, 4 percent of our population was 65 years of age or more. By 1970, 11 percent of the United States population was aged 65 or more. Depending on whose projection one uses, approximately 15 to 20 percent of our population will have reached age 65 by the year 2030. What these numbers serve to demonstrate, among other things, is that elders represent an increasing piece of an expanding pie—our population is getting larger and the percentage of the elders within that population is getting larger.

It is indeed time then that we look from their perspective, that we examine their special needs and see whether or not our systems, in general, and our health care system, in particular, are adequate in meeting the special needs of elders. In understanding the health care system available to elders at present, I have found it useful to remember that the present is a patchwork of solutions to the most serious single problems of the past. Few people suggest that the present system is either coordinated or comprehensive for elders. We can reflect a little on the last 20 years and recall that in 1961 we had a White House Conference on Aging which focused in large part on the most glaring kinds of health care problems older people face. You will recall then, in 1965, we had the passage of two hallmark pieces of legislation dealing with the area of health care available to older people, namely Medicare and Medicaid. These two Federal initiatives tried, among other things, to insure adequate hospital insurance coverage packages for older people whose incomes are usually lower than other age groups and are unset incomes, and also to provide some insurance for physician visits and other health care services for any low-income person regardless of age. The thrust of these programs was to solve a serious problem which limited the access of the aged and the poor to the health care system. Most nonaged people obtain their health insurance coverage through their employment, but since most elders are retired, they needed another source to provide health insurance. We then had our first major patchwork.

We next had another White House Conference on Aging in 1971. Four years later, in 1975, we had the passage of another bit of hallmark legislation—the Title XX amendment to the Social Security Act—which, among other things, recognized that the health care and social service needs of older people are intertwined and that to try and solve the problems of an individual person who happens to be over age 65 by focusing exclusively on their health care without addressing their social service needs will not, in the long run, solve that individual person's problems. So there was the passage of the Title XX amendments to provide social support for older people, another major patch in the health care system presently available to older people.

It is interesting to realize that there will be a 1981 White House Conference on Aging. We can speculate that, presumably in the 1985 time span or thereabouts, we can anticipate another significant bit of legislation dealing with the special needs of older people.

Now, if we examine this patchwork of Title XVIII, XIX, and XX amendments as the principal legislation for health care and social service supports for older people, one interpretation which emerges is that each individual initiative tried to solve the most glaring problem facing the older people at that point in time. The political process developed a consensus and suggested a solution to the most glaring problem. And we have done this in a step-wise fashion. The most significant problem facing elders all recognized in the early 1960s was the incredible cost that acute hospitalization care can impose upon anyone. Elders were not exempt from the severe financial repercussion of a long, acute care hospitalization episode.

Another element of the Medicare program allowed home health visits following an acute hospitalization episode. The intent of this benefit was clearly and correctly to see whether or not the length of stay of the very costly acute care patients could be shortened, if appropriate home health care services were available. It is a reasonable idea; it has worked well, but it serves to point out that the regulations were such that these home health care visits could only be started following an acute hospitalization episode. The conventional medical wisdom eventually suggested that perhaps we ought to be able to use home health visits to present acute hospitalization episodes for elderly people. If it works to shorten a costly acute care stay, could it also be used to prevent a costly acute hospitalization stay altogether?

Again, consensus was developed around this issue. The regulation has changed and now, in most areas, home health aid visits can be used for older people and medically indigent people to prevent acute hospitalization episodes. Again, another step forward. But notice it follows the step-by-step method.

Thus far I have presented a very brief history of how the Federal initiatives dealing with health care for older people have been fashioned. I have tried to suggest that the outcomes have not been insignificant. There, indeed, has been repeated recognition that elders as a subgroup have had trouble with access to health care, and there have been attempts to deal with these problems. It is at this juncture that, as a person representing the health care needs of older people in this consultancy, probably I am expected to take a militant advocate position and point out exactly where the elders are not getting sufficient coverage.

With your permission, I would like not to do that. It is my opinion that many of the reasons why elders are not getting appropriate access to health care are endemic to the problems of health care systems, not a special problem for older people. There are, indeed, many problems with our health care system that elder people face, but many of these problems exist not because they are old, but because of the system.

Let me offer another set of figures to support this position. Most of the Federal and State data suggest that approximately 5 to 15 percent of the users of the health care system consume about 50 percent of the expenditures of the system. Nearly half of the expenditures of the whole health care system are targeted for a fairly small group, 5 to 15 percent. This same trend exists for the subgroup of older people. This is—approximately 10 percent of the older people consume nearly half of the health care expenditures expended for older people. It is helpful to bear this perspective in mind, that we have a small group of people who functionally require a larger amount of resources, and that the pattern does not change for elders. It exists across all age bands in our population. Many of the most serious problems of our health care system are attributable to a present inability to provide effective, efficient, coordinated, and comprehensive care for these high users of the system, be they 25 or 75 years of age. Our health care system must come to grips with this kind of patient care management problem.

What I would like to do at this point is backtrack a little and suggest that we concern ourselves with certain concepts which are often offered in connection with the Federal initiatives for health care of older people, and look at their implications. Dr. Davis used a phrase in her presentation which causes me concern. Of course we all recognize that she did not coin the phrase. It is in our common lexicon, and has been for a number of years now. The phrase was to the effect that our Federal initiatives are going to deal with the "most vulnerable—the poor, the aged, and disabled."

I concur that disabled represent a group of people who by definition have functional limitations. But the aged are simply a group of people. There should be no suggestion that members of this age group automatically or by definition have functional limitations. Ascribing a "most vulnerable" status to them simply on the basis of their age does a disservice, in my opinion.

It is not too difficult to understand the roots of this assumption of most vulnerable status for all elders. For 25 years or so, in which we have recognized the special problems of older people, our whole emphasis has been on trying to insure that they get the piece of the pie that they deserve. This is a laudable effort, but it runs the risk of occasionally overstating the case, and thereby creating a negative stereotype—to be old is to be among the most vulnerable. I would quibble both with that expression and with the logic which fosters it.

The vast majority of older people are independent and self-sufficient. Some studies suggest that as many as 60 percent of the elders are just as self-sufficient and independent as anyone else, have no more health care needs than anyone else, and definitely are not what most people would include in that concept of the "most vulnerable."

Again, consider another set of common information. Most of the Federal studies on the utilization of health care services demonstrate that the elders use about two to three times the amount of health care services as the rest of the population. Okay, but let us turn that notion around a bit, if we can, and ask each of you to introspect on your own lives. If you had twice as many hospitalizations last year, twice as many hospital days, twice as many sick days, twice as many doctors visits, would you have categorized yourself as among the "most vulnerable" in our society? Probably not. In many respects, we have pretty healthy individuals in our society.

This is not to say that I am unconcerned about that 10 percent of the elders who really have special needs. I am incredibly concerned about that 10 percent of the elders, but I am concerned because their needs are functional, not categorical.

So I have two messages. Let us indeed be concerned with that 10 percent of elders who have needs, but let us try to get away from the categorization of people on nonfunctional criteria. In this instance, the criterion of age, in my opinion does a disservice to most of the people over age 65. It creates a negative stereotype for them.

Similarly, one might also examine the concept of categorical entitlements as a way of providing special services for older people. Most people who have had responsibilty or even a casual brush with administering some of our large scale programs know that it is important to find an administratively easy way of determining eligibility for people. I am not questioning this goal. I do sometimes question the means. If for the sake of administrative ease, one opts for a categorical entitlement like age because the eligibility criterion is easy to apply (that is, everyone over a certain age is entitled to a certain benefit that is associated but not caused by increasing age) is this not in some cases an enfranchisement as a function of age? And if we allow enfranchisement as a function of age, are we not very close to allowing a disenfranchisement by the same nonfunctional criterion? And that is what would bother me.

To summarize, what I tried to do was present a little demographic information concerning older people, so that we can have the perspective that older people are a large segment of our population and they are getting larger. I also tried to document that the elders have special needs, that as an age group, they use two to three times the health care services compared to the general population, and that we have a history of trying to meet the special needs of older people in a step-by-step fashion.

Then I deviated from the typical advocate's role and suggested that some of the concepts and some of the methods for trying to meet the special needs of older people have overstated the case and thereby created a negative stereotype for perhaps 60 percent of the elders who are as independent and self-sufficient as you and I, but just differ as a function of chronologic age. Thank you.

COMMISSIONER FREEMAN. Thank you, Dr. Branch. Our other respondent is Marcia Greenberger.

Ms. Greenberger is currently an attorney with the Women's Rights Project at the Center for Law and Social Policy. In this position, she has litigated cases in Federal courts, participated in agency rulemaking, and testified before Congress in the areas of health, education, and employment.

Ms. Greenberger has been involved in a number of other activities, including membership on the Board of Governors, Health Law Forum, American Bar Association, and membership of Advisory Panel to American College of Obstetrics and Gynecology on Development of Guidelines for Physicians on Pregnancy and Work. Membership in professional organizations include the American Bar Association and the Women's Legal Defense Fund.

Her publications include, *The Effectiveness of Federal Laws Prohibiting Sex Discrimination in Employment in the United States* and *A Consumer's View of the FDA's Procedures and Practices.*

Ms. Greenberger received an A.B. degree from the University of Pennsylvania and J.D. degree *cum laude* from the University of Pennsylvania Law School, receiving an award for outstanding woman law student.

Ms. Greenberger.

RESPONSE OF MARCIA D. GREENBERGER, ATTORNEY, CENTER FOR LAW AND SOCIAL POLICY

MS. GREENBERGER. Thank you. I would like to talk about the problems of the largest group in our society, women, and in particular the effect that national health insurance might have on addressing the health care needs of women in our country.

At the moment, women have serious problems in securing adequate health care in our country. Many of the problems can be linked to the fact that the majority of the poor are women. Women have low incomes for a number of reasons. Their education has been discriminatory. They have inadequate access to higher paying jobs, to decisonmaking positions, and they have been basically placed in a position of relying upon men for support. As a result of all of these societal forces, many women simply can not afford to buy health coverage on their own. The jobs that they hold often are at the lowest rung in our society, and employers are least likely in those kind of instances to provide health care coverage for their employees.

Women have to rely, where they have husbands, on their husbands' plans. When the marital relation dissolves, the women are often left without coverage. If they have problems within the marriage which make it difficult for them to use their husbands' plans, they are denied that coverage as well.

Also, the majority of older persons in our country are women. I do think that to some degree we do have to talk about categories of people, although I certainly recognize problems of stereotyping. But I don't think that sometimes the way societies make judgments about how coverage will be mandated, provided, and how health care systems will be set up is blind to the way it affects groups in our country. And I think that problem affects older people and especially affects women, both older and younger women.

As a practical matter, the problems that women have in getting more health care coverage is exacerbated by the private insurance system which is in place in our country today. The Civil Rights Commission has held a consultation sometime ago about problems involving sex discrimination in insurance, and I think that consultation illuminated the many problems that women face in insurance coverage today. And those problems, by and large, have not been solved since that consultation was held.

First of all, the rates that insurance companies charge are sex-based. Even when maternity coverage is excluded from health care insurance, insurance companies traditionally charge more to cover women than they do to cover men. To buy maternity coverage is a prohibitively expensive proposition. Single women may be forced to buy family coverage in order to get maternity coverage. Even where they can buy special maternity coverage, because it's often treated as a separate optional item it is very expensive. This is so because, since it is optional, the cost is not spread across the insured population as a group. Therefore, those who want to buy maternity coverage have to pay a lot of money to secure it, unlike other physical conditions which require health care at some point, that are covered by insurance routinely and for which all bear the cost and the risk.

Abortion coverage presents another problem. It is also not included in private insurance plans and I think we're all aware of the serious problems with government provided insurance to the poor in our country. And abortion coverage limitations are routinely now placed on coverage and are routinely raised in Congress for other plans, such as CHAP, which was mentioned by Dr. Davis earlier.

There are also special problems which affect women's access to health care because women play a very limited role as health care providers. They are limited in the sense that they are not represented according to fair distributions of their numbers in the upper echelons of decisionmaking policies and positions. In contrast, they are the ones who are faced with the obligation and responsibility to provide health care to their families and fill in disproportionate numbers of the lower echelon positions in the health care system.

This employment pattern skews the health care system in a number of ways. In hospitals, for instance, when decisions have to be made about money going to cardiac departments versus maternity and child health care areas, those financial decisions are sometimes skewed. Pediatric and obstetric gynecologic departments in many hospitals are the most poorly funded. There are skewing results as well in the obligations, the authority, and the responsibilities given to the midlevel health care professional, such as nurse practitioners and nurse midwives, whose role and responsibilities may be arbitrarily limited in the kinds of care that they can give and in their ability to set up an independent practice from physicians.

Finally, the kind of health care services that women need differs to some degree from the services demanded and required by men. Preventive care is of special importance to women, with gynecological and obstetric services representing a significant portion of health care services needed by women. Also, the great majority of persons in nursing homes are women, more than two-thirds. They have special needs for long term care.

I thought with this background, it would be useful to turn to national health care insurance and see how that would affect the very basic problems that women face in securing health care. I do think certainly the administration proposal that Dr. Davis reviewed does provide some important additional safeguards that women don't have today. On the other hand, it adopts and implements and further institutionalizes some of the serious problems that women face and, as a result, is a very inadequate solution even to the insurance problems that women have.

I think one of the most important salutary provisions is the prenatal care, natal care coverage to one year old. It's a very critical and important and key provision in the administration bill. It's key to assure that abortion coverage would not be excluded from this general provision.

But then there are serious problems with the bill. For instance, preventive care is not mandated to be included and the kinds of health care services that women need depend very much upon preventive care, which is something that most health care professionals want to encourage, rather than discourage. So, to set up an insurance system that doesn't mandate preventive care coverage, really flies in the face of the kind of health care services that women need and should have.

A second problem is that nursing home care is excluded, again affecting large numbers of older women in our country.

A third major problem is the financing system. It is based upon the private sector and therefore builds upon the discrimination in the insurance sector which exists today. The rates would continue to be sex-based. Therefore, women would be more expensive to insure than men.

There are serious problems, many of which were raised in the earlier consultation, about the way insurance companies do set rates based on sex, the assumptions, the fact that many of these rate tables are more than 40 years old. And it is still far from clear how new rates would be set, when they would be implemented, and whether the assumptions underlying the table would be any fairer and less discriminatory to women than the old tables. But assuming that the sex-based rate table would continue, which is certainly, I think, a fair assumption, when one ties that to the fact that the insurance would be employer-provided, one sees a very dangerous tying in of an incentive of employers to discriminate in their employment of women because, in fact, their insurance rates will be tied to the percentage of women, among other factors, in their work place. And if they employ more women, their insurance rates will be higher.

That is certainly not something which one should encourage, when, in fact, the national judgment has been made that the sex discrimination in employment is a serious problem that needs to be combated.

There are also problems that remain with the fact that much of the insurance is employer related. It is based on the old traditional notion, which does not apply in many cases anymore, that the wage earner is a man and women have the primary responsibilities for home and children. The expectation is that the woman would be securing health care coverage through her husband's employer.

There is an advantage, I think, in the administration bill and its provision for carrying through the dependent, and in the event that the marriage relation dissolves through legal separation or divorce, for a certain period of time—I think it's 90 days—and then a requirement that the wife be able to buy insurance on her own. However, one is then faced with the same difficulty of rates. There is now, I believe, a provision that no higher than 125 percent of the rate that the man was paying could be charged to the woman. This provision is certainly not an enormous protection for the woman, at what is often the most economically troubled period in her life, to provide health care coverage for herself.

The same problems exist if, in fact, the marital relationship is less than ideal and there is no formal legal separation or dissolution of the marriage where the woman is forced to secure her own coverage through her husband.

Finally, for the poor in this country who do qualify for Medicaid coverage, there are enumerable problems not only in the coverage and the rates of pay and the financial contributions that those poor people have to make, as well as the problems of access to health care systems in general, which have been discussed, but there are problems in the whole process of welfare determination and how a poor person can establish his or her qualifications for this kind of coverage. And I think those problems would remain and become a serious drawback in the administration health care provisions as well.

I do want to say, in all fairness, that none of the national health insurance provisions adequately deal with women's needs and concerns. The administration bill is not alone in its failures in this regard. But I think that all of it highlights the fact that inadequate attention has been given by decisionmakers to the health care problems of women. There is, for instance, no Federal legislation that prohibits sex discrimination in access to health care, unlike Title VI which prohibits race and national origin discrimination in health care in this country. That has a wide range effect and there are these kinds of serious problems which, really, it is time to address.

Thank you.

Discussion

COMMISSIONER FREEMAN. Thank you. Before proceeding to the questions from my colleagues, I would like to ask Dr. Davis if she would like to respond to any of the points that have been made.

DR. DAVIS. Thank you, Commissioner. I would like to make a few remarks in response to the very thoughtful comments that have been raised by the various respondents. I'd like to start with some of the comments that Ms. Greenberger made about the National Health Plan. I think she did touch on a number of the very serious pitfalls that lie in store for various groups, particularly women, but also minorities and the aged in any kind of national health plan. I think, on the positive side, that we should keep in mind that the National Health Plan the administration has proposed has other alternatives, very important benefits for women by simply expanding the number of poor people who are covered. It's not widely known that over half of the poor are not covered by Medicaid. They do not get covered because they are not the so-called right type of family. The Medicaid does not cover, for the most part, two-parent families; it does not cover singles and childless couples. So that many women under age 65, many of them divorced, separated, or alone or even spouses of individuals over the age of 65 do not get covered under Medicaid, no matter how desperate their situation is.

Now, the administration plan could cover another 12 million poor people. Many of those would be women and just expanding coverage of women is very important for women. Also the comprehensive maternity and infant care provisions, I think, are very important for women. The administration plan with the support of Congressman Rangel and Congressman Corman and a number of individuals that have been interested in this, does provide free care for those services. There is no preempt, there is no coinsurance, there is no deductible. It's very comprehensive care for pregnant women and infants through the first year of life.

Some of the problems that were noted with the private insurance coverage, I think, are well-taken. The basic decision by the administration in nearly all insurance plans before the Congress is to not set up a totally new Federal or public system of health care insurance, but to build on our current system which is predominantly employee-based, that over 80 percent of the employed population do get some form of coverage through their employer.

Rather than displacing that, most national health plans build upon it and, in particular, take set standards for what employers must do, and I think, in that regard, the administration would have important benefits for women. First of all, it requires all employers to cover all full-time employees, so that many of those marginal jobs for women have to become concentrated and would get health insurance coverage for the first time by mandating that all employers provide such coverage to their employees.

It requires the employers to cover all the dependents; it does have provisions for extension of coverage in the event of either termination of employment on the part of the worker or in the event of divorce, separation, or death that would jeopardize the dependent's coverage.

The administration plan, as Ms. Greenberger noted, does extend coverage for 90 days following any of the events that would lead to a loss of coverage and then guarantee conversion of a group plan to individual coverage. Ms. Greenberger is correct in noting that the individual premiums may be somewhat higher than a group premium, although there is a limit set. But it extends the coverage for 90 days.

I might add that the Senate Finance Committee, in looking at this provision, has decided to tentatively extend coverage for one year for any spouse or dependent losing coverage as a result of dealth, loss of work, divorce, or separation so that they have gone somewhat further than the administration proposed. We tried to deal somewhat with the premium structures where higher premiums are sometimes charged for women. In some instances, although I don't think we can respond completely to the kind of concerns that were raised by Ms. Greenberger for smaller firms, those with 50 or fewer employees, the insurance must provide a community rated premium, so it cannot be differentiated on the basis of sex or any other factor. However, in the larger firms, insurance companies would continue to experience rates which are current pattern, so that if women are incurring the higher expenses, then the employers premiums are higher as a result of that.

Ms. Greenberger also noted some of the problems with Medicaid. We have tried to make some major improvements. First of all, our plan would abolish the Medicaid program. It would institute a Federal program for both the poor and the aged, also many other individuals, such as those desiring to purchase coverage because they are not covered by an employer because they are not employed, or for firms that choose to purchase coverage publicly rather than through the private sector. It would eliminate all limits on coverage, it would have a standard benefit package, hospital, lab, and X-ray, some home health and infant and prenatal care. But it would eliminate the current Medicaid practice of setting limits on hospital days or numbers of physician visits that curtail access to services for many of the poor. It would set up a single reimbursement system.

One problem with Medicaid, which was noted by one of the panelists, is that States set very low physician fee reimbursement rates under Medicaid and, therefore, many physicians don't accept Medicaid patients. We would bring all Medicaid payments up to Medicare levels and institute a single rate of payment for these groups.

We have also proposed moving away from the whole State administration system and the linkage with the welfare program. First of all, expanding coverage to all individuals, regardless of welfare status, regardless of employment status, regardless of family composition, regardless of geographical location. So everyone would be covered under the National Health Plan. It would be federally administered and we would hope to eliminate a lot of the problems that are as a result of this linkage.

I'd like to make some comments on particular problems of the aged, raised by Mr. Branch and also touched on by Ms. Greenberger. It is true that the administration's National Health Plan, and it is also true of the other plans under consideration, that it does not do a very good job of covering long term care. It is an important problem for the aged. The administration plan would retain the current Medicaid program or long term care benefits. Part of our concern had to do with, of course, the cost of such coverage, but I think beyond that, some coverage that we really don't have good answers to, what are operation models of long term care.

We have begun funding substantial numbers of demonstrations in the long term care area to really see how home health services can be tied in and if there are ways that we can keep the individual in the home, rather than in institutions. And we are proceeding with that. But I think at some point, we will have to come forward with a more broad-based program for a proposal to deal with the long term care needs.

With regard to the aged, I think it's important to make some other points. First of all, with regard to minorities, I think not very many people realize that minorities don't enjoy a lot of social security benefits, simply because they don't live to the age of 65. Half of all black males born do not live to age 65. So that there is a serious problem in terms of access of minorities to some of these benefits, simply because of the lower life expectancies and higher death rates in younger years for minorities.

I think it's also important to point out that even with Medicare and Medicaid providing some benefits for the aged, that there are still very substantial financial burdens placed on the aged. These only pick up 40 percent of the expenditures of the aged because they do require the aged to contribute toward their care, they do have limits on the benefits such as long term care. They don't cover dentures or hearing aids or eyeglasses or even prescription drugs outside the hospital. So there are limits on benefits.

What the administration plan has done is to provide putting a ceiling on the maximum amount that the aged person would have to pay for coverage benefits under the plan of $1,250 a year, so that the most, the maximum, they would have to spend would be that amount.

Currently, Medicare is open ended and they pay 20 percent of what their bills are. I think another problem I'd like to point out is that even with Medicare, since there are exclusions of benefits and certain gaps, private insurance policies have grown up to try to fill some of those gaps. And this has led to very serious problems, which is usually termed the medi-gap problem.

Many of these insurance plans have actually exploited the aged. There is a lot of documentation of duplication of coverage, selling of policies to the aged that really don't go beyond Medicare or that return very low benefit payments on the dollar, some as low as paying 10, 20, 25 cents per premium dollar expended.

Congress has been considering legislation in that area, but the House and Senate committees have taken favorable action. It's a piece of legislation that could go through this year to have certificates of these policies. I think this would be a very important step and make some difference. While Medicare has been more protected than many other programs, I am also concerned about the future of just maintaining what we have. I think we all tend to see the need to go further with the Medicare and Medicaid in terms of coverage. But with the budgetary pressures, there continues to be pressures to either reduce the number of people covered or reduce the scope of benefits. I think neither of these are really desirable alternatives, and the other alternative that we have looked forward to is really to try to reduce the reimbursements to providers.

If there are budgetary limitations, we should try to achieve economies, not by cutting back the number of people covered or the number of benefits, but we should try to curtail the rate of payment to providers, and, in particular, have looked at hospital costs which really absorb very dramatic portions of Medicaid and Medicare budgets. Every year the Medicaid and Medicare budget goes up by $5 or $6 billion. And that is the result not by covering more people, not by covering more benefits, but by paying more for the same services. This is larger, as large as our entire expenditure for the Public Health Service. And in times of budgetary cuts, we think it's time to try to put some restraint on providers' payments, to make some cuts in that area in order to protect the basic coverage benefits, as well as to make some more expansion.

I think there are a number of other important steps, but I'm going to stop there.

COMMISSIONER FREEMAN. Mr. Chairman.

CHAIRMAN FLEMMING. First of all, I'd like to express appreciation for the kind of dialogue that has taken place. I am particularly interested in the dialogue that has taken place in the field of aging. I think it's been very helpful. The Commission is very much concerned about the denial of access to services that have already been provided for, and obviously we have the same concern relevant to any new services that might be provided for as a result of legislation.

Dr. Davis, I was wondering whether your office has examined legislative proposals from the various program units, whether any proposal has come before you from the program units relative to any changes in Title VI of the Civil Rights Act.

DR. DAVIS. I am not familiar with any legislative proposals. There may be some that I am just not aware of.

CHAIRMAN FLEMMING. The General Accounting Office recently issued a report which they prepared at the request of the House Judiciary Committee in which they stated that virtually no Federal money has been withheld under Title VI or has been put under this provision for the most comprehensive civil rights law ever enacted. And Congressman Edwards of California, who was Chairman of the Subcommittee of the Judiciary Committee on Constitutional Rights, has been holding hearings on the General Accounting Office report. He has indicated that he intends to hold further hearings with other agencies as witnesses to try, as he put it, to get Title VI into action after 16 years. As one has the opportunity of asking questions about the failure to utilize Title VI over a period of 15 or 16 years, often administrators will voice objection to the sanctions embodied in Title VI, namely the sanction of cutting off funds.

The position this Commission has taken is that as long as that sanction is in the law, the administrator has an obligation to use it. If the administrator feels that there is a better sanction to bring about implementation of Title VI, then the administrator has an obligation to propose to the Congress that better sanction.

So I was just interested in knowing whether or not any of the administrators, any of the heads of program units, particularly on the health service side, and the Department of Health, Education, and Welfare have made any proposal that you are aware of to amend Title VI to provide a different type of sanction. I understand that you do not recall any such proposal.

The next question that I would like to ask is this. If persons who have program responsibility in the health service side develop proposed guidelines for the implementation of Title VI, would those guidelines normally be looked at by your office, along with the other offices in the Office of the Secretary?

DR. DAVIS. On occasion those come to us. The Office for Civil Rights works closely with our Office of General Counsel on those matters, and from time to time we are involved in specific instances.

CHAIRMAN FLEMMING. The record shows that since the passage of Title VI there have been only two instances where the Department has put out any guidelines in the health service area. I think both of those occurred somewhere around 1968, 1969. We did receive testimony to the effect that the Department now has under consideration the possibility of issuing 11 proposed guidelines for the implementation of Title VI in the area of delivery of health services. Have any of those proposed guidelines come to your office up to the present time, to the best of your knowledge?

DR. DAVIS. Not to the present time.

CHAIRMAN FLEMMING. But, and as I understand, they might or might not. There isn't a requirement that all guidelines of that kind clear through your office?

DR. DAVIS. Typically, if this were to be published in the *Federal Register,* it would come to us for review before going to the Secretary.

CHAIRMAN FLEMMING. That's what I thought, and these would have to go in the *Federal Register,* if they could go in first as proposed guidelines and finally, of course, would be published in the *Federal Register* as final guidelines.

The evidence that we listened to indicates that the hope, the expectation, is that those guidelines will be out. I'm not too clear whether out means proposed or out means in the final form by the end of this calendar year, 1980. I hope that when they do come to your office, that your office will be alert for that.

DR. DAVIS. We will not only be alert, but we will try to speed them up.

CHAIRMAN FLEMMING. Personally, this is, it seems to me, a commentary on our system or on our commitments, lack of commitment as a Nation to really implement civil rights legislation. The fact that for a period of 15, 16 years we have had no adequate guidelines to implement Title VI, and obviously have had no meaningful action under Title VI. But we did ask yesterday, whether the witness could recall any situation where funds had been cut off in terms of standpoint of delivery of health services, and the response to that question was no.

Personally, I have the feeling that until the time comes when some action is taken to cut off funds, people are not going to feel that the Government means business in terms of the implementation of Title VI.

I might say, in the field of aging we now have a parallel piece of legislation in the Age Discrimination Act of 1975 that just became operative on July 1. But that is going to be subjected to the same kind of test. Right along this line, Mr. Holloman, do you recall any—well, the first question I'd like to ask is whether or not the General Accounting Office report, which was prepared at the request of the House Judiciary Committee, was also made available to the House Ways and Means Committee. Are you aware of the existence of that particular report?

DR. HOLLOMAN. I have not seen it, so that I can't say that I have any input. With reference to the first part of your question, when the Title VI was first passed in health, the Secretary John Gardner then created the Office of Equal Health Opportunity, as Marilyn Rose probably referred to yesterday.

The initial purpose of that office was to prepare the hospitals for the advent of Medicare with a compliance to Title VI of the Civil Rights Act of 1964, and there was a genuine enforcement effort on the part of this agency. However, following the initial success with hospitals there was a decline in the commitment of Congress, which I think was afraid to see this agency move too fast and too far. So it was abolished, and the agency was placed into Health, Education, and Welfare as the Office for Civil Rights.

After that action happened, we saw a significant slowdown in civil rights activity, so that even before nursing homes, homes for the aged, extended care facilities, etc., were examined for Title VI, the impetus had been cut off. There was no longer any overt commitment to move the program any farther than it had moved in the desegregation of hospitals. Since that time, to my knowledge, there has been no cutoff of funds from offending health institutions. It has been often said that those individuals who are most in need would be the individuals who would be hurt by the Federal withholding of funds, rather than the providers who have all along had alternative sources of funds.

CHAIRMAN FLEMMING. Well, the courts have recognized from the beginning that, as you put it, there is that to a degree. But I have the feeling, and of course this has not been subjected to a test, but it could be subjected to a test, but I have the feeling that if it was cut off in that particular instance, the cutoff wouldn't last very long because the persons who were affected by the cutoff would bring the pressures to bear, which would result in that particular agency getting in line. And in addition to that, it would begin to open up these services to the thousands, the tens of thousands of people who are being denied access on racial grounds.

It seems to me that unless we move on this, we are not going to solve this problem of minorities being denied access. Now, here again, this Commission has adopted the attitude that if anybody can come up with a better sanction than that, well, all right, we are willing to take a look at it and we are willing to engage in dialogue as to the development of a better sanction. But this has been on the books 16 years and, until another sanction is developed, certainly there is a legal responsibility on an administrator to use it so as to protect the constitutional rights of minorities. And this is—

DR. HOLLOMAN. I sort of share that feeling. I am certainly convinced that when funds are cut off, people do manage to bring about change very rapidly. But I am also convinced that there is no intent on the part of most of the political administrations to challenge very seriously the very powerful forces that provide and control the health care industry in this country, starting first with the American Medical Association going on to the American Hospital Association and going on to other professional organizations and recognizing the political action committees and the powers. Political survival is at stake.

We have to look very realistically at the fact that angels don't always rush in, and I think that perhaps this also has something to do with fools. I'm not really sure that we have in our government the statesmen that can circumvent the political realities of a Nation that is indeed racist in most of its institutions and most particularly in health.

CHAIRMAN FLEMMING. I'd like to yield to Commissioner Horn.

VICE CHAIRMAN HORN. Before we leave the original question that the Chairman asked, let me ask Mr. Holloman this. You said this Office of Equal Health Opportunity was set up by Secretary Gardner after the Civil Rights Act of 1964 was passed to relate Title VI to hospitals. Then you said it was subsumed, I believe, into HEW. Do you mean into OCR? Do you know the history of this all?

DR. HOLLOMAN. Well, yes.

VICE CHAIRMAN HORN. When was it abolished?

DR. HOLLOMAN. Well, it was created in March or April of 1966. And it was abolished by attrition within the next 2 years, moving from an independent agency of the Public Health Service into the Office for Civil Rights in HEW. I think that probably Peter Libbassi may well have been the person who inherited that, which had been a very vigorous and a very glorious effort on the part of this agency. The office of Equal Health Opportunity was headed at the time by Robert Nash, who, I understand, after that particular assignment and because he did so well with it, managed to find that his phones were cut off and that he managed to sit somewhere in some dark, out-of-the-way corner in HEW without having any further duties until the time he was retired several years later.

VICE CHAIRMAN HORN. Did this happen under Secretary Gardner's successor or under Secretary Gardner?

DR. HOLLOMAN. It's my impression that it happened under Secretary Gardner's successor, although at the time the agency was set up, there were two people in HEW—all of HEW responsibility of civil rights. There was a Mr. James Quigley and, I believe, a Ms. Sherrie Arnstein, and they had the entire civil rights responsibility prior to the formation of the Office of Equal Health Opportunity.

One of the commitments that was made by Bill Stewart, who was then the Surgeon General, was that 18,000 nursing homes would be inspected for Title VI. But we, at that time, had the problem of Mrs. Murphy's boarding house. And whether or not you would want to disturb these old people who were quite accustomed to racial discrimination, and whether or not we wanted to let them vegetate and die out in peace, or whether or not we wanted to force horrible integration on these people who were, at the time, prepared to be supported by Federal funds.

My suggestion was that they could stay segregated, but let's not support them with Federal funds. So we had quite a debate about it. But the point is that Bill Stewart promised that these homes would be inspected under Title VI and they never were. There were no inspections. And the legacy of nursing home wrongdoings and scandals continues today.

VICE CHAIRMAN HORN. Was this little office in the Public Health Service abolished at the initiation of the administration or under congressional pressure in the Appropriation Act or did the issue ever escalate to the Hill? Did they wipe the funding out of the budget, do you know that aspect?

DR. HOLLOMAN. Yes. The very strong southern legislative bloc in the Congress wiped out the funds.

VICE CHAIRMAN HORN. All right.

CHAIRMAN FLEMMING. I'd like to make this comment. The nursing homes still need to be audited under Title VI. We have had testimony here to the effect that the percentage of minorities in nursing homes—somebody said 4 percent, somebody said 7 percent. That's just about the—

DR. HOLLOMAN. In New York, a study has been recently done in the South Bronx by the HSA showing that there were less than 1 percent of blacks; and minorities are waiting to be placed in nursing homes.

CHAIRMAN FLEMMING. I'm fully aware of the fact that that's one of the most serious areas and involves the field of aging, and also between 4 and 7 percent are members of minority groups. So that it shows that we have not made any progress along that line.

If I could just turn for a moment to Dr. Branch's comments, I'd like to say that I feel he's put his finger on some very important matters as we approach the field of aging. I think that he is correct in his feeling that if we keep conveying to the public the feeling that to be old is almost automatically to be among the most vulnerable, we are creating a negative stereotype, which it seems to me is serious, because there are many older persons, as you pointed out—I mean, I thought you tried to keep it in balance—who need services, health services and other services. But there are far more who need to have the opportunity to serve. And that brings us to the Age Discrimination in Employment Act.

And they are being denied that opportunity to serve because of the stereotype that you identified. But I did think that it would be well to include in your historical summary the Age Discrimination Act, because this Commission held hearings and took testimony which pointed very clearly to the conclusion that older persons are denied access to health services solely because of their age, because they are older persons. And we listened to administrators justify that on the ground that that's a better way to invest taxpayer's money—to invest it with younger persons. They weren't quite as blunt about it, but they certainly left us with the impression the older persons aren't going to be around very long, so why worry too much about them.

There is a problem of access, the denial of access to older persons who oftentimes desperately need it, and simply because of the fact that they are old—and that brings up the enforcement of the Age Discrimination Act and we have some of the same problems in enforcing that, that we have in enforcing Title VI.

But, nevertheless, I felt the major point you tried to emphasize is a very important one in an effort to deal with this negative stereotype. Would you like to make a comment?

DR. BRANCH. I appreciate your perspective and I also would emphasize the point you just made a minute ago about the enforcement issues and—if you had had a better method of applying sanctions, you are more than willing to entertain them. I think that that problem of what are appropriate sanctions as applied to the nursing home industry is a perfect case in point. As Dr. Holloman has pointed out, the individuals involved are the ones who are most often hurt when sanctions need to be applied, particularly in nursing homes. If the nursing home administrators are denied Federal funding because of inappropriate policies, the burden of that decision of that implementation of sanction falls more heavily on the nursing home residents than it does on the administrators, and I wish you success in your search for a better sanction.

CHAIRMAN FLEMMING. The question is how long the Federal Government should be a coconspirator, as far as the use of its funds are concerned in such a way as to deny a person their constitutional rights.

DR. BRANCH. I agree with you that 16 years is probably too long.

COMMISSIONER FREEMAN. It is too long. Vice Chairman Horn.

VICE CHAIRMAN HORN. I'd like to ask you, Dr. Davis, does Health, Education, and Welfare have any estimate or any internal working papers as to the degree to which government support of health care in some form or the other, since the 1960s, has led to excessive hospital costs?

DR. DAVIS. This is an area where there has been some research done. There has been a tendency to point to Medicare and Medicaid as the villain in rising hospital costs. But what the studies have shown is that it took place, first of all, before Medicare and Medicaid started. The hospital costs were going up more than twice as fast as the consumer price index, that Medicaid and Medicare added to that, to the trend, but that the basic problem seems to be the very pervasive growth of third-party payment in open ended reimbursement systems that guarantee to a hospital that whatever their costs are, whatever they charge, they can be assured of recovering those amounts.

Currently, over 90 percent of all hospital revenues come from some third-party payer, rather than from the patient. Most, about 60 percent of all hospital revenues, come from cost-based reimbursement plans, Medicare, Medicaid, or Blue Cross in about 33 States on cost pay basis. But regardless of the source of payment, whether it's public or private, I think there is a general recognition that basically giving hospitals a blank check and assuring them that no matter what they charge, no matter what they ask for, they would be paid at that rate, has certainly contributed to the problem of rising costs.

VICE CHAIRMAN HORN. Has the Government discussed any possible strategy to deal with the third-party payer, in terms of bringing them together to work out programs and establishing a voluntary system to control what some commentators believe are excessive hospital costs?

DR. DAVIS. We have been reluctant to date to do that, to move only on the Medicare and Medicaid side without simultaneously having the involvement of the private insurance sector. Our concern has been that if you hold down Medicare and Medicaid payments to hospitals, you will lead to a situation of two-class care, which does persist on the physicians' side, where Medicaid rates have been already lower than the private payers.

It is important to move not only unilaterally, but in conjunction with the private insurance payers, rather than having a Medicare/Medicaid only approach. The strategy we have used is to try to seek legislative authority to limit the rate of increase payments by both Medicare/Medicaid on the public side and all private insurances, and we have done that through the form of hospital cost containment legislation.

This legislation was originally proposed in April of 1977, considered by the Congress, and reproposed in 1979. The basic proposal would have some voluntary provisions that would basically set goals for the rate of increasing hospital costs. If hospitals held to that rate of increase voluntarily, then they wouldn't trigger any new kind of mandatory provisions. That legislation was defeated on the House side in the fall of 1979. The administration continues to deal with that and to feel that some legislative remedy is important.

But we are continuing to establish these voluntary goals for hospital industry across all payers, not just public, and to urge them to show restraint voluntarily.

VICE CHAIRMAN HORN. How much cooperation have you had from the private insurance payers of health care in this effort?

DR. DAVIS. We have had fairly good support in trying to seek legislation from the commercial insurance companies through the Health Insurance Association of America. They were very supportive of the legislation. They lobbied intensively for it. Blue Cross/Blue Shield took a more neutral stand and did not support the legislation.

On the other hand, Blue Cross/Blue Shield did participate in a counteroffer, if you want to call it that, by the hospital industry, where they formed their own voluntary effort to hold down hospital costs. Blue Cross/Blue Shield has been active on that voluntary commitment.

VICE CHAIRMAN HORN. In terms of the legislative proposal to the administration, you mentioned that they cover full-time employees. That greatly concerns me in the sense that, increasingly and especially for women, there is a need for part-time job or work-sharing opportunities. Single-parent families come to bear on this question as do older persons, who are largely women, etc. Aren't we overlooking a major area where a sensible government program is needed in terms of an increasing trend in the work force, when not only does the single-parent want some time at home to help raise the children and a part-time job to provide needed income, where the older person wants a job for 4 hours a day versus 8 hours a day as a supplement to retirement in order to assure survival in a time of inflation.

I mentioned job-sharing. I think of it in a university context where Ph.D.s who are turned out of the graduate schools of America cannot get jobs full time in one institution. Often they must piece together three or four part-time jobs in order to try to secure the semi-equivalent of a full-time job. Aren't we overlooking a major aspect of our work force by taking that stand?

DR. DAVIS. Well, I think that is a good point. It's obviously the case that part-time employees need adequate access to health care and adequate health insurance coverage every bit as much as full-time employees, if not more. We did consider that very carefully in the design of the National Health Plan. The President's proposal is a phased-in approach to health insurance coverage. It submitted a first phase legislative proposal that simultaneously put out a white paper on what coverage would ultimately be desired. A decision was made to postpone part-time coverage until later phases. But there was a commitment in the white paper to eventually cover all part-time workers, as well.

Our definition of full-time workers is fairly generous, 25 hours a week or more, but it obviously does restrict some individuals from coverage. Our reasons for doing that were in part the economic impact of mandating coverage on employers. Most employers have health insurance coverage for their employees. Many of those employees would meet the standards of this plan, but for those firms who don't currently have health insurance coverage, there will be a fairly substantial economic burden on these firms.

We estimate that just covering the full-time workers and setting the standards established in our plan, which are pretty minimal, will add about $6 billion to employer health insurance premium cost. We estimate that will have some slight impact on employment and inflation as you increase labor costs to firms. We were hesitant to go beyond that first phase initially, in terms of either mandating coverage of part-time workers or having more comprehensive coverage, for fear that that would be too much of an economic burden on employers and, therefore, did not go beyond that in the first phase.

VICE CHAIRMAN HORN. To what degree does Planning and Evaluation get involved in policy decisions regarding budget decisions in the health care area?

DR. DAVIS. Traditionally the Office of Planning and Evaluation has been involved in the budget decisions. We were less involved in the more recent budget revision. But normally the agencies will submit budgets to the Office of the Secretary in June of each year. Our office and the Office of the Assistant Secretary for Management and Budget will review those budget requests, will submit a recommendation to the Secretary, Under Secretary, forward the first line decisions on the budget, and then those go through various appeal mechanisms within the Department, and are finally submitted to the Office of Management and Budget in September.

VICE CHAIRMAN HORN. The reason I ask is obvious, that one of the concerns of this Commission is not only in the delivery of services in a nondiscriminatory way, but also assuring access for members of minority groups and women to become providers in the health care area. That might improve the delivery of services to minority communities. Yet recently, the administration has asked for a 1980 recision of $77.4 million for nurse training out of $106 million, $5.5 million in allied health, out of $10 million, etc.

As for the cuts in nurse training, there is a real problem in center cities, inner cities. How do you staff hospitals to meet the needs of the minority population? How do you staff hospitals for the night shift, etc., etc.? What sort of thinking or input has Planning and Evaluation had in these areas from that civil rights context to try and relate the program activities and services which the Federal Government renders under existing law with the budgetary pressures to cut back? I can understand that cuts must be made in some areas to solve the problems of inflation, but is your Department looking at where we should be 5 or 10 years from now—in a planning and evaluation sense—to meet the very real health care personnel needs which this country will be facing? How much have you been involved in those particular cases?

DR. DAVIS. Well, perhaps I'd rather not admit to involvement, but we have tried to grapple very seriously with the issue of nurse training. Our office has reviewed the studies that have been done, the major studies, trying to project the demand and supply for nurses and to make some assessment whether there will be an overall adequate supply of nurses. Our review of that literature and the data generated by the Department indicates that the supply of nurses will be roughly equal to the demand for nurses in 1985. But there continued to be serious maldistribution problems both with regard to geography and with regard to income and race of population served by their profession. So that while the overall supply/demand position should be pretty much in balance by 1985, there continued to be serious pockets of underservice in the nurse area.

We have looked at what is an appropriate strategy for dealing with this imbalance. We are moving toward encouraging more nurses through the National Health Service Corps. With regard to health personnel to the underserved areas, we are conditioning support for nurse practitioner training, which we do have in the budget, upon service in underserved areas. But the main thing that we have identified is that the problem seems to be not so much overall numbers of nurses, but retention of nurses in the nursing profession.

A large number of nurses do not continue to practice. They either drop out of the labor force or take other jobs, other than nursing. So we have asked the Institute of Medicine to try to figure out what are the major factors causing individuals who are trained for nursing to fail to participate in the nursing market. Whether that's the problem of the wage structure, or whether it's a problem of position, or professionalism, or the feeling that the nurses are subjugated in the whole health care team. Whether it is a result of opening up opportunities for women in other employment fields, so that women have had other opportunities that are more attractive than nursing.

We feel that the way to deal with this problem is by looking at retention, rather than overall numbers. We are focusing our efforts in that regard.

VICE CHAIRMAN HORN. I assume you will not only look at retention, but you will look at reentry into the force after several years. I think we ought to realize that because you train the nurse and the nurse only works 1 to 3 or 5 years, may get married, might raise a family, they are not totally lost to the labor force in terms of reentry into the profession.

DR. DAVIS. Right.

VICE CHAIRMAN HORN. Now, yesterday we had a witness with whom we discussed the relationship between the Office for Civil Rights and program responsibilities of the various HEW agencies. In the course of that, we got into a discussion of what is the relationship between the Office for Civil Rights and program agencies in the consideration of program objectives. And to that, I would add, since you are Deputy Assistant Secretary of Planning and Evaluation, to what degree does your office involve itself in reviewing actual program plans and the objectives set by the constituent HEW agencies and relate those program objectives to the other overall plans and goals of the Department in terms of legislation, in terms of budgetary resources, etc. Obviously, I am interested in the response from the civil rights aspect as to the degree to which services for minority populations in an area are targeted. I would like to know the degree to which representatives of the Secretary, in this case your office, as well as Budget and Management and so forth, review those program implementations to see that overall Federal policies, the will of the Congress and the President, and the various executive orders are being implemented. Would you describe that process for me?

DR. DAVIS. I've been at the Department for about 3 years, 3-1/2 years, and over that period have seen an increasing improvement in the Office for Civil Rights, not only in program operation issues, but in policy issues. I think this has been accelerated under Secretary Harris. It's very rare to be in a major meeting on a program issue or a policy issue where the Office for Civil Rights is not represented.

There have also been a number of instances of specific program issues where it had to do with closure of a particular hospital, health plan issues, or health service issue, or Hill-Burton regulations issues, where the Office for Civil Rights has been extraordinarily influential and has worked closely with our office, with the Office of General Counsel, in trying to reach some accomodation with concerns of programs and see the rights of minorities are well represented.

In terms of the program plans of the various agencies and to what role we play on that, there are a number of mechanisms. Currently, there is a place in the Department's Operations Management System, OMS for short, as all things are turned into acronyms in government. These are indicators that each program sets forth what are basically quantitative goals, objectives, of the programs. We review these along with the Office of the Assistant Secretary for Management and Budget and those are presented to the Secretary, both what the indicators of program performance are and progress towards those indicators.

Secretary Harris, last week, spent 4-1/2 hours in meetings reviewing the Public Health Service OMS and both the indicators in progress toward those. For example, in the area of the National Institute on Alcoholism, they have selected program indicators to increase the number of women, youth, and Indians served by their projects. They found that women are 33 percent of the problem drinkers, but only 20 percent of the people served under the programs; youth, 10 percent are problem drinkers, but only 3 percent of the individuals served under the program.

So they selected specific program indicators, increased by the end of the year, and have targets for each quarter of how many of their program users will be in the various categories. So we help make suggestions on what indicators ought to be used, review performances of those. The Secretary is very intensively involved in that. That's one process whereby we try to see the needs of the minorities are addressed in program review. More broadly, as we undergo the budget cycle every year, we are quite sensitive to those programs that do serve minorities, do serve the poor, and try to give higher budgetary priority to those programs.

I think the best example of that is the Community Health Center Program. Eighty percent of all the users of Community Health Center Programs are minorities—60 percent black, 20 percent Spanish-speaking and Indian population. So, altogether, out of all those program users, 80 percent are members of minority groups. In the last 3-1/2 years I have been there, we have doubled the budget of the Community Health Center Program, in large part because we do think it's a very important form of service delivery for minorities and helps offset some of the imbalance of Medicaid/Medicare benefits that we talked about before.

VICE CHAIRMAN HORN. I'd like, Mr. Chairman, to secure from HEW, for insertion in the record of the hearing, the Operations Management System categories and indicators for the current and next fiscal year, whatever is available, and have them analyzed from a civil rights perspective. I would like that portion of the program objectives and OMS indicators to be put in the record. (See exhibit 11.)

CHAIRMAN FLEMMING. This relates to the health program. On the mental health indicators, Community Health indicated—did you have before you information as to the percentage of older persons that were being served by the Mental Health Clinic?

Dr. Davis. These particular indicators that I talked about had to do with the alcoholism projects. The Community Mental Health Center is also developing program indicators in that area, somewhat less developed than maybe the other areas, but we have reviewed studies that have indicated that coverage of the aged in Community Mental Health Care Centers is a very serious problem, that the aged are underrepresented in that program, and we have been trying to identify steps to remedy that.

Vice Chairman Horn. One last question. I noticed with interest in our briefing book an article, which, I believe, appeared in *The New York Times*, by Dr. Gordon K. MacLeod, professor of Health Services and Administration of the Graduate School of Public Health, and associate clinical professor, School of Medicine, University of Pittsburgh. In this article, he advocates the idea of health stamps, the analogy being food stamps. Presumably, it's an attempt to cut out some of the bureaucratic paperwork and processing within the health care system. Has your office reviewed that type of an idea, and, if so, what's the reaction to it?

Dr. Davis. The health area, it's sometimes called the health voucher approach, which basically would give individuals a fixed amount to use to purchase a private health insurance coverage. As the Department began its National Health Plan package back in 1977, we did review a number of alternative approaches, and, in particular, asked Professor Alain Enthoven at Stanford University to develop, for the Department's consideration, one option for a National Health Plan. And Professor Enthoven selected a voucher type proposal, whereby individuals would receive tax credits, which would enable them to go out into the private insurance sector and purchase private insurance. That voucher system would not only cover additional people not now covered by insurance, but it would basically replace Medicare and Medicaid and even current employer health insurance coverages.

As we reviewed that option quite seriously, within the administration, we identified a number of concerns with it. First of all, using a tax system, wound up shifting large sums of money from the private sector into the Federal budget and led to very expensive proposals. But beyond that, we were quite troubled by the notion of basically giving the poor a piece of paper to go out and confront the private insurance industry that hadn't been supportive in the past toward providing them with coverage.

The thing that's different from health care than food is that insurance is very invariable. Individuals encounter invariability. So that where you may have a predictable food budget requirement, the medical services expenditures and even the health care premiums will vary among individuals, depending upon their health risk, whether they are disabled, whether they have a very serious health condition. What we were concerned with is that, if you give everyone an equal voucher dollar amount, the health insurance response to that would be to have adverse risk selection. They will want a relatively healthier individual, but not want the relatively sicker individual, and that is very difficult.

You would really have had to have massive regulation of the private insurance industry to see that they didn't act in what is their own self-interest to act. By shunning these risks that were a high-health risk, therefore, these individuals who were given a fixed dollar amount to buy an insurance plan, if they were sicker, really wouldn't be able to take care of their own needs. We really feel that a public program where you have government acting collectively on behalf of the poor can do a better job and a more economical job in purchasing services for individuals, negotiating reimbursement rates for providers, than any single individual acting on their own. So we are not supportive of a voucher program.

VICE CHAIRMAN HORN. Did Professor Enthoven's study get into the effect of the plan on minority population?

DR. DAVIS. It did not address that. It did try to address the general problem of the poor by graduating the level of the voucher with the income of the individual. So that those below a certain poverty level would get 100 percent voucher on an average and then taper down to 30 percent for higher income individuals. But even that was indexed over time with the CPI [Consumer Price Index] which might not be adequate to cover the increase in Medicare.

VICE CHAIRMAN HORN. I'd like to enter in the record the clipping of the article of the so-called health stamp proposal by Dr. MacLeod and the study by Professor Enthoven and any comment which the Department wishes to make from a civil rights context.

CHAIRMAN FLEMMING. Okay. No objection. (See exhibit 12.)

COMMISSIONER FREEMAN. Mr. Saltzman.

COMMISSIONER SALTZMAN. Dr. Holloman, you referred to the closure in New York of a municipal hospital and you interpreted this as a discriminatory reality, that this is occurring in, essentially, where there is a higher proportionate number of black population. Are you aware of a bibliography of studies to support that point of view? Is there anything on which you base that?

DR. HOLLOMAN. I happen to have Allan Sager's paper on that, and he studied it for the past 40 years. I'll be glad to submit that to you for the record.

COMMISSIONER SALTZMAN. We had asked for it, but something happened.

DR. HOLLOMAN. I happen to have it.

COMMISSIONER SALTZMAN. Could we have that?

DR. HOLLOMAN. Yes, you may have it.

COMMISSIONER SALTZMAN. Is that the major source for this?

DR. HOLLOMAN. No, I think there are other sources. I just happen to have this one. This is a list of institutions and the cities in which the institutions closed. This represents—

COMMISSIONER SALTZMAN. Who was this compiled by?

DR. HOLLOMAN. Alan Sager of Brandeis.

COMMISSIONER SALTZMAN. He compiled this list?

DR. HOLLOMAN. Yes. I think that he took it from other sources.

COMMISSIONER SALTZMAN. And you have his paper too?

DR. HOLLOMAN. Yes. This is part of his testimony to the Health Subcommittee on Ways and Means as we were considering the financially troubled hospitals. I might add that those hearings are continuing, so that, hopefully, by the time the hearings are completed, we'll have a very complete record which we will also make available to you, since they are of public record.

COMMISSIONER SALTZMAN. I would appreciate that.

DR. HOLLOMAN. This then is the paper. That's the testimony.

COMMISSIONER SALTZMAN. Mr. Chairman, I assume that these will be entered into the record.

CHAIRMAN FLEMMING. Unobjectionably done. (See exhibit 1.)

COMMISSIONER SALTZMAN. Are there any other corroborating sources that you know on this—studies?

DR. HOLLOMAN. The American Public Health Association has now developed a section on the public general hospital. The Under Secretary of Health, Education, and Welfare, Nathan Stark, has a task force which is currently preparing a report. I would suggest that the report of that task force be looked at as a very authentic and very current source as to the problem. The American Public Health Association's group will probably have a report available at the time of the annual meeting in the fall.

COMMISSIONER SALTZMAN. Well, may I ask that the staff at this point in the record look for those two additional sources to be entered in, if they are available?

CHAIRMAN FLEMMING. That will be done. (See exhibits 13 and 14.)

COMMISSIONER SALTZMAN. May I ask you, Dr. Davis, is there in the planning process any thought being given as to legislative initiatives which may be required relative to this seemingly growing problem?

DR. DAVIS. Yes. As Dr. Holloman indicated, the Under Secretary of the Department has established a task force on financially troubled hospitals. Our office and others—the Public Health Service and the Health Care Financing Administration within the Department, have been serving on that task force and meeting regularly. Our staff has worked closely with the staff of the American Hospital Association to identify some data so we can get a better indication on the exact scope and magnitude of the problem that is involved with financially distressed hospitals. We also, through this task force, have been reviewing—

COMMISSIONER SALTZMAN. You're saying financially distressed hospitals. If I get Dr. Holloman's point, financially distressed is not ultimately the reason they are being closed, but the fact that they are in high black populated areas. The financial distress is secondary to that fact. Am I stating it right?

DR. HOLLOMAN. Well, I think it's very difficult to really tease out the incestuous relationship between poverty and race many times. And when we look at a very powerful industry such as the provision of health care, it becomes even more difficult. If we ask Sager, why does an institution close, the executive director may say that it failed financially, not enough political clout among the blacks in that community to get their fair share of the political pie or the grants or whatever else was available to enable the community to continue.

It's very difficult to say that this was given just—we are not giving this to you because you are black. It's much easier to say that we prefer to give it to someone who has, perhaps, a better quality institution to provide the care. We've seen as a result of, for instance, integration, the elimination first of the black hospital. They didn't say it was eliminated because it was black. They said it was eliminated because the larger majority hospital could give better care.

Actually, we are competing for the same dollars. As we look at the pattern of closure, it just reflects, not necessarily coincidentally, but I don't think that we can go—we have much success in proving that this is purely on the basis of discrimination.

COMMISSIONER SALTZMAN. I'm sorry to interrupt.

DR. DAVIS. I think we do need to be very careful about what it is we are talking about when we use phrases such as financially distressed or financially troubled hospitals. We are waiting to get more data from the American Hospital Association, but it's our view that the primary problems are among the public general hospitals, among those private hospitals that happen to serve large populations of minorities or low-income populations, but, and I'm sure that racial discrimination is a factor, that there are other factors as well.

The truth of the matter is that if everyone were well-insured and high income, even if they were minorities, many of these institutions could make it economically even with political factors, racial factors, being what they are. The basic reason these institutions go under is the lack of an adequate financial base to be able to make it on their own and withstand these kinds of pressures. For example, we are convinced that a major problem underlying this is the lack of insurance coverage among many poor people. That there are simply many minorities, many poor people, who are not covered by Medicaid, and therefore the hospital that serves those individuals must find through public sources or some way of covering their inpatient care, their outpatient care, that they cannot collect through the insurance, Medicaid, or patient payments, so it is in large part a matter of an inadequate financial base.

So we are looking at legislative proposals. Certainly no decisions made at this point. But we are looking at a wide range of proposals, including things like perhaps making capitation grants to public general hospitals or certain institutions that do serve minorities and poor to cover a comprehensive range of services, not just inpatient hospital services, but many of these institutions are also the sole source of ambulatory care for the communities that they serve. So to look at some system of capitation grants that would provide some financing coverage for individuals who are poor, can't pay themselves, that are not covered by Medicaid or private insurance, that fall through the gaps currently.

COMMISSIONER SALTZMAN. Thank you.

COMMISSIONER FREEMAN. Commissioner-designate Berry.

COMMISSIONER-DESIGNATE BERRY. Thank you very much. I think that I am aware, Dr. Davis, that there may be some proposals on the sanctions problem that were generated in OCR's General Counsel's Office, somewhere else other than your office. So I would hope that we would ask the staff to find out whether there are any such proposals in the General Counsel's Office, in Health and Human Services, or at OCR, as well as asking your office. But you said, if I understood you correctly, that the Healthcare proposal would abolish most of the State role in determining who is eligible under Medicaid. But then when I read the description that was provided of President Carter's National Health Plan legislation, there is a section on page 8 which says that the States will continue their traditional roles in certification, licensing, insuring, determining eligibility, and the like. Would you please clarify that for me?

DR. DAVIS. Because I do think I did go too quickly over that, let me clarify that point. The Healthcare plan would abolish the current Medicaid program and change the State role in that there would be uniform eligibility. The States could not set their own income level as to who would be covered. There would be uniform benefits. States would no longer have the discretion to set limits on hospital days or physician visits covered. There would be uniform reimbursement rates.

States would no longer be able to set their own physician fee schedules or rates of payments for providers. In terms of determining eligibility though, there is a retained role for State government. Any individual being covered under AFDC would be automatically given a Healthcare card, so that at the same time eligibility is determined for AFDC, that population would be enrolled in Healthcare and that would be done through State welfare offices, as it is presently.

The plan covers all poor people below the income level, whether or not they are on welfare. For those individuals, the eligibility would either be determined federally or through performance contracts with States where that would be deemed to be desirable to determine their eligibility. State roles in terms of licensing physicians, those kinds of things that they do now would continue, we would not alter those at all. So there are State roles, but it would be vastly different from the broad discretion that they have currently in the Medicaid program.

COMMISSIONER-DESIGNATE BERRY. I asked that because we had testimony that one of the major problems that minorities face in terms of medical care often has to do with State determination of who is eligible as, for example, if a parent—the male parent is at home, they are not eligible for AFDC. They are not eligible for Medicaid and since these major areas were pointed out, I was just curious as to whether Healthcare had taken care of those problems.

DR. DAVIS. It does in terms of setting uniform rules that don't depend upon the family composition, don't depend upon assets. There are not asset tests, and are not at the discretion of the States to set the income levels at which they would be eligible.

COMMISSIONER-DESIGNATE BERRY. You published an article in 1975, "Equal Treatment and Unequal Benefits: The Medicare Program." Are you familiar with it? There is a section in this article in which you describe the problems with Medicare and you point out such things as the necessity for cost sharing and coinsurance, and you suggest such things as a graduated scale for people with higher incomes having contributed more, and there is a long list of items that you suggest on page 483 of that article. I wonder if you are satisfied that the Healthcare proposal meets every point that you raised in this list of about six items that you thought were absolutely essential in reforming Medicare?

DR. DAVIS. Well, I would like to point out again, that Healthcare is a phased-in plan and not the ultimate solution, but at least a major step towards remedying a lot of gaps. One of the things that I found and others have found in looking at Medicare is that the lowest users are those aged who are low-income, but not covered by Medicaid and do not purchase supplementary private insurance coverage. You have relatively high use among, or average use among, low-income aged who are on Medicaid and relatively high use by higher income individuals who supplement Medicare with private insurance coverage. But, basically, it is a U-shaped program for those who are not poor enough to get on Medicaid and not rich enough to buy private insurance, those individuals lag alarmingly behind all other income groups among the aged in use of services.

One thing the administration's plan does is to bring in many more aged persons into coverage. It sets an income level and all aged persons below that level would get complete free care, so that there are no coinsurance deductibles that obtain to other individuals. Plus, there is a sliding scale above that, something we call a spin-down. Basically, for every dollar your income goes above that income level, you pay a dollar at most for medical care and the plan picks up the rest.

So it has done it there. We do guarantee that everyone below the 55 percent poverty will get complete free care for the benefits provided. But I think we all recognize that 55 percent of the poverty level is a very low rate. For a family of four, the poverty level is about $7,500. In 1980, 55 percent of that is $4,200 for a family of four. So for that level, people are covered fully, but then it tapers off quickly as your income goes above that level. Again, as I indicated, it's a phase-in plan, and white paper puts a commitment to go into 100 percent of poverty as resources permit, but $10 billion to bring all poor people into 55 percent of poverty, so that's a first step and a major step.

COMMISSIONER-DESIGNATE BERRY. But if you want to improve access to health care and if you had your druthers, you would implement the suggestions that you made in that article in 1975?

DR. DAVIS. I am impatient. I'd be happy to move forward more rapidly. I think we do have to be aware of certain economic constraints that do dictate how quickly we should go, and we shouldn't despair if we can't afford it all right now. Let's just get started to do whatever part we can do now.

COMMISSIONER-DESIGNATE BERRY. You have a section in that article in which you talk about minorities and discrimination and what you think would be required. You point out again the disparity in access to nursing homes. I wonder if there are any legislative proposals, since you pointed out there were areas of discrimination at that time, are there any legislative proposals that would address this list of items in terms of access to physicians, nursing homes, and the like, that you pointed out in 1975? And is it your impression that HEW and Health and Human Services is doing a better job of seeing to it that these disparities don't exist than HEW did in 1975 when you wrote the article?

DR. DAVIS. Well, I think there are some things we have done, like try to expand the number of Community Health Centers, such as covering nurse practitioners. We did get the Rural Clinics Act enacted, so that there have been a number of legislative proposals, budgetary changes that have helped. On the other hand, I'm disappointed that we haven't done more. I guess the one provision in the Medicare program that bothers me the most is not extending Title VI to Part B of the Medicare for physician service. That physicians can maintain, as many in the South do, segregated waiting rooms and not be found in violation of Title VI, because an administrative interpretation has determined that physician services under Medicare are not Federal purchase of services. But it's an insurance program and we pay individuals, who pay their physicians. Therefore, it's not direct.

I don't know whether that requires legislative change or could be done through a more liberal interpretation of that. But I think it's an area where there should be change.

COMMISSIONER FREEMAN. Should this be an administrative interpretation?

CHAIRMAN FLEMMING. Yes.

DR. DAVIS. I just mean—there are two kinds of lawyers, those that say "Yes" and those that say "No." I'm not a lawyer. I've often wondered if that couldn't be reappraised. We did raise within the Office of General Counsel in '77. It was their indication at that time that we could not do it under current statutory authority. There have not been, to my knowledge, legislative proposals to change that. I don't know if a new look, a fresh look, would find that to be the case.

CHAIRMAN FLEMMING. Has that been tested in the courts?

DR. DAVIS. Not to my knowledge. Before I started at HEW I conducted a study of rural health care in the South and visited over 70 rural health care projects in the South, and did find a number of just very flagrant examples of overt discrimination. Waiting rooms that were segregated are very common in the South. In one instance, we went in and there were even signs saying that it was a colored waiting room. When the physician was told that was offensive, he said "If I cover it up with tape, would it be all right?" We said yes. He covered it up with Scotch tape. This is just an example of that sort of thing.

One hospital visited, where hospitals are subject to this kind of repute, there were black and white tables in the cafeteria, so people would know where to sit.

COMMISSIONER-DESIGNATE BERRY. And it's your understanding, Dr. Davis, that the Department's interpretation of Title VI is that it does not apply to the physicians' waiting rooms? Was that an administrative interpretation or just someone in the Department saying that Title VI probably—

DR. DAVIS. Well, that was decided very early in 1966, very early in the implementation of the Medicare program, that Title VI applied to the hospital side of Medicare, but not the physician side. As I indicated, we reraised that in 1977. At that time, General Counsel thought that it was correct.

COMMISSIONER-DESIGNATE BERRY. I would hope that we could ask the Department about its interpretation.

CHAIRMAN FLEMMING. Yes.

COMMISSIONER FREEMAN. Mr. Chairman, I believe we should ask our General Counsel to pursue this and that we should send a communication to the Secretary. It is incredible that it's not been litigated.

VICE CHAIRMAN HORN. It's also incredible that it's not been reconsidered in Health, Education, and Welfare, if that was a 1966 decision. Did I hear correctly?

DR. DAVIS. As I indicated, it was reconsidered in 1977.

VICE CHAIRMAN HORN. I would hope the program administrator would ask for reconsideration every month until he or she found a lawyer that could say yes.

COMMISSIONER-DESIGNATE BERRY. I just had one or two—

CHAIRMAN FLEMMING. Just to nail this down in connection with the suggestion of Commissioner Freeman: we will, as soon as the Staff Director has General Counsel develop a memorandum for us on this, after appropriate contact with the Department. (See exhibit 15.)

COMMISSIONER-DESIGNATE BERRY. I wondered, on the issue of nursing homes, to whom you gave a great deal of attention in that article you wrote, and some other things you have written and I have read, I wonder why the Department has not used some kind of incentive program to get nursing homes and providers to provide nursing home care for minorities and other people who are underserved. Has there been anything about doing something of that sort?

DR. DAVIS. As I indicated, a lot of the long term care area is under review in the Department. I think already mention has been made of the lack of actual site visits to see if nursing homes are in compliance. I know hearings the Justice Department held indicated that only about 3 percent of nursing homes are actually site visited. Again, I think that is an area where there is a tremendous imbalance in access to care and benefits that are available, and one problem that could take some reexamination.

COMMISSIONER-DESIGNATE BERRY. Also on health professionals, you talk about the nurse training problem and the retention problem. Has there been any consideration of financial incentives for nurse retention in underserviced areas? You said a major problem was people not staying in nursing and you gave a list of items that are being considered, as when you try to find out why they don't stay in nursing, but what about the notion of giving incentives to people to stay in the field? Have you considered that?

DR. DAVIS. Those are among the ideas that are under consideration. I must confess that in the nursing area we are not very far along in coming up with a proposal to address that, pending some additional information on whether it is financial incentives or status, or prestige or what the factors are.

COMMISSIONER-DESIGNATE BERRY. And, finally, do you think that, as Ms. Greenberger stated if I understand her correctly, that we would need to have a statute which prohibited discrimination against women in the provision of Federal services, including health care, in order to solve some of those problems which she raised concerning inadequate access for women, that we need a statute like Title VI in the absence of the ERA, which I assume would take care of the problem? Would you agree that's something that would be needed and that perhaps the Commission ought to consider in order to solve problems that women face in terms of access to health care?

DR. DAVIS. I guess I am somewhat hesitant to answer without knowing a little bit more whether that particular legislative remedy is desirable or not. I thought Ms. Greenberger raised a number of salient points about difficulties women face in getting access to health care and health insurance.

COMMISSIONER-DESIGNATE BERRY. Thank you.

CHAIRMAN FLEMMING. Ms. Berry, I am glad you raised that, because I meant to refer to that. We do have Title VI. We do have the Age Discrimination Act, but we don't have anything of a legislative nature as far as discrimination on the basis of sex and the delivery of health services is concerned. I think this area should be explored.

COMMISSIONER FREEMAN. Mr. Nunez?

MR. NUNEZ. I have one question concerning the closing of the financially distressed hospitals. Obviously, we have to differentiate between those hospitals who are publicly supported and those which are private, nonprofit hospitals. And in the situation that Dr. Holloman is referring to, the New York situation, there is a choice made by the city fathers among 18 hospitals, which ones they will close.

Obviously, all of them are financially distressed. Now, my question to you is, does Health, Education, and Welfare have any criteria in giving guidance to any kind of entity, governmental entity, in determining which hospitals among a group of hospitals should be closed? And primarily, criteria focusing on what the disparity impact of closing that hospital would be for the minority community, which is traditionally the one that takes advantage of those public hospitals? Do you have any criteria for guiding any of these municipal governments?

DR. DAVIS. We do have criteria. The Office for Civil Rights is quite concerned about its impact on access for minorities, in many of those instances has been involved in trying to collect basic data to ascertain whether those criteria would be met or not. We are concerned about that particular point, among many others, impact on employment, etc.

MR. NUNEZ. Where is that case in New York? As I understand it, it is a major controversy whether those hospitals, the one in Central Harlem and the one in East Harlem—I think it's gone to HEW. Would you know where it is?

DR. DAVIS. I guess I'd rather not comment on that, both because I am not sure and current in that or as knowledgeable as others in the Department.

COMMISSIONER FREEMAN. Dr. Davis, Dr. Holloman, Dr. Branch, Ms. Greenberger—

DR. HOLLOMAN. May I, before you bring this to a close? There was a question about documented cases of racial discrimination, whether I had any more, by Commissioner Saltzman. And I do have one from the National Health Law Program, at least I have a list of documented cases with the source of the documentation rather detailed. I am prepared to submit that.

COMMISSIONER FREEMAN. Would you leave that for the record?

DR. HOLLOMAN. Yes, I most certainly will.

CHAIRMAN FLEMMING. Without objection, it will be entered into the record. (See exhibit 16.)

COMMISSIONER FREEMAN. I want to thank each of you for an excellent contribution. You really made—well, you can tell from the discussion that this has been very interesting and a a very meaningful contribution. I want to thank you. Mr. Chairman, that concludes the morning session.

CHAIRMAN FLEMMING. Consultation will be in recess until 1:30. Again, thank you all very, very much.

Afternoon Session, April 16, 1980

CHAIRMAN FLEMMING. You have undoubtedly already noted this will be the final session and, as far as this particular consultation is concerned, the focus of this afternoon will be on access to medical training. The presenter is Dr. Alonzo Atencio.

He is presently the assistant dean and assistant professor of biochemistry at the University of New Mexico. As assistant dean, he has been active in the recruitment, preparation, retention, and seeking financial assistance for minority medical students, as well as recruitment of minority graduates, science students, and faculty for colleges and universities.

He has served as chairman of the board of the National Chicano Health Organization, National Health Task Force, and also as director of the New Mexico Clinical Education Program.

Dr. Atencio received his B.A. and M.A. and Ph.D. in medicine from the University of Colorado, as well as an NIH post doctoral fellowship at Northwestern University.

We are delighted to have you with us and appreciate your being willing to spend some time with us, looking at what we regard as a very important aspect of the total problem.

DR. ATENCIO. Thank you very much, Mr. Chairman. I must forewarn you that I have a lingering cold and if I happen to lose my voice in the process, please bear with me. I will state our task. I am prepared to elaborate, as I am going along.

CHAIRMAN FLEMMING. You plan to take about 25 minutes?

STATEMENT OF ALONZO ATENCIO, ASSISTANT DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF NEW MEXICO

DR. ATENCIO. About 25 minutes. As has been well documented throughout this hearing, there have been a lot of serious problems with the health care delivery system. In the 1960s, there were severe shortages arising from limited access, maldistribution of resources, and uneven quality of care, both in the private office and in the public clinic. The problems seemed to arise from poverty. But, as people dug a little deeper into the problem, maldistribution of physicians was primarily concentrated in ghettos, barrios, and rural areas where a lot of minorities are more concentrated.

Closer examination of the health care delivery in the United States at the time revealed that we had lower health care qualities than other nations, such as Sweden, Switzerland, and some of the European countries. We've had a higher infant mortality rate, for instance. We had a lower life expectancy. This is all part of the history of the sixties, before legislation to increase health manpower was enacted. It was alarming that such problems of health care and poverty could exist in this country with its advanced knowledge and scientific achievement. Something seemed to have gone out of the health care delivery system. At first it was thought to be caused by physician and other health care personnel shortages. Closer examination, however, showed that the physicians were not practicing in the rural ghetto, barrio, and Indian reservations or in the poorer urban sections of the city. There was also a shortage of physicians and other health care personnel, greater in the areas of predominantly minority, Chicano—and let me just define the word Chicano, as I use it. The word Chicano to me means Mexicano. It doesn't mean radical, and other terms that have been attached to it. The word Chicano represents a population of the Southwest who were conquered by the United States and abandoned by Mexico, and we used to identify ourselves as Mexicano before Chicano. It's a very affectionate term with us.

The vital health statistics were bad for poor whites, but were significantly worse for the minority population. The data alone fails to indicate the extent to which the health problems affect the minorities. The evidence, however, clearly showed that the health care has failed the minorities, not only through omission of health services, but actively discriminating against them in a way that continued to place them at a disadvantage. Increasing expenditures through Medicare and Medicaid have failed to address the underlying problems.

The problem of minorities is poverty, overlayed with racial discrimination. It is not surprising to find that over 30 percent of the minorities earn incomes less than $10,000 annually, compared to only 10 percent of the white population. To be poor means you can purchase less education, especially at the college level, purchase less health care, and purchase less adequate housing. In short, be subjected to a substandard environment predisposed to illness, trauma, and violence. To be poor means more disability, affecting the early education of children. Studies have shown that children of both whites and nonwhites with annual incomes less than $5,000 lose more school days due to chronic ailments.

Although poverty and disease transcend racial lines, to racial minorities it is a double burden. In 1974 and '75, the average life expectancy at birth was 73 for whites, compared to 67 for nonwhites. During their lifetime, nonwhites are three times as likely to die from hypertension, kidney disease, and diabetes. A nonwhite is twice as likely to be a victim of homicide. Uncontrolled, illicit drug traffic in minority communities is prevalent.

Discrimination limits access to housing, employment, and recreational facilities supportive of good health. It contributes to internal conflicts, repressed anger, inner stress, and all elements capable of not only precipitating disease episodes, but also liable to create destructive behavior. Alcoholism takes its toll of lives in the minority community.

All of the elements of conditions cited above are symptomatic and, in general, services provided the minority communities are deficient in the characteristics essential to a well-organized system: availability, accessibility, continuity, comprehensive, coordinated, and appropriate. You must understand that the services provided to minorities are frequently inferior in quality, and caused by overt or subtle discrimination, a lack of cultural empathy, and a lack of a second language in monolingual communities. The resources in general are inadequate in number, type of care, long or acute mental health care.

Torrey recently cites statistics relative to involvement of psychiatrists in the delivery of mental health care, indicating that over 65 percent of their time is involved in private practice or in the private general hospitals, as opposed to State or county mental health centers or in alcoholic rehabilitation centers. The area of mental health treatment is culturally loaded.

One of the most crucial resources to adequate health care, which is the center of the talk of this paper, is health care personnel. There is a severe shortage of minority health professionals. For instance, while there were less than 25 or 26 black physicians per 100,000 black Americans, in 1975 there were 177 white physicians per 100,000 population. Among Chicanos, there were fewer than 250 practicing physicians. Of over a million Native Americans and Alaskans, there were only 72 participating physicians.

In this monograph, as I mentioned, I will address what has occurred in the medical school and medical education of minorities in the last decade—what role the Federal Government has played in increasing minority participation in medical education, what changes have occurred in medical school admissions, and what effect the *Bakke* decision has had on the admissions process, what steps could be taken to increase the enrollment of minorities.

However, in order to understand the nature of the barriers to minority access to medical education, we have to know something about the process leading to admission to medical school.

The preparation for a career in medicine begins early, around the seventh or eighth grade. As a child moves on through the educational pipeline, he begins to make choices on what he would like to become professionally as an adult. It requires an uninterrupted flow through the pipeline from high school on to college before reaching out for professional school. For minorities the flow is often interrupted early. Starting with, say, 1,000 elementary school children, through a compulsory attendance, as they move on through the pipeline, there are losses occurring at the junior and high school level. Many will drop out, either because they find school noneducational or they need to work to contribute to family income.

In New Mexico in 1970, for instance, we found that 80 percent of the Chicano and Native American high school students did not plan to enroll in college. Of the original, that left only about 200 viable candidates for college. Coming from substandard secondary schools, they found college difficult, accelerated, foreign, causing a 65 percent dropout rate by the second year of college. That left only 70 continuing their education. Of the remaining 70, a larger percentage would stop their education to pursue work after their bachelors degree, perhaps one of the original 1,000 would eventually end up in a professional school.

We found, also, that while the population of New Mexico was 40 percent Chicano, only 19 percent of the college and 3 percent of the medical school enrollment was Chicano. For their Anglo counterpart, the representation rose from 48 percent of the State population to 91 percent at the medical school level. There is a clear divergence in the pathway for these two groups, as each progresses on up through the educational pipeline.

Many have investigated the causes of this divergence. The reasons range from the absence of role models in the professions to overt exclusion due to racial discrimination. Role modeling has certainly played a major role in the exclusion of females from the medical profession, but this is self-exclusionary more than discriminatory, and can also be attributed to sexist views held by the admissions committees.

Relative to Chicanos in the Southwest, the Commission on Civil Rights in 1972 found that there were certain practices affecting the education of Mexican Americans. There were two publications to that effect. While not being overtly racist, they noted that teachers praised and encouraged Anglo student participation in class exclusively.

I would like to suggest probably that the Commission conduct similar studies relative to professional schools as to what effect teaching, the way they are treated, graded, and evaluated and how that affects their performance.

A quote from the report illustrates this point: "There were several Chicano children who kept raising their hands," and this is a direct quote, "eagerly at every question. Mrs. G. would repeatedly look right over their hands, and call on the same Anglo students over and over again. In some cases, she would call on the Chicano children only because the Anglos stopped raising their hands."

They also found that teachers built upon the contributions of the Anglo students 40 percent more frequently than those of the Chicanos. Overall, the Chicano student received less attention from teachers than their Anglo counterparts. I can relate similar personal experiences, but suffice it to say that the Commission has independently recorded these incidents of educational neglect that are still being implemented. Similar episodes happen to blacks, American Indians, and mainland Puerto Ricans.

These dynamics obviously do not foster creativity or cultivate the facilities of mind, rather they make students feel inferior, create anger, rebellion, and eventually a disdain for the educational system. Of course, this negative stroking does not promote self-worth and self-esteem. Rather it creates insecurity by nonparticipation eventually leading to self-elimination from the educational system.

The economic barrier is another hurdle in the path of minorities achieving a higher education. We live in a socioeconomic reality that requires people to purchase education. At lower income levels, people tend to prioritize the expenditures of their meager incomes. Usually, education and necessary health services are delegated lower priorities over, say, food or shelter.

In 1974 a study of 55,053 families showed that 49 percent in nonmetropolitan areas earned less than $10,000 per year. The correlation to educational attainments of persons older than 25 years was significantly lower for nonwhites.

Financial need has had a long range effect on minority education, particularly those desiring to pursue professional careers in medicine. Even though the awareness created by the civil rights movement led to increased efforts by colleges and universities to enroll more minorities, there is still a fear of accumulating debt by minorities. In the mind of minorities, a $6,000 debt accumulated in college is significantly high to preclude the student anticipating adding $30,000 more by the time he or she finishes medical school. This is compounded by the obvious fear of failing in school and being saddled with a high debt. The fear is real since most minority students are considered academic risks by most professional schools.

As mentioned previously, the process of preparing for a medical degree begins early. The process of selection and admission to medical school is based on long range preparation. A preparation at least to conditioning to test taking and a belief that following a given series of courses will produce a well-qualified student.

The admissions process is strongly dependent on measurable cognitive variables in the initial stages and noncognitive subjective variables at the later stages. It is in this initial stage that minority applicants, that is, those who have survived college to apply, are eliminated from the process. The noncognitive evaluation, which is unquantifiable, therefore becomes the most meaningful parameter in the admission of minority medical students.

In the initial stage, the screening stage, the grade point average and the medical college admission scores play a significant role. Medical schools tend to have a GPA [Grade Point Average] cutoff of 3.5 on a scale of 4, and the MCAT [Medical College Admissions Test] scores above the 85th percentile. It is from these survivors of the initial screening that the matriculants are selected.

Minorities seldom achieve high cognitive scores, therefore seldom survive the initial screening. One medical school developed a formula for screening medical applicants that included points with adequate multiplying factors for GPA, MCAT, letters of recommendation, college attended, and so forth. The formula had a high predictability for students scoring above a certain score. It worked so well that not a single minority fell within the admissable range.

It has been well-established that minority applicants score at or below the 30 or 40 percentile in the MCAT and bring GPA averages around a 2.7. A cognitive profile for the majority and minority applicants clearly show a biphasic distribution or two distinct populations. Schools, therefore, feel justified in screening out those with the lower scores and grade point averages without taking into consideration the events causing them.

This myth of measurability is based on the assumption that the qualities desirable in a physician are measureable. Using such selection criteria not only serves to feed the ego of those selected, but will also select a homogeneous population of overachievers trained in test taking and perhaps rather insensitive to human frailities. Unfortunately, their emphasis has been to score well, rather than to learn more about human interaction.

In the period from 1947 to 1956, for instance, there was an increase of only 173 black medical students compared to 5,900 whites in medical school. However, the enrollment of blacks at Meharry and Howard accounted for two-thirds of these enrolled. Thus, two-thirds of 761 black medical students in 1956 were enrolled at two black medical schools and the remaining one-third in the remaining U.S. medical schools. There is no evidence that those students enrolled and graduated from Howard and Meharry were inferior physicians.

By the same reasoning, those graduated from predominantly white institutions were evidently not superior physicians. If anything, the selection of a homogeneous population of overachieving medical students has led to a maldistribution problem, as witnessed by the decline in general practitioners.

The second stage in the selection of students surviving the preliminary screening is largely noncognitive if implemented fairly. There are many qualities, difficult to quantify, that are desirable in a physician. Admissions committees attempt to glean these qualities through a personal interview and analyze the student's involvement in community organizations and so forth. Given a preselected group in which the committee is reasonably assured they do not present an academic risk, the noncognitive evaluation is reasonably safe, unless they detect some obvious qualities of insensitivity or sociopathic behavior. This is difficult to achieve in a 30-minute interview and from self-identified student involvement, indicating a sensitivity to people. Since the medical profession has high rates of suicide, drug abuse, alcoholism, and divorce, something must not be working properly in the selection of medical school applicants.

Reacting to social pressure, U.S. medical schools in 1968–69 began to seriously address the absence of minority medical students. In 1970, at the annual AAMC meeting in Los Angeles, there was an aura of frustration. For some naive reason, many schools felt that once they opened their doors and go out and "beat the bushes," there would be a flood of minority applicants. Much to their dismay, qualified minority applicants were not that easily located. Years of educational neglect had taken its toll. Very few minorities have survived the educational trauma and even fewer were enrolled as premed students. The medical schools had to turn to seeking minorities majoring in the sciences totally unrelated to medicine. These students became the potential pool of applicants. Furthermore, they had to examine their admissions procedure in order to give the applicants a more equitable evaulation.

The Federal Government, meanwhile, reacted to a perceived shortage of physicians and initiated physician augmentation programs and capitation grants to medical schools, rewarding them for increasing their enrollment. What was neglected in this analysis was the maldistribution of physicians arising from overspecialization and the near elimination of the general practitioner, which has changed since then.

Enrollment in medical schools increased as schools expanded the class size. But the problem of increasing minority enrollment in particular continued to lag. Admissions committees encountered much difficulty in accepting students with what they considered substandard academic credentials. Medical school facilities reacted similarly and felt that minority students could not cope with the rigors of medical education. One resistance to the admission of minorities also came from white applicants who felt discriminated against. This was not without some justification; after all, they had been preparing for a medical education most of their life. They also represented a small percentage of survivors of premedical students. (A large number of college freshmen enroll as premed students, but only about 10 percent actually become applicants by the end of their junior and senior years.)

This change placed some medical schools in a dilemma. On the one hand, those which wanted to enroll more minorities now felt that their standards had to be lowered to accommodate the minority and more women applicants. Naturally, under these circumstances, the graduate from medical school would also be considered substandard, which is a fallacy. Many discussions on the criteria for admitting minorities ended in stalemates.

Much to their surprise, however, women applicants were bringing with them excellent credentials from colleges, so their admissions did not require drastic changes in admission policies. The only major adjustment was altering or accepting women as equals in a predominantly male profession. The problems remain with the minority and statistics comparing the rise in enrollment of minorities and women verifies the above statement.

The U.S. medical schools, some more rigorously than others, began to alter their admissions policies and initiated special programs for identifying, recruiting, admitting, and retaining minority medical students. The emphasis was placed with identifying minority students.

CHAIRMAN FLEMMING. I don't like to interrupt, but you have about 25 minutes left and I notice there is quite a little bit remaining. You might want to go to certain parts of your statement that you would like to underline particularly.

DR. ATENCIO. I was just begining to address my primary concern. Well, I'll start on the next page.

As I mentioned before, there were several minority programs started for recruitment and retention and educational counseling. In 1980 there are 25 medical schools now offering summer programs to high school level students; 32 offering summer programs at the undergraduate college level; and 43 offering summer programs to minority students accepted to their medical schools; 5 offering post-baccalaureate programs, and 2 offering pre-entry programs to minority students accepted at any medical school. Of the 112 U.S. medical schools responding to the AAMC inquiry, 76 offer some form of summer or yearly motivational program. This leaves some 36 schools that have not yet made any form of commitment.

As a result of the effort enrollment at medical schools has increased from 37,000 in 1969 to 63,000 in 1979 for a net increase of 25,110 students. During this decade, minority enrollment rose from 1,178 to 5,084 or 8.1 to 7.9 percent, actually a small decrease.

Perhaps the most significant figure is the change of the first year enrollments.

From 1969 the total first year enrollment in U.S. medical schools rose from 10,422 to 16,930 for a net increase of 6,508. Minority first year enrollment rose from 501 to 1,540 during this decade. In percentage, the first year minority enrollment rose from 4.8 percent to 9.1 percent.

First year enrollment of women starting in 1971 meanwhile, rose from 1,359 to 4,707 in 1979. During this same period, the total first year enrollment rose from 12,000 to 16,579 for a net increase of 4,569. Minority enrollment increased, as I mentioned previously, for a net increase of 489. Thus, women enrollment in first year classes represented a net increase of 3,348, accounting for 73 percent of the overall increase. Minorities account for only 10.7 percent and white males for 16 percent. The rise has been largely in women enrollment during this decade.

Before white males become concerned, it should be pointed out that they still represent 63 percent of the total first year medical student enrollment of 16,000.

The initiative to increase minority enrollment in medical schools was challenged in *Bakke v. University of California.* The impact of this challenge has had some effects. The internal challenge created an aura of disdain for the minority students in the medical student body and manifested in an unwillingness to participate in tutorial and other special programs even if the money to pay for services was available. This unwillingness seemed, justified amongst faculty, to fulfill their prophecies that minorities could not succeed. In fact, I heard faculty committees make statements, "You cannot make a silk purse out of a sow's ear or a medical doctor out of a minority student."

After the Supreme Court in California ruled in favor of Bakke, there was a lot of caution in admission of minority students. There was a decline from 10.1 percent to 8.1 percent of the total medical student enrollment after that decision. However, since the U.S. Supreme Court decided, I believe the trend is somewhat reversed, but now we face another problem, we face a problem of financing medical student support. I will get to that from here. Am I going to have time to get to that?

CHAIRMAN FLEMMING. Yes, take 3 or 4 minutes.

DR. ATENCIO. Since the enactment of the Health Professions Educational Assistance Act in 1963, Federal assistance to U.S. medical schools in the form of capitation and physician augmentation grants has led to an expansion in medical student enrollment, but a decrease in scholarship financial assistance. This financial effort seems to have been originally designed to increase health manpower, but more recently to distribute it to underserved areas. For instance, during this period, 1963–1979, 40 new medical schools and osteopathic schools of medicine have opened and the medical student enrollment has doubled.

To reach the accepted ratio of 600 patients per physician, minorities would have to have had a combined number of 67,000 minority physicians by 1976. Minorities are still a long way from reaching the desired ratio, while the current enrollment of medical students is projected to cause an oversupply of physicians. The projected supply of physicians is expected to rise from 379,000 in '79 to 519,000 in 1985 for a 222 physicians per 100,000 population. Unfortunately, this projection does not hold for minority physicians when enrollment seems to have plateaued, rather than rising to reach an equitable physician to patient ratio. The current graduation rate of minorities is

1,058. This represents an increase of 260 from 1974. At this rate, we will never reach the 600 to 1 ratio.

The Bureau of Health Manpower, formed in 1967, has been responsible for administering some $6 billion to support expansion in training facilities and enrollment. During this time, the Bureau has had several major accomplishments in health manpower development and distribution. It has increased the number of National Health Service Corps Scholarships to 5,249 in 1978, has issued new criteria for identifying and designating nearly 4,000 new health manpower shortage areas, has involved local planning agencies in reviewing health manpower training grant applications, initiating training programs for primary care practitioners, expanded area Health Education Centers to 20 projects in 22 States, has launched new scholarships for students with exceptional financial needs, which is very small, and money for projects to assist disadvantaged students in health careers, and has formed two divisions to administer student assistance and manpower.

Financial assistance to medical students in the forms of Health Professions Scholarships initiated in 1967, originally designed to be administered as part of a scholarship grant, has now become totally a loan program for all medical students. For instance, at our school in 1973–74 we were awarded $29,000 as scholarship money and $69,000 for loans. Now, in 1979 we were awarded only $25,000 for loans alone. This is a school that has had, since 1970, an average of 25 percent minority enrollment. The University of New Mexico, not unlike other committed medical schools, is now being stretched to the limit to support its minority medical students.

With the decline of scholarship support and a stronger reliance on loan money, compounded by the rise in medical school tuition, minority students are having second thoughts about pursuing a career in medicine. This, in part, may be responsible for the decline in minority applicant pool.

Minority students, somewhat reluctantly, are now enrolling in the National Health Service Corps. Part of their reluctance is their fear of having to pay back the financial support in an underserved area removed from their environment. They also feel that the majority student is more capable of buying out of their commitment, leaving them holding the bag. They view this as a debt, as well, and coming from a lower socioeconomic background, the debt is out of their realm of reality. They also question whether because of their financial need, they are being channeled to help solve the maldistribution problem to areas of the general population and minority population.

In concept, the Exceptional Financial Need Program could assist the financial need of minority students, but in actuality it only supports a student for one year, and insufficient money has been appropriated. It seems to address the first year when a high risk student may be more susceptible to failure, but it leaves him financially insecure as he must seek support for the second year.

CHAIRMAN FLEMMING. Thank you. Time has expired.

DR. ATENCIO. All right.

CHAIRMAN FLEMMING. As you know, the full text of your statement will be made a part of the record of the hearing and some of the points that you haven't had an opportunity to cover will undoubtedly come up in the discussion that will take place.

The first member of the panel that will discuss this paper, and the issues are identified in the paper, is Dr. Rayna Green, who at present is the director of the Projects on Native Americans in Science, Office of Opportunities in Science, American Association for the Advancement of Science. Dr. Green is also visiting professor of Native American Studies at Dartmouth College.

Dr. Green has served in top level administration and program development as a consultant and advisor to various programs and projects, among them the Education and Cultural Advisory Task Force, president, National Advisory Committee on Women, and the Native American Advisory Group, Smithsonian Institution. Dr. Green has participated in various conferences and symposiums, such as Native American and Hispanic Contribution to Sciences, American Indian Energy Resource Development, and the Women's Studies Association Panel on Indian Women.

Dr. Green received her B.A. and M.A. degrees from Southern Methodist University and her Ph.D. degree from Indiana University.

Dr. Green, we are very happy to have you with us.

RESPONSE OF RAYNA GREEN, DIRECTOR, PROJECT ON NATIVE AMERICANS IN SCIENCE AND VISITING PROFESSOR, DARTMOUTH COLLEGE

DR. GREEN. There are some things Dr. Atencio did not get to discuss, although in his paper there is an extensive discussion of the various programs which are available to offer funding in support of medical education for minorities and women. I would like to elaborate on those comments and point out some areas which seem to me to be extraordinarily important in support of producing more minority and female medical students. I should say that I support all his comments in line with the awkwardness with which most minority and female students find themselves in approaching the medical profession simply as a profession because, it is my opinion and I think the opinion of many of us, that the values, goals, and incentives of medical education don't even remotely represent the values, goals, and incentives for work that many of the minority and female community find.

Certainly the Civil Rights Commission can do nothing about that. I do want to underline the radical difference that many people feel. I also want to underline the suggestion that while money isn't everything, it certainly is a major stumbling block and want to move further to the suggestion that the very beginning of potential for medical education, that is science and mathematic education, for minorities and women is still terribly underfunded and more importantly, I think, simply discouraged throughout the United States and I don't think there is much deviance from that.

Let me point out some important programs in Federal funding that I think would clue us to at least the latter problem, that is, the importance of science and mathematics education, in the latter part of that education producing people who could then serve as role models and serve as inspirations for young minority and female people to go into medical professions and to health care in general. Let me talk about a number of programs in the Federal Government that do fund such things.

Dr. Atencio has mentioned a number of them. One, the totally admirable minority biomedical support program (MBS) in the National Institutes of Health, which is admirable not only because of the thrust of its funding, which does bring young minority people into research careers through its funding in undergraduate institutions, but because of the dedication and the commitment of its staff, which even pushed and pushed and pushed until they got permission to fund 2-year institutions, because this is where many minority and female students are. I think the 2-year institutions are vastly underserved in these areas. Many of the students are there. And science and mathematics play very little role in most of those institutions, unless they get outside funding.

The MBS program has been in the "avant garde." In contrast to this program, however, within the same National Institutes of Health, the faculty and undergraduate research program does not have permission to and has not sought permission to go into the 2-year institutions. Now there are no 2-year Hispanic institutions, several where people are primarily Hispanic.

However, with a number of growing Indian institutions where students are headed, and a large number of female, particularly older women returning to 2-year institutions, this is crucial. I think what we have in NIH, if I give the strong line here, is a case of de facto discrimination, essentially against Hispanics, females, and Indians, where the monies, important monies that go to producing more professionals in health care, are simply not available. Two programs which I think could be potentially very important, three programs, out of the National Science Foundation, the Women in Science Program, the Minority Institute of Science Improvement Program, and the Graduate Resource Centers for Minority Education in Science are all threatened in one way or another.

The MISIP Program was removed along with several other of the science education programs from NSF to the new Department of Education and the complete thrust of it is totally uncertain now. While I certainly think it could fare well in the Department of Education, scientists and science educators are worried because those programs, which very much provided funding supports for minority institutions to produce young scientists and eventually to produce young medical doctors, are simply being submerged. It's possible that their submergence in the new Department might prove beneficial, but I don't think anyone thinks so at this moment.

Moreover, these programs have lost a certain amount of their visibility and autonomy. The Graduate Minority Resource Centers which were funded—two of them now funded—I believe a third one is about to be funded—have been removed as line items from the budget and, therefore, once again, submerged and I think terribly threatened. In addition, only recently, a second try to establish an American Indian school of medicine has virtually failed, though new hearings might be called up. When you put this in contrast with the situation that has supported medical military training for a long time, even though these training programs have been questioned, I would certainly suggest to you that American Indians have every right—considering their underpopulation in the health care profession—have every right to wonder if service in the army isn't the only way you can get good health care and get physician training.

I suggest to you that this might make them more cynical after a certain point in time. The total absence of any medical training directed directly toward Hispanics, I think, is profoundly important. Certainly, even with the large increase in the number of women entering medical school, I think the absence of any particular incentive or special attention paid to their difficulties once they get into medical school is a visible sign to them that nobody wants them. Certainly, no one wants them as doctors.

Another instance in which I think that the Commission can pay particular attention to problems in terms of access to medical education is that with most of the programs, some so confusing and some so multiple that no one can figure out where to go for funding, that is an instance that pretty much excludes smaller rural groups, smaller rural education groups, and smaller institutes from sorting through the Federal—in order to get funding to them and some of these programs. Quite frankly, the duplication and narrow guidelines pit these constituencies against each other, and I think that is an instance in which the Commission ought to pay serious attention because that is an instance in which no one can win. I think all of us have begun to know that much more profoundly.

I want to mention the 2-year colleges again. While many programs funding go towards high schools and then go to the medical schools, the 2-year colleges get dropped in the hole. And when we find over 40 percent of the minority and women in these institutions, the fact that none of these multiple programs can serve these institutions, I think is a de facto instance of simply ignoring a live constituency.

One other point I would like to make and then I will be finished, except again to reaffirm all that Alonzo has said, is to suggest that until we are able to focus on the potential for a medical professional pool that is there, and here I am talking about taking them where they are, for example, up through the paramedical ranks, paraprofessional training, paramedics, the medical technical fields, and through nursing, and until we can direct some funds and attention to minority and females who are—exist now in these pools and bring them up through medical education, instead of treating them like second-class citizens, we will continue to miss an enormous pool of already interested health care personnel that are there and lively and being dropped in the garbage heap.

Thank you.

CHAIRMAN FLEMMING. Thank you very much. Next we will hear from Ms. Magdalena Miranda.

Ms. Miranda is presently the Chief of the International Education program section in the Bureau of Health Manpower at the Health Resources Administration. Her responsibilities include monitoring the entry of foreign doctors in. medicine, assessment of the study of medicine by U.S. citizens, and implementing the International Educational Exchange Program.

In addition to her government services, Ms. Miranda has been a member of committees that have looked at issues related to health manpower training and health care. She has likewise participated in a great many seminars and conferences dealing with these issues.

She received her M.S. degree in 1952 from Hunter College and later her M.S. degree from Columbia University School of Social Work. She is presently a Ph.D. candidate at the New York University, Graduate School of Public Administration.

We are very happy to have you with us.

RESPONSE OF MAGDALENA MIRANDA, CHIEF, INTERNATIONAL EDUCATION PROGRAMS SECTION, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

MS. MIRANDA. Thank you, Mr. Chairman, Commissioners, Dr. Atencio. A couple of years ago Dr. Alonzo and I were together, engaged in "sensitizing" the Bureau I now work in, and whenever I get frustrated, I remember a comment he made at one conference, (I believe he had probably just become a faculty member at a medical school), about "our services being purchased, but we hoped we hadn't sold out."

I very much support the points Alonzo was making in the paper, and, as I heard Ms. Green's presentation, felt very supportive about the issues and concerns that exist within the minority communities and the attempts at trying to remove some of the barriers which exist to expanding minority participation in the health professions. As I read Alonzo's paper, I thought that my contribution to this consultation might be to incorporate information about medical education per se, the context within which medical education has operated in the last 15 to 20 years and where the minority concerns fit into this. I will also quickly review and give you some statistics on scholarship and loan programs and some of the concerns that currently exist regarding these.

Prior to 1963, as some of you who are familiar with the medical profession in the United States may know, the involvement of the Federal Government with medicine or with medical education was anathema. Essentially, as the schools of medicine experienced increasing financial problems, assistance was sought from the Federal Government but with the intent of trying to keep in balance the interest of the medical profession. A research support strategy was developed, essentially out of the National Institutes of Health (NIH). In fact, a couple of reports reflect the general awareness that the research support that went into the schools of medicine was a mechanism used for helping keep the schools viable and functioning.

Years later and into the present, other concerns have surfaced regarding the medical education and the career orientation of medical students. The move has been into extensive clinical subspecialization, with a concomitant reduction of primary care physicians.

By 1968 physicians' manpower concerns were shifting into concerns regarding the availability of physicians generally. There was some concern about specialization, but not extensive. The first health manpower legislation, enacted about 1968, essentially addressed the issue of the shortage of physicians in the country. Rural areas were specifically identified as lacking physicians, but there were no extensive concerns expressed regarding other aspects of medical education and/or the availability of physician manpower for other than rural communities. Capitation grants for the schools of medicine were initiated with the intent of increasing the supply of physicians in the country. From the Federal and national perspective, the rationale for the support was based on the perception of medical schools as national resources which required national support. Others questioned the wisdom of utilizing public tax dollars to support the educational system of a lucrative profession.

In addition to capitation grants directed toward increasing the numbers of students, school construction funds were provided, at first to help develop research centers and later to develop teaching facilities.

By 1972 physician geographic and specialty distribution issues dominated the Federal perspective, and concerns regarding the underrepresentation of minorities in the health profession schools also received some attention. This latter concern was probably a reflection of the general societal concern with poverty and minority issues that had prevailed during the 1960s.

Interest in the contextual aspects of medicine were given some attention and special grants were provided for curriculum development in "humanistic medicine" and "team care," among others. The recruitment of minorities, women, and economically disadvantaged was encouraged through the placement of conditions on capitation grants. However, schools were provided a list of program options, of which they were required to implement a selected number. The recruitment of minorities, women, and economicaly disadvantaged was one of these program options, but was not a requirement per se.

A Health Careers Opportunity Program (HCOP), which is a separate program, awards grants to public and nonprofit private health or educational entities to support projects to assist individuals from disadvantaged backgrounds to undertake and complete education in a health profession.

In summary, between 1963 and 1980 the primary programs of the medical education effort at the Federal level were designed to provide incentives for growth of medical manpower generally but with increased targeting on expanding the supply of primary care physicians and expansion of physicians in medically underserved areas. The major strategies used for this effort were capitation grants, targeted support for primary care physician training, and student assistance in exchange for a service commitment in federally designated health manpower shortage areas. Assistance for minority recruitment was incorporated in special grant programs for the "economically disadvantaged," not a separate program per se.

Current debate regarding an appropriate Federal physician education effort has focused on the issue of the supply of physicians. Termination of capitation grants are proposed by the administration, with continued targeted support for primary care physician training, an expanded service commitment program, and a disadvantaged assistance program as major Federal efforts.

A different approach is proposed by others interested in medical education. They have proposed that capitation grants be retained but that the amounts would be dependent on each school's achievements in selected areas of national priorities. One of these priorities would be the admission rate of minority students to the educational program of the school. The intent of the incentive would be to give higher rewards, in Federal dollars, to those schools which contribute to resolving nationally defined problems and less to those which may have other worthy but less nationally oriented goals and interests.

Regarding the educational support efforts for medical students, i.e., the scholarship and loan program—Alonzo, I checked that out this morning. The scholarship program for students with exceptional financial need still exists. It may be that your school did not ask for scholarship assistance for any students. I understand scholarship funds are requested by the schools, based on the economic situation of students in that school and screened for eligibility. Because past evaluations of this scholarship program revealed deficiencies in the implementation of general income guidelines, current regulations establish very rigid and circumscribed eligibility criteria.

Statistics regarding recipients of the Exceptional Financial Needs Scholarship Program indicate that 44.4 percent of all scholarships went to minorities and 31.2 went to women. Of recipients in medical schools, 53.1 percent were minorities and 32.1 percent were women. In fiscal year 1979 there were 644 scholarships awarded in all the health profession schools. Although only approximately 6 percent of students in any school are recipients of these scholarship funds, a large percentage does appear to be provided to minorities and women. These statistics may also be reflective of the economic background of minority students in medical schools.

The National Health Service Corps Scholarship Program, the program to recruit practitioners for underserved areas, has gone from a $3 million program in 1973 to $75 million in 1979. The loan program, however, which had a 1980 appropriation of $16.5 million is "zeroed" out in the latest recision message. Of the total National Health Service Corps scholarships, 19.5 percent went to blacks, 3.9 percent to Hispanics, 1.2 percent to American Indians, and 22.5 percent to women.

As indicated earlier, the National Health Service Corps scholarship program, which was first authorized in 1972, is designed to exchange support for educational expenses for commitment to serve in areas with shortages of physicians. From the outset the program was designed to improve the geographic distribution of health professionals. Applicants are not required to be in financial need and awardees are selected on the basis of relative promise for continued service in a health manpower shortage area. The NHSC itself is considered a major effort to meet the needs of those who will not be adequately served without intervention in the normal market forces which influence most physicians in choosing a practice location. Dr. Foley has mentioned that private schools seem to be very heavily represented in the group of medical schools with many National Health Service Corps scholarship recipients. Although not severe, there may be some tension between the "dual-purpose" of the NHSC program, in that it is both a service program and a student assistance program.

Discussion

CHAIRMAN FLEMMING. Thank you very much. Dr. Atencio, would you like to take about 5 minutes to respond to any of the comments that the other members of the panel have made?

DR. ATENCIO. I would like to amplify on the minority biomedical science program. It started as a $2 million program about '72 or '73 and now with the current level of funding is $18 million within the Division of Research Resources. That division, the HEW authorization, allows $164 million, which is $5 million below the appropriated amount. That is a $5 million cut. The program funded about 10 percent of that amount, so of about $18 million, $1.7 million has been cut for that program. The cut thus comes to 34 percent, which I think is disappropriate.

I find that somewhat alarming, because it seems that with minority programs, the last ones to come in, will probably be the first to go. This is the trend being established in one of the most prolific and one of the most extensive programs the minority bioscience program has. The MBS is operating in about 70 schools throughout the country, both minority and not necessarily minority institutions. They have also had close to 3,000 students participate since its inception. It is also one of the primary sources of medical students though it was not intended to do that. It was intended primarily to get students into the sciences after good preparation in chemistry and biology, but many are applying to medical schools,

Again, here I would like to see the suggestion that Magdalena proposed, capitation for schools that have a commitment to enroll minority students, be implemented. I think that would be a good mechanism to support medical schools committed to minority education. It is very difficult to finance students right now without any support. We in New Mexico have had State legislation for financial support but with mixed success.

CHAIRMAN FLEMMING. Vice Chairman Horn?

VICE CHAIRMAN HORN. We have heard discussions here concerning college financial aid programs for minorities. We have heard discussions of the need for 2-year college programs for minorities. But I haven't really heard discussion of what I think is a fundamental question and that is the type of aid in science and mathematics which should be provided in elementary school, in junior high school, and in secondary school, if we are to help minority students. The fact is, college is too late to prepare minorities with the scientific, quantitative, and mathematical background needed to survive in science and medicine. So what is your thinking on this? I would also like to hear what administration programs are available. I know of some of them in science education. You can have demonstration projects, my university has been particularly interested in this sort of thing. As you have pointed out, statistics show that many Mexican American, Native American, Puerto Rican children simply never get to a 4-year or a 2-year college. They drop out. So what are we doing to solve this problem?

DR. ATENCIO. Very simply, to my knowledge, very little. I think enough on an on-site basis by individuals within the system, but there is no systematic support for any type of science reinforcement education that I know of.

DR. GREEN. I have to second that. While the National Science Foundation has had some admirable programs, like the minority Science Improvement Program, by and large, those are post-secondary, and the great thrust for elementary and secondary science education in the country, period, is minimal. I am talking about white students. I am talking about good well-off suburban areas. That thrust for science and mathematics is minimal and when you come down to minorities and women, it gets worse. Most of the funding has come for short term programs, which by and large are privately funded. And here we are talking about corporation and foundation funding but these are small efforts that fall off after 2 years. We've done a number of studies of such programs. AAAS [American Association for the Advancement of Science] is producing one for a program directed toward women.

What we find, where there are 2 or 3-year programs, they go away. Not to harp on the situation in the Department of Education. By and large, no special effort by name has been designated, and I think we all know the history of the reason that education has not had certain initiatives in specific curriculum efforts except for bilingual education and reading. For example, there is simply no major effort and, as far as I can see, no sign of it. This is the most persuasive problem. Everyone says it. We all know it and nothing is happening.

COMMISSIONER-DESIGNATE BERRY. There is a new program in the Department of Education, which was enacted by Congress last year as part of the Education Amendments of '78, which the Administration proposed. Shirley Chisholm, Congresswoman from New York, was the major person behind the legislation which was called a Biomedical Program for Junior High and High School Students to interest them in the sciences, and our budget request 2 years ago was $3 million for that program. I don't know what the situation is now, but I also wanted to point out there is that program. It's not going to solve the problem, but I also wanted to point out that in our work on the other program in HEW, the Professional Opportunities for Minorities and Women, we discovered that despite arguments, that there were not enough minorities and women who would get the fellowships because of the high school, junior high problem, when we started that program.

We discovered that there were plenty of people out there who are eligible, who need money now to go to school. While we focus on the junior high and high school population, I just thought I would point that out.

DR. GREEN. That is true. I should have mentioned that program. I'm sorry, Mary. Because Mary initiated one of the few resources of funding that gets theirs through that program and through another program in the Office of Indian Education, which is for Indians in critically needed fields like forestry and science.

We also found there were many more people qualified for the programs, but the money wasn't there. So this occurred throughout. It is classic.

VICE CHAIRMAN HORN. I wanted to yield to my colleague who has a question.

COMMISSIONER SALTZMAN. On this specific line of thought, Dr. Atencio, the objective, what should be the criteria for public policy in terms of increasing minority participation in the medical programs of the Nation, the educational programs, are we, in terms of education, attempting to merely duplicate overachievers that you pointed to? What really do we want to do? Do we want to get all of the minority students to be able to compete successfully with the white overachievers? You have some negative feelings towards that. Should we lower the requirements? What should be the basis in criteria for public policy? Just creating a mathematic and science program adequate for whites and minorities? Will that improve medical education, medical professionalism?

In your paper, you indicate that the student from Howard University is quite as good a professional as the overachiever. What are we looking for in our public policy?

DR. ATENCIO. That is a difficult question to answer. In the first place, a lot of the secondary schools that minorities attend are understaffed, overpopulated, underequipped. That places them at a big disadvantage in competing for places in good schools, good universities. That is one part of the problem, equity is not there in terms of education. I think the minorities also would like the opportunity to overachieve, if you like, and be selected one amongst the overachievers.

Unfortunately, that is not true. All the data indicates that this is definitely a biphasic distribution, as far as testing is concerned. I believe that we should initiate mechanisms to include minorities in science and to train teachers who are sensitive and knowledgeable of minority problems. You will find that most of the so-called counselors in minority institutions are not really counselors. They are disciplinarians. The minority student is very reluctant to go see a counselor because he perceives he is in trouble. They avoid the counselor whose primary role is to counsel the student into a career choice. Very frequently you find that a student with some talent in mathematics is channeled into TV repair or a young minority lady considered to be a beauty shop operator. This type of tracking still goes on in 1980.

I think what happened in 1968–69, as a result of civil rights social pressure, institutions began responding to the educational inadequacy. But now we are slipping back, a sort of retrenchment, back to what it was in 1960. I see it in medical schools, even in medical schools enrolling more minorities and with high retention rates. We look at a student who has, let's say, C average for instance, but has courses that have a high degree of difficulty, like physical chemistry.

Now, look at another student who has a 3.3 average, but has withdrawn from physical chemistry and taking tennis to improve his grade. This student presents a much different profile than the one with more constant performance. He could make a good medical student.

All these are some of the ways of trying to look for a student who can do well in medical school. I maintain that medical school makes more demands on your energy than it does on your intellect. If you have the staying power you do not necessarily have to be a scholar to successfully complete medical school.

So, there is some measurability, but we should develop a means of exposing students at an early age. Dr. Casavantes, a psychologist, documented that students make decisions about what they are going to be by the time they are in seventh or eighth grade. So, it's a very crucial age for them if they are to prepare accordingly. It is very difficult to make an educated rejection or acceptance of a career without a proper information base to choose from.

COMMISSIONER SALTZMAN. You're pointing toward a multifaceted public policy that provides remedial programs for students coming from minority schools, for not lowering the graduating standards but the entrance standards in accordance with the preparation of the students, providing scholarships for minority students that aren't burdensome to the extent that he looks forward to a debt after graduation of $40,000 or $60,000, so it is multiphasing—

DR. ATENCIO. Yes, it is a very complex problem.

COMMISSIONER SALTZMAN. That you look for.

VICE CHAIRMAN HORN. My own feeling is that over time you do not have to worry about lowering the standards for minority students. To me that isn't a question. I think we get off in a wrong direction when we talk in those terms. The problem is that you've got to give minority students an opportunity to prepare themselves so that they can compete equally with all other students. That's why I talk about doing something in the elementary schools and in the junior high and high schools. It is simply too late to try to make up an 8-to-10- year gap in college. One is kidding oneself if you think it can be made up. It can't.

COMMISSIONER SALTZMAN. There is a comment over here.

MS. MIRANDA. To return to the issue of "overachievers," the problem of selection of students in medical schools is compounded by the intensive competition for admission. Once admitted, minority students have been found to be quite capable of completing the educational process while the schools have not lowered their performance standards. The traditional measures of academic competence, such as the previous grade record and standarized tests, have weaknesses as selection measures, particularly for fields like medicine where the competition for admission is intense and professional competencies are broader than academic skills per se.

VICE CHAIRMAN HORN. I do think that there is a difference between a 2.5–2.7 GPA and a 3.5, and I don't think you are doing society or members of various minority groups any favors if, in terms of what one needs to survive in modern science and to adapt to constant changes in technology, you let in students who can't grapple with science.

MS. MIRANDA. Is there any difference between a 3.0 and a 3.5?

VICE CHAIRMAN HORN. I am saying that somewhere there has to be what is the minimal criteria for competency in the field and—

COMMISSIONER SALTZMAN. An overachiever is not necessarily a competent doctor.

VICE CHAIRMAN HORN. I understand that. I am not saying than an overachiever is, but I also am saying that I don't think you can slide around that problem either. Maybe you need different methods of assessment as to competency.

Again, I don't want to see doctors that can't perform in a minority community. I think those in a minority community deserve as good medical and health care as any others in society, and I don't think—

DR. ATENCIO. May I just make a comment from that? Our experience at New Mexico, the last decade, we have graduated quite a number of minority students. While they have difficulty in more challenging intellectual or abstraction of biochemisry and physiology, when they get into the clinical areas, they can relate better to patients. As feeling types they make a person relax more and come through more concerned rather than being distant and removed.

The other thing that is interesting, and which is something the government is trying very hard to do, is to get people to go back to their area to do their thing after they graduate. Preliminary evidence indicates that, of our graduates from New Mexico, 70 percent of the minorities are coming back to New Mexico.

VICE CHAIRMAN HORN. Let me move to a couple of other questions. Let's talk about financing medical students and nursing students.

We mentioned the problem of bank loans. Is it your feeling that the reason we have difficulty in this area in terms of the administration's proposal is that an attitude of, "Well, they are doctors. They get through the first year. They can get a loan and pay it off," etc., is sort of the basic assumption?

DR. ATENCIO. It is. Doctors make a lot of money.

DR. GREEN. Let me say that at 38, after just paying off my loan for graduate school after 10 years, it's especially a keen problem, and I don't even have the problems that most others of my people in the Indian community have. I didn't get married at 18. I don't have three children. I didn't go into the professional school when I was over 35. Those are three instances right there which fit the profile of many of the people who entered health professions or who enter a profession in minority communities. I think that assumption that, "Oh, they are doctors. They can pay it off," is an assumption that's made about people that don't fit our profile. They don't fit a lot of women. I had no one paying my way through graduate school. In that instance, I fit the profile. I think those kinds of assumptions are simply erroneous when they come to communities that already don't fit anybody's statistics.

VICE CHAIRMAN HORN. I have mentioned with several witnesses the problem posed by the administration budget recision of $77.4

million for nursing training. We have all discussed that a little as to the distribution of nurses. I look at various bits and pieces of testimony and, frankly, I end up in utter confusion as to what is the state of nursing education or the potential nursing employment in this country. I am told that 70 percent of the full-time equivalent of people who have R.N. degrees are working and that there is only a 2 percent unemployment rate among nurses. I have an article which states that there were 1,800 openings for nurses in 106 Illinois hospitals. The National League for Nursing reports that Arizona cannot fill 21 percent of its budgeted nursing slots. In western Tennessee the number of unfilled positions is 33 percent; in Texas, 14 percent; in California, 17 percent. We all know that in urban minority inner-city areas we have difficulty staffing the night shift, etc. It's certainly true in the Charles Drew Hospital in Los Angeles.

Then we read the testimony of the Secretary. Her attitude seems to be, "Well, there are plenty of nurses. That is really not a problem." Here, Secretary Harris testifies that the administration policy is to continue the subsidies to train family physicians and nurse practitioners who are in short supply, but she defended the administration's budget cut of $77.4 million that I mentioned with the statement that enough nurses are trained, produced, and certified to meet the community needs, but they are leaving. She told the House Labor-HEW Subcommittee on Appropriations: "We shouldn't use support for nurse education to train people to be administrative assistants and secretaries in business."

Now, do you have some ideas as to how we might get more minority access to the nursing and other allied health professions related to medicine?

To assure adequate distribution in the country, whether minority or nonminority, could that be accomplished through loan waiver systems? For example, if you served in an inner-city certified area, your repayment would be waived? What are your thoughts on that?

DR. ATENCIO. There is a certain culture within the medical profession, at least I will speak of M.D.s in particular right now. In fact, there is a lawsuit pending in New Mexico from the College of Surgeons and Physicians relative to rural practitioners and their ability to perform surgery. A general practitioner in a rural area is viewed as a second-class doctor. In relationship to the direction of nurses or medical personnel, again you get into the same type of phenomena. You place nurses, for instance, in an underserved area and they are always going to be lower on the totem pole, as viewed by their professional peers and in the certification process.

In order to increase the enrollment of nurses you have to increase the admissions and improve the retention of minority nursing students.

They have a lot of LPN programs but with a high attrition rate. The attrition rate of Native Americans in nursing school in Albuquerque, New Mexico, is high. I don't think this problem is being monitored as closely as medical schools and dental schools, but they exist.

I would propose that we take more nursing students into accredited nursing schools and graduate more in that particular level.

VICE CHAIRMAN HORN. Any other thoughts?

DR. GREEN. I think one of the problems—I do think the administration's rather hardline position on LPNs and nonbaccalaureate degree nursing is quite serious, particularly in rural communities.

I talked earlier about bringing people up through the pipeline. I think it is tremendously important to look at those pipelines, the professional pipelines, because that is where the minorities are coming in. It's certainly where a lot of women come in and there are plenty of those in that pipeline. We are not taking them out of there and giving them the kind of education they need. We are simply dropping them. We are saying, "LPNs are no longer acceptable. Good-bye. Thank you very much." Not, "We are going to take you, LPN and then bring you through the baccalaureate pipeline." That is not happening, and in fact there are disincentives for schools dropping out of those programs, not bringing people through, and that is where they begin. Nurses aides are the largest number of Indian nurse professionals. They came through nurses aides and LPN programs, and the American Indian Nursing Association was one group that said that is where they are going to get the nurses. They are not going to get them out of baccalaureate programs right now. But what is happening is a disincentive for bringing them through. We have to support those programs. We have to look a little more carefully at existing programs, like military programs, for bringing people out of existing training into better training, and the military programs are, as far as I know, totally ignored as a source for already trained people. They are simply brought out and brought to urban areas, and they were put out where needed.

MS. MIRANDA. You know, as you speak, it reminds me of the discussions inside the Bureau of Health Manpower regarding where the emphasis of the Division of Nursing has been over the years. It has been classically oriented toward the baccalaureate degree program. Suggested changes which might impact on areas with shortages of nurses have implied a reorientation to a different level and/or type of nursing education.

VICE CHAIRMAN HORN. Do you feel the Nation's Health Service Corps is the best approach to solve the problem of maldistribution and to secure the proper assignment of people?

MS. MIRANDA. I think currently it probably is the best method available for targeting service providers into areas with shortages of health manpower. We won't know for a couple of years whether "buy-out" options by physicians at the point of entry into the NHSC will reduce the effectiveness of this program. The cost of "buy-out" is somewhat prohibitive and may act as a deterrent to this option. On the other hand, for nursing, the "buy-out" option may be more available because the amount of scholarship support which must be paid back is not as high as for medicine.

DR. GREEN. There is one other issue, too. So much of the very traditional, very family-oriented minority students that I know, and I think in fact relates to a large number of females entering the profession, are very oriented toward specific communities, and in the National Health Service Corps there is no guarantee that you can go to the community that you wish to serve. And, I think a simple clause insertion that a choice can be made when you do sign up for the National Health Service Corps that you could serve, insofar as the slot was reasonably near, you could serve in a community of your choice. I think that is terribly important. I know a young man who is refusing to go to medical school now because there is no medical school near him. He is going to optometry school, and most of the Indian people and the people in the NBS program at his school think that is a terrible loss, and I think so too—not that optometry isn't a good profession, but he is medical school quality. We are losing him because he wants to stay home. He wants to make sure he stays home. I think we ought to be able to quarantee that.

VICE CHAIRMAN HORN. Let me say I agree with your comment on the latter approach. California State University, Long Beach, is involved in an integrated ladder program involving the LPN and the RN as well as offering the BS, MS, and doctorate through the Orange County Nursing Consortium in terms of providing an opportunity in one area for students to move from high school, community college into senior State universities and finally into the medical school of the University of California-Irvine. I think we ought to have more of those cooperative endeavors around the country if we are to assure minority access.

Now, let me move on to another area.

I note a headline in the *Washington Star* of April 14, 1980, that "U.S. May Have Too Many Doctors by 1990, HEW Report Asserts." The report did not include the figures as to the number of nurses, but Secretary Harris is quoted as stating that the problem in the field is that once they are trained, nurses often leave the profession for other types of work. A point we made earlier. The report concludes that the supply of doctors is expected to reduce overreliance on foreign trained physicians, who currently have been needed to fill the gap and who comprised 20 percent of the American physician force in 1977.

Now, what I would like to know, Ms. Miranda, is: How dependent are we on the supply of foreign doctors, especially in the inner cities? My impression is that a lot of our inner-city hospitals are staffed to a great degree by foreign trained doctors. How dependent are we on foreign physicians as a source to render health care to minority communities?

MS. MIRANDA. Historically, dependence of inner-city hospitals, particularly public hospitals, on foreign physicians has been very high. In New York City, as an example, the graduate medical education structure has been very dependent on foreign medical graduates for many years. Teaching hospitals, of which there are 2,000, are heavily concentrated in large cities in the East and North Central parts of the country, for example, New York, Baltimore, Detroit, Chicago, Cleveland. The expansion and the development of hospital-based medical care, brought about in part by insurance incentives oriented towards hospitalization, contributed to strong demands for physician care. The gap between the number of students who were graduating from U.S. medical schools to fill expanding hospital-based graduate education programs in the United States was filled by foreign physicians. Some of these foreign physicians returned to their own countries after completing their graduate education, while others remained to provide physician services in areas with shortages of physicians. Foreign physicians did receive preference for entry into the United States as immigrants for a number of years but have not had such priority status since 1976.

VICE CHAIRMAN HORN. If we take Secretary Harris' assumption as to nurse overproductivity and/or nurse over-supply and apply that to doctors in 1990, we are going to have some Secretaries of Health and Human Services saying, "Well, we produce enough doctors in the country. Forget about admitting foreign immigrant doctors. We have got plenty." But the problem is, they just won't be in a free society in the inner cities where you want them to be to meet minority population needs.

Now, is there any planning going on or working papers developed that examine these problems?

MS. MIRANDA. Some thought is being given and options are being considered for utilizing the National Health Service Corps as a mechanism for providing incentives for U.S. graduates to enter those hospitals for completion of service commitments. Some thought is being given to whether some options for service commitment could be enacted which would impact positively on attracting U.S. medical students to take their residency training in inner-city teaching hospitals in places like New York City. However, changes in the legislation governing the National Health Service Corps would be needed since residency training is excluded as a "pay-back" assignment.

VICE CHAIRMAN HORN. So, what specific recommendations—

MS. MIRANDA. A specific recommendation should include the option for an NHSC physician to complete service commitments while undertaking graduate training in institutions with shortage area designation. There are at least a half dozen hospitals that are currently designated as shortage areas. Most of these institutions are located in inner cities and provide health services predominantly to minority populations.

VICE CHAIRMAN HORN. Dr. Atencio?

DR. ATENCIO. I believe the AAMC has gone on record to deemphasize the entry of foreign medical graduates into this country. They were very dependent on foreign medical graduates to supply hospitals in ghettos and barios, and that has created some problems. Many of them were coming from India. They were unfamiliar with English as well as Spanish, and that created a serious problem in communication. I believe they are to diminish demand for foreign graduates. There is an overproduction of physicians and I hope the American public becomes aware that it doesn't necessarily mean that in minority populations physicians have been overproduced. They are still very underrepresented in medical schools, and, hopefully, legislative mandates will not come out saying, "Well, we don't need any more doctors," and therefore deemphasize the enrollment of minorities into medical school.

I think the suggestion that Magdalena brought up, that was discussed earlier, may be a form of capitation grant to medical schools to attract minorities would be a way of inducing, if you like, medical schools to continue to take in more minority trainee positions. I believe from our experience, as I mentioned before, that most of the minority students are going back into their own communities by free will, not by being pulled in by any—

MS. MIRANDA. The problem though, is that you have a break between the M.D. degree granting institution and the graduate training institution. Once the M.D. is granted, the school itself terminates its relationship with that student and the student enters another system, which is the one that we are talking about. I think historically it has been shown, in terms of specialty and geographic distribution of physicians, that strong incentives will have to continue to be offered to provide physician services for underserved areas nationally. An oversupply per se, now predicted, is not going to pull physicians into settings with the greatest general social and economic deprivation.

DR. ATENCIO. I just want to make a comment on what she just said. I think the statistics from North Carolina, for instance, which has a State funded program to support medical students from rural areas, I think the return was from 30 to 40 percent as opposed to 15 percent from other urban students going to some of the underserved areas. I think the same thing has happened with minority students in New Mexico. They have already done their residency in San Francisco, Los Angeles, or whatever, but they come back to set up shop in a New Mexico particular area. I believe there is sort of a homing device that we haven't tapped into, whether it's by choice or whatever. I think black physicians tend to practice among black populations. I think the trend is there, and if we focus too much on the overproduction of physicians, we are going to neglect that particular fact.

VICE CHAIRMAN HORN. If one views the issue of doctor supply in a global perspective, then despite realizing that foreign doctors coming here do meet very basic needs in America, one must be concerned that there is also a real loss in the talent being trained in India and other countries leaving those countries and not being available to help those people. When I was in Nepal and Pakistan, a few years ago, 90 percent of the graduating class in pharmacy practically took the next plane to the United States. Although the Indian Government has a post doctoral requirement of 2 years service in the villages for M.D.s, that seems to be ignored, laughed at, and avoided. The sooner the young, Indian-trained doctors can get a plane to London, New York, or Los Angeles, the happier they are. This pattern is a real detriment to the provision of adequate health care abroad. Since we have a concern that adequate health care is provided in the developing world, I believe that we need creative solutions to get our own people, especially minorities, educated to meet our health care needs.

I want to enter one question into the record and have the staff follow up on it. It doesn't necessarily apply at this point, although it is somewhat relevant to what we have been discussing. I should have asked it when we considered access. The increasing number of nonwhite and European immigrants who have illegally entered the United States in the last decade tend to settle in communities of persons of the same or similar ethnic or racial background. Is this new population affecting the delivery of health care services? What is being done within existing community facilities to adapt to the needs of immigrant groups, and what efforts are made to provide services consistent with the language of recipients? (See exhibit 5.)

CHAIRMAN FLEMMING. Commissioner Saltzman?

COMMISSIONER SALTZMAN. Just one question. I'm sorry I wasn't here for the rest of the question, but are academic requirements for nursing essential for the provision of nursing care, in line with the questioning that Dr. Horn was asking with the problems of providing adequate nursing care?

Dr. Green. You can ask the same question of whether the academic requirements for physicians are the requirement that should be for producing a physician, and the biggest part of me says no, that they might not even be relevant and relative in any way.

Commissioner Saltzman. The present tendency to advance the requirement not only has a deleterious effect on the entrance of minorities into the nursing profession but makes it even more difficult, or else to provide the kind of nursing care that we should be—

Dr. Green. Back to Dr. Horn's question. We are not talking about mathematics or science competency. I don't think that is at all the case, because that is not what medicine really is about in the most fundamental levels. The basic science competency is the interest tool. It's the place that gets you into thinking about what you have to do to understand how to provide medical care, but it gets way beyond that. I think one of the kinds of things we want to think about is a full range of things that have to do with imagination and perception in another kind of intellect—I was standing with a young Indian physician who just finished his residency, and he had his beeper on, and the beeper honked a red alert on the ward he was serving on, and I just sort of trotted down with him, and another physician ran past him and said that a kidney in 409 has gone sour. And the young Indian physician stopped dead in his tracks and said, "That is what I'm going to do. I'm going to fix a kidney in 409 and not a human being," and he was horrified 2 weeks out of his residency, and he knew what he had done, and he felt bad about what he had done. He had felt bad about being a doctor that serves a kidney. Yes, basic science competency is necessary to understand that kidney, but I don't think it's the door to understanding the human being who has a kidney.

Vice Chairman Horn. Could I just say, as one who spent a little time on this, Commissioner Saltzman, I think most nurses in hospitals and most physicians, most hospital administrators, would tell you there is a difference between the RN/BS 4-year college-trained nurse who enters into practice and the RN 2-year community college-trained nurse. A higher and higher level of technology is being applied in hospitals. Thus, there is an increased need for creativity and imagination and a need to adapt to change rapidly. I don't think there is any question that there is a difference in performance between a student who has taken more basic sciences and also more liberal arts as a result of a 4-year higher education, if you will, and a student who simply takes the required training for the RN, which you can also complete in 2 years in California. Do you agree with that?

DR. GREEN. Yes, I do, but I am talking about—because many physicians, many nurses train in the baccalaureate program, stop dead right there even though they go on with BMAs, they stop there. They don't have the incentives to go on and gain that kind of training. I think locating that kind of people who have that kind of incentive as well, plus the basic comprehension of the system—

DR. ATENCIO. There is also another part in the curriculum of nursing, the baccalaureate type, that the first year of college is entirely wasted if they change their mind and want to go into medical school later on. There is no feedback to it at all. I mean, the courses can never be accredited as premedical courses, so they have to go back to zero again and start again.

CHAIRMAN FLEMMING. Commissioner Berry?

COMMISSIONER-DESIGNATE BERRY. Thank you very much, Mr. Chairman. I have a number of questions to ask you because I am somewhat frustrated as to the tack this hearing has taken.

In the first place, Dr. Atencio, in your paper you say that there is no evidence that students who enroll and graduated from Howard and Meharry were inferior physicians. Is there any evidence that you know of which indicates that the minority who attends medical school, whether Howard, Meharry, predominently white schools, or anywhere else in the country, are in fact all underachievers in need of remediation?

DR. ATENCIO. The final product coming out of the medical schools, minority medical students, I don't know of any particular exception to that, but they do come out very well-trained.

COMMISSIONER-DESIGNATE BERRY. That is not my question. Is there any evidence—

DR. ATENCIO. I don't know of any.

COMMISSIONER-DESIGNATE BERRY. That minorities that are admitted to medical schools, whether it is Howard and Meharry, University of Colorado, or anywhere else you can think of, that they are uniformly underachievers who need remediation, whereas all white students are not under-achievers and do not need remediation? Is there any evidence of that disparity?

DR. ATENCIO. I don't have any specific documented evidence. I do know that the distribution of minorities applying or entering medical school covers a whole spectrum. There are some that are overachievers; some are underachievers. You know, in terms of that distribution they come out pretty much as a regular medical student graduate. The feedback you get from internships and what have you of a lot of graduates whether it be minority or majority.

COMMISSIONER-DESIGNATE BERRY. Well, I am interested in the admissions.

DR. GREEN. What are the MCATs?

COMMISSIONER-DESIGNATE BERRY. My understanding then is that the MCAT shows some disparity.

DR. ATENCIO. The MCAT is definitely lower.

COMMISSIONER-DESIGNATE BERRY. Across the board, is it the case that every minority student that goes to medical school has a low MCAT score?

DR. ATENCIO. No, not everyone.

COMMISSIONER-DESIGNATE BERRY. Okay, you are saying there is a gap in the scores overall.

DR. ANTENCIO. Yes.

COMMISSIONER-DESIGNATE BERRY. Is there any evidence that there is correlation indicating cause and effect between the MCAT scores of a person entering medical school and how well they do as a physician?

DR. ATENCIO. No. The only correlation that I know of is their performance in the first year of medical school.

COMMISSIONER-DESIGNATE BERRY. As physicians, that is what I am interested in.

DR. ATENCIO. But there is also the National Board Licensing Examination. There is a cause and effect there. If they do poorly in the MCAT, they will probably do poorly in the national boards, Part I, which is required in many medical schools to advance to the third year, so their career would be interrupted.

COMMISSIONER-DESIGNATE BERRY. I am talking about the people who graduated from medical school and become doctors. So, do the MCAT scores correlate positively and negatively with how well they serve people as physicians later on?

DR. ATENCIO. There is no correlation. There is also no correlation with the performance on the board to how they perform as physicians—

COMMISSIONER-DESIGNATE BERRY. Now, if that is the case, could you tell me why there is such a small percentage of minority students in medical schools? What is the reason? Is it just that they don't have any money as other people do, or is it racial discrimination or ethnic discrimination, or what is the reason then if all the facts that we have gone over are in fact accurate, if there is no evidence that they do any worse as doctors if they graduate. If there is no correlation really between MCAT scores and how well you do as a doctor, then what is the reason that there are so few minority students in medical schools?

DR. ATENCIO. Well, there is discrimination, racial discrimination. There is a sort of pedantic snobbery that exists in medical school selection committees, and unless you have certain numbers, you know, you are viewed negatively. And, therefore, you are denied entrance in the screening process, and that is where most of the minorities drop out, in the initial screening process, where they have strict criteria before you are invited for an interview. They look and see your MCAT and GPA. Secondly, there is discrimination. Some schools have refused to commit themselves to affirmative action programs by admitting of medical students. Up until now, minority medical students—they have different ways of rationalizing and so on and so on. The process of education also reveals other types of discrimination. The racial discrimination now and then is there. I cite in my paper an example of the big "unsatisfactory" across a student's paper, a sort of scarlet letter effect, and that happens frequently. The students are viewed as if they cannot really handlle analytical data, and they are always subjected to remedial programs, and this is through the whole process, if you like. Not only does it not stop once you are in, it continues throughout.

COMMISSIONER-DESIGNATE BERRY. Well, if there is no correlation between MCAT scores and how well people do as physicians, if that is the case, then MCAT and GPA scores are merely used as a sorting device to determine who goes to medical school or what is the whole purpose —

DR. ATENCIO. Let me just say something. There is a sorting out process of the MCAT, but it is at the extreme level. If you get in the range from five to about eight, which is the range for minorities, there is very little discrimination of the ability, but if you get down to that two range, you know, which is in the 10th percentile, there is discrimination. Some students in this category will not be able to perform. There are no ifs, ands, or buts about that. It is a pretty strong correlate, but I don't know of any specific statistical data—this is within my own experience.

That same thing applies to the national boards again. If you score on the national boards about 200 points, which is in the one to three percentile, and you repeat, if you bring up your score by 100 points you won't pass the boards on the second attempt.

COMMISSIONER-DESIGNATE BERRY. But that would be true of anybody, not just minorities.

DR. ATENCIO. Yes. So there is that limitation on anybody, not just the minorities who score in the three level, for instance, in the MCAT and scores on the 200 level on the board. That is just an impossibility to be able to succeed on a second attempt.

COMMISSIONER-DESIGNATE BERRY. Let me ask you about the *Bakke* case. In your paper you indicate that in 1974 first year minority enrollment in medical schools was at 10.1 percent and that it was 9.1 in '75 and then you say in 1979 it was 9.1 again. In other words, in 1975 it was 9.1 and in 1979 it was 9.1. That is what you say in your paper.

DR. ATENCIO. Let's take a breakdown here. In 1974–75 the percentage of minorities in first year class was 9.98. It dropped down to 8.7 in 1978–79. In 1976 it was 8.9, so on and so forth. Now it is back to 9.14.

COMMISSIONER-DESIGNATE BERRY. Right. And then you say we will not know until a few years out what effect the *Bakke* decision has had. Would you agree that since the *Bakke* decision was, in fact, the victory for higher education institutions because it permits them to set their own admission standards, and *Bakke* indicated while race may be taken into account, race may also not be taken into account, that we, in terms of trying to remedy discrimination legally, that we do not have as many weapons in our arsenal as we would have before the *Bakke* case because now race does not have to be taken into account? Race may be taken into account, along with other factors, and do you think that, therefore, the *Bakke* decision may have had a chilling effect on the admissions of minority students in medical schools, given the numbers that you give in your paper?

DR. ATENCIO. It may have at some institutions. I know some of the more committed institutions it hasn't. They validated their admission policies, using these as a factor. Those institutions that do that in the first place will probably continue their own way. I do not know how many of the latter we are finding now. You have to take about 2 or 3 years to foresee any trend, in which direction it was going to go.

COMMISSIONER-DESIGNATE BERRY. If I understand your paper, it will depend on the commitment of the institutions.

DR. ATENCIO. Yes, it does.

COMMISSIONER-DESIGNATE BERRY. Not any legal requirements, but whether they choose to take race into account.

DR. ATENCIO. The legal requirements justify ethnicity as a factor for admissions. In fact, some schools are playing around with a scale, let's say of one to seven, you know, how many points you are allowed for ethnicity. I don't know whether it is going to go, but that is what they are doing with it now.

COMMISSIONER-DESIGNATE BERRY. Did you want to say something?

DR. GREEN. The other thing that is happening is that they are not applying. It's not so much only that they are being turned down. It's simply that they are not applying. I had three Indian students in the last year that took all the premedical requirements and decided that they did not want to go into a profession which their own people would despise, and that is happening all over the country.

MS. MIRANDA. Can I give you some figures again? In 1970, when interest in minority admissions became a concern, the black applicant pool numbered 1,250; in 1971 it went to 1,552, then went to 2,382 in

1972, and has stayed in that range. It has not gone higher than 2,888 since 1972 and was 2,599 in 1979–80.

The nonminority pool, interestingly enough, rose from 37,000 in 1973–74 to 42,270 in 1977–78 but has dropped to 32,700 in 1979–80. The reasons for the precipitous drop are not known, however. As with the blacks, American Indians remained in the low 130s between 1974 and 1979, although the pool went up to 151 this year. The Mexican American pool of applicants were 349 in 1973–74, rose to 487 but has dropped in the last 2 years. The Puerto Rican applicant pool was 202 in one year but had decreased to 173 in 1973–74.

The most interesting statistics, however, are those that show that while the percentage of total medical schools applicants who were accepted increased from 35 percent to 47 percent between 1974 and 1979–80, the percentage of underrepresented minority applicants who were accepted decreased from 44 percent to 41 percent in the same period.

COMMISSIONER-DESIGNATE BERRY. Right. I'm aware of those figures, Ms. Miranda. I am aware of those figures. It just seems to me the point I was trying to elicit from the witness was, is it the case that since *Bakke* we, one, can rely on the commitment of those institutions that have commitments to increase admissions of minority students, but as far as any kind of legal strategy to deal with any kind of discrimination that exists, we might better spend our time and manpower or women power policy in terms of trying to increase resources. That is why I'd like to turn to the issue of the budget cut.

If it is true that we have to rely on budget policy or programs to try to increase the application pool and also the number and percentage of minorities in the medical profession, doesn't it make it clear that this budget cut and recision that you talked about are absolutely detrimental to the objective of trying to do that? If that's the strategy we have since *Bakke*, and you have indicated that there are a number of cuts in the budget, a number of recisions, isn't that the case?

MS. MIRANDA. Yes, I would totally support that.

VICE CHAIRMAN HORN. Before you leave that, could we get that chart in the record?

MS. MIRANDA. We will also give you the one on acceptance.

CHAIRMAN FLEMMING. Without objection, both of them will be entered in the record. (See exhibit 17.)

COMMISSIONER-DESIGNATE BERRY. In dealing with the problem of applicant pool, Ms. Green, you talked about 2-year institutions and about the need for putting some of the biomedical money and other funds in 2-year institutions because that's where a number of minority students are. In fact, isn't it the case that the figures show that the vast majority of minority students that are in higher education today are in 2-year institutions, whether they're Hispanic, Indians, or whatever.

DR. GREEN. And older women, which is a huge pool.

COMMISSIONER-DESIGNATE BERRY. But isn't there something inconsistent about focusing on improving science education and mathematics education and the like in the 2-year institutions, when 2-year institutions as a matter of educational policy are supposed to be only transitional to 4-year institutions, which is where you have concentration and things like laboratories and science and the like, and wouldn't you be better off to think in terms of trying to get more minority students into 4-year institutions?

DR. GREEN. I think you would be better off to think about that sort of strategy in one respect, but the fact is the pool is there and it's not going to change, especially with the cost of higher education in 4-year institutions rising so rapidly. The community colleges are filling the role. I mean community colleges in the most important sense, drawing people back into the community.

I also think what happened is that we lose the minority students when we push. Often we push them on in the 4-year institutions. We use the 2 years as transitional because then they have to go back and repeat all the basic work, if they are interested in science, once they get to that 4-year institution; therefore, making it a 6-year institution and we have lost 2 years of time and training. Why not put our money in the basic sciences or in special kinds of training which are appropriate to those institutions that could drop people into that pool. We don't have to replicate basic science funds at every 2-year institution. I think we ought to look at the institution, see what they just might do, and single out certain kinds of tasks for them to do. That would draw people into that pool.

COMMISSIONER-DESIGNATE BERRY. I only ask because I know—I don't know the number for Indians, but I am told that in the case of blacks, for example, that more than 50 percent of the blacks who get baccalaureate degrees go to 86 black colleges which are 4-year institutions. That is more than all the black baccalaureates that are produced by 1,500 predominantly white 4-year institutions. I am also aware that for Indians and Hispanics and blacks, many of the students that do go to 2-year institutions flunk out before they ever make the transition. That is why I was wondering if it might not be better to try to focus on 4-years, but I understand your response.

Another question in terms of trying to address this problem. You mentioned, Ms. Miranda, the capitation grants and bounties, if I may use that expression, for medical students who are minorities, as one strategy. How about a strategy, both to you and to Dr. Green and Dr. Atencio, how about a strategy of setting up more minority institutions for Indians, for Hispanics to train health professionals as we have Meharry and Howard, which train—now they have a lot of white students, but for years they have been training black students, and there's a new medical school at Morehouse. How about Hispanic and black institutions as a way of trying to increase the number of professions?

DR. GREEN. I mentioned to you that two separate bills trying to sponsor an American Indian school of medicine have totally failed and totally quashed in every way. I certainly think that that is an important strategy, not only because it would instantly produce a number, specifically the Indian professionals, but it would provide, in the way the school is set up, a culturally based and culturally appropriate medical education, a very different kind of education. I think it's a terrific strategy, if it could be possible.

COMMISSIONER-DESIGNATE BERRY. And the last question I have is: In some areas of HEW health policy,, or educational policy as it were, there are programs that provide fellowship and scholarship support to graduating students and students in professional schools. Have you thought about, in the manpower area of health, having not just loans or not just an exceptional financial need program, but a program that would pay the entire cost of the education in these fields for minority students, medical schools and otherwise, without strings attached, like the National Health Service Corps?

MS. MIRANDA. I would think if it ever surfaced, it wouldn't get too far. There has never been any proposed legislation which clearly designates support programs for minorities per se. Programs for scholarship or loan assistance have been addressed to the "economically deprived." Minorities have benefited from these programs but they have not been legislated to address the issue of minority underrepresentation in the profession.

COMMISSIONER-DESIGNATE BERRY. Do you think it would be a good idea?

MS. MIRANDA. My personal opinion, yes.

DR. ATENCIO. May I?

CHAIRMAN FLEMMING. Our 3:30 has arrived. Go right ahead.

DR. ATENCIO. Minority Biomedical Science Program was enacted by legislation and so was the MARC Program. There is no program like that for medical education in HEW. The only minority grant support for medical students comes from the National Fellowships Foundation. That's the only one and it could be a mechanism to which the National Fellowships could act as a funnel, if you like, for administering grants from the Government this way, that would be another mechanism that wouldn't require much.

I would like to see something of that.

CHAIRMAN FLEMMING. May I express to the members of this panel our deep appreciation for the contributions that you have made and suggestions of a very, very important aspect of this total problem. May I also express to the staff director, Mr. Nunez, the appreciation of the members of the Commission for the way this consultation was organized and the kind of persons who are persuaded to come in and share with us their insight. It has been one of the best consultations that I think the Commission has had, and I think that it has provided us with a record on the basis of which we can follow up some additional activities in this area, which I hope will lead to some findings and recommendations which I hope will, in turn, get backup, and they in turn will lead to real action to correct the situation, which certainly cries aloud for correction—particularly as far as access of minorities to health service is concerned.

Thank you very much and the consultation is adjourned.

THE FEDERAL GOVERNMENT, HEALTH POLICY, AND THE HEALTH CARE OF THE DISADVANTAGED

Philip R. Lee,* Carroll L. Estes,† and Sharon Solkowitz‡

Introduction

For the past 45 years the United States has been moving toward a national health policy. Although the present wide range of policies and programs does not add up to a coherent national policy, progress has been made in understanding the basic health problems facing the people of this country and in seeking solutions to the problems. The concept that health is based on biological, behavioral (life style), sociocultural (e.g., income, social class), and environmental factors is gradually replacing the view that access to medical care was the primary ingredient in assuring good health.

Just as the concepts and definitions of health have changed, so have the relationships between the levels of government and the relationship between the government and the private sector. Many Federal programs evolved because of failures of the private sector to provide needed support (e.g., biomedical research), because the results were grossly inequitable (e.g., hospital construction), or because they were so costly that many could not afford the private option (e.g., health insurance).

Some Federal health programs have affected virtually everyone (e.g., biomedical research, hospital construction), while others have affected only a small, but very needy, segment of the population (e.g., Indian Health Service). Some programs have been very effective in achieving their goals (e.g., poliomyelitis immunization, health manpower development); others have failed to achieve their goals at much higher cost than originally anticipated (e.g., Medicare). For some programs public expectations exceeded the possibilities (e.g., the war on cancer). It is not surprising, perhaps, that the score card would be a mixed one. When compared against the conditions of a decade or two ago, however, very real progress is evident.

However, the political context in which these health policy advances have occurred has limited this progress. Most of the Federal laws designed to affect the health of the American people, their access

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to health care or the resources available for such care reflect the public's faith in the ideology of pluralism and the strength of special interests. Medicare and Medicaid are particularly costly examples of the powerful influence of physicians and hospitals, as well as their allies in the health insurance industry. Congress, in enacting Medicare, wanted to be certain that the law did not in any way affect the physician-patient relationship, including the physician's method of billing the patient. The usual, customary, and reasonable system of physician reimbursement has been highly inflationary, has provided a strong incentive to physicians to raise their prices (which they have done), and to provide ancillary services (e.g., laboratory tests, electrocardiograms). Hospital reimbursement has been based on costs and has been even more inflationary. In spite of the impact of the rapid increase in Medicare costs on the social security trust fund, social security taxes, Federal general revenues, and the pocketbook of the aged, Congress has steadfastly refused to alter the methods of payment to physicians or hospitals.

How did this situation come to pass? What is the present picture? How effective are Federal policies and programs in meeting the needs of the aged, the poor, the handicapped, the minorities, and women? What can be learned by more careful analysis of the factors affecting health policy and the interaction of these forces with the policies themselves?

Approaches to the Problem: Assessing Federal Policies and Programs Affecting the Health of the Disadvantaged

A variety of different approaches have been used to assess the impact of public policy on health care. One has been to trace the changing Federal role through the steady march of legislation enacted during the country's history. Another approach is to examine trends in Federal spending for health. A third approach is to analyze on a program-by-program basis the Federal role in providing, supporting, or paying for health care.

A different approach has been used by Andersen and Aday and their associates at the University of Chicago. Using carefully designed survey research methods they have provided primary data on people's access to health services (Aday and Andersen, 1975; Aday, 1976; Robert Wood Johnson Foundation, 1978). Many others have used health services research methods to assess the impact of specific policies or programs on access to health care, the quality of care, and the costs of care. A fifth approach, using health policy research and analytical methodology, has been to examine the range of policies and programs affecting specific populations. We have done this recently by attempting to catalog the multiplicity of Federal programs impacting on long-term care services for the aged (Lee and Estes, 1979; Estes and Lee, 1980). Recently, Kovar has completed an excellent review of the impact of health policies and programs on the elderly. This important descriptive study is included as an attachment to this report because it provides a wealth of basic data on health status of the aged, their utilization of medical services and expenditures on medical care (appendix I). Finally, specific studies have been undertaken of Federal programs to assess the impact of age discrimination (U.S. Commission on Civil Rights, 1977).

A review of these approaches convinced us that an assessment of the major factors affecting the development and implementation of health policies in the 1980s, particularly as these forces affect the health of specific disadvantaged populations, would be useful. This approach provides a backdrop against which the changing Federal role in health policy can be analyzed, with an understanding of some of the major dynamics underlying these changes and their likely impact on the disadvantaged.

To provide both an overview of the Federal role in health as well as a specific example of Federal policies and programs affecting the health of one large disadvantaged population—the aged—we first examine trends in Federal legislation from the 1790s through the 1970s, which provides the foundation for policy developments; we then briefly review the dramatic impact that Federal legislation has had on Federal health spending since 1965 and note the range of programs affecting health and health care. We follow this review with an assessment of the social context of policy development and the factors (e.g., the social construction of reality, inflation, New Federalism, the growing role of medicine) that will affect the health policies of the 1980s. Finally, we review the impact of these factors on health care of the aged to illustrate the complexity of the problem.

The Legislative Scorecard, the Federal Budget, and Federal Programs: The Changing Federal Role in Health, 1978-1980

The Legislative Record

The Federal responsibility for health began in 1798, when Congress passed the Act for the Relief of Sick and Disabled Seamen, which imposed a 20 cent per month tax on seamen's wages to pay for their medical care. In the century that followed there was only a very modest expansion of the Federal role in public health and medical care. An important step in the late 1870s, was the authorization given to the Surgeon of the Marine Hospital Service to help the States impose quarantines to stop epidemics. This was to be the foundation of the present U.S. Public Health Service.

Although more than 225 health laws have been enacted in the past 100 years related to health care, only a few are of major importance. One of the earliest, the Federal Food and Drug Act of 1906, remains one of the most important. This law regulated adulteration and misbranding of foods and drugs. It was followed by the Food, Drug, and Cosmetic Act of 1938 that required that manufacturers of prescription drugs demonstrate the safety of drugs before marketing and the 1962 amendments which added that drugs had to be effective as well as safe. Although the effects of drug regulation by the Food and Drug Administration (FDA) on health care are indirect, there are few countries in the world where the public is as well-protected from hazardous and unsafe drugs (e.g., Thalidomide, enterovioform) as the United States.

The establishment of the National Institutes of Health (NIH) in 1930, followed by the National Cancer Act of 1937 and the multiple legislative enactments after World War II that created the present-day institutes at NIH, primarily focused on broad classes of disease (e.g., Cancer Institute and the Heart, Lung, and Blood Institute). The NIH grew from a small government research laboratory to the most significant biomedical research institute in the world in the 15 years after World War II. The support of basic clinical and developmental research (e.g., kidney dialysis) was to have—and continues to have—a profound effect on medical care. The growth of specialization and subspecialization which has accompanied the rapid advance in biomedical research and the applications of technological advances to care have been of major importance.

It was not until 1963 that Congress created its first major noncategorical institute—the Institute of Child Health and Human Development. It was not until 1974 that Congress—over the opposition of NIH and the administration—created the National Institute on Aging (NIA). It was not until 1976 that the funds were appropriated for the NIA. The predominant emphasis of NIH on diseases and the low status accorded the NIA has been reflected in medical schools throughout the country—in their research, education, and patient care.

Federal-State relations have been a key element in domestic social programs—particularly for the aged, the poor, and for women and children. The Shepard-Towner Act of 1921 established the first Federal-State programs for child health services. Although terminated in 1929, the programs were the forerunners of present day child health programs, as well as many other Federal grant-in-aid programs.

The Social Security Act of 1935 was, without doubt, the most significant domestic social program ever enacted by Congress. It adopted the principle of Federal aid to the States for public health and welfare assistance. It provided Federal grants to States for maternal and child health and crippled children's services (Title V). It also provided for cash assistance grants to the aged, blind, and families with dependent children who were destitute.

This cash assistance program was to provide the basis for the Medical Assistance for the Aged program (Kerr-Mills) in 1960 and the Medicaid program in 1965. Both programs linked eligiblity for medical care to eligibility for cash assistance. More important, however, the Social Security Act of 1935 established the Old Age, Survivors', and Disability Insurance (OASDI) programs.

Federal concern for maternal and child health, particularly the poor, was reflected in a temporary program in World War II to pay for the maternity care of the wives of enlisted men in the Army and Navy. This means-tested program was very successful and demonstrated the Federal Government's capacity to administer a national health insurance program. With the rapid demobilization after the war the program was terminated, but it was to be cited often by advocates of national health insurance, particularly those who would accord mothers and infants first priority.

After World War II it was evident that many of America's hospitals were woefully inadequate and a major Federal-State program of hospital planning and construction (the Hill-Burton Program) was launched. The initial purpose of the act was to provide funds to States to survey the hospital bed needs and develop plans to meet the needs. The purpose was to overcome the serious shortage of hospitals and hospital beds in most rural areas. The Hill-Burton Act was amended many times as many of the initial goals were met. The legislation provided the stimulus for a massive hospital construction program, with Federal and State subsidies primarily for community, nonprofit, voluntary hospitals. The public hospitals, which were supported largely by local tax funds and provided care for the poor, received little or no support until the private institutions' needs were met. The program was a model of Federal-State-private sector cooperation. It was the major force—until the enactment of Medicare and Medicaid—responsible for the modernization of America's voluntary hospital system.

By 1953, when the Department of Health, Education, and Welfare was created, the Federal Government's role in the Nation's health and medical care system was firmly established. This role was primarily to support programs and services in the private sector. Biomedical research and hospital construction were the two major pathways for Federal support. Traditional public health programs (e.g., venereal disease control, tuberculosis control, maternal and child health) were supported at very modest levels. Federal support for medical care was restricted to military personnel, veterans, merchant seamen, and Native Americans (Indians) until enactment of the Kerr-Mills law in 1960, which authorized Federal grants to States for medical assistance for the aged. This program proved short-lived, but it pointed up the need for a far broader Federal effort in medical care for the poor and the aged.

Just as the Social Security Act was the centerpiece of President Roosevelt's domestic social programs, so was the Civil Rights Act the centerpiece of Lyndon Johnson's Presidency. It, more than any other single piece of legislation, exemplified the commitment to social justice, equality of opportunity, and equal protection under the law.

The mid-1960s (1963–1967) was a period of intensive legislative activity. Only twice in this country had there been anything comparable: the first term of Woodrow Wilson (1913–1917) and the first term of Franklin Roosevelt (1933–1937). Most important, in terms of the Civil Rights Commission's concern for health care of the disadvantaged, were the Assistance to Migratory Workers Act of 1961, which authorized Federal aid for medical clinics serving migratory agricultural workers and their families; the Vaccination Assistance Act of 1962; the Health Professions Educational Assistance Act of 1963, which opened the door for direct Federal aid to medical, dental, pharmacy, and other professional schools and the students in these schools; the Maternal and Child Health and Mental Retardation Planning Amendments of 1963, which initiated a program of comprehensive maternal and infant care projects and centers serving the mentally retarded; the Civil Rights Act (1964); the Economic Opportunity Act (1964), which provided authority and funds to establish neighborhood health centers serving low-income populations; the Social Security Amendments of 1965 (particularly Medicare and Medicaid); and the Comprehensive Health Planning and Public Health Service Amendments of 1966, which reestablished the principle of block grants for States for public health services (reversing a 30-year trend of categorical Federal grants in health) and created the first nationwide health planning system, which was to be dramatically changed in the 1970s to focus on regulation as well as health planning.

The 1970s witnessed dramatic changes in Federal social policy, including health policy. Except for the Social Security Amendments of 1972, which extended Medicare to a limited number of disabled and those with end stage renal disease, and the Developmentally Disabled Assistance and Bill of Rights Act of 1975, and the Age Discrimination Act of 1975, the emphasis was not on assuring the disadvantaged their rights to health care, but rather on New Federalism, decentralization of policy and program decisions, an expanded role for the private sector (e.g., health maintenance organizations), cost containment, and competition.

Federal Health Programs and Expenditures

The Federal budget has long intrigued policymakers and is, indeed, a reflection of the policy choices and priorities of program managers, Departmental Secretaries, the Office of Management and Budget, the President and, finally, the Congress. The Federal budget has a lot to tell us about health care for the disadvantaged and the priority accorded one group or program over another.

The most useful analyses of the Federal budget in the past decade have been those performed annually by the staff of the Brookings Institution. First issued in 1970, their *Setting National Priorities* proved to be a widely read analysis. The reports usually include an analysis of such major areas as defense, foreign policy, revenue sharing, and education. Trends in health expenditures have been analyzed, including programs for health care. Particularly important were the studies by Dr. Karen Davis. In addition to her contributions to the annual Brookings volume, she analyzed expenditures as well as a great deal of additional data for two other works, "A Decade of Policy Developments in Providing Health Care for Low Income Families" (1975), and *Health and the War on Poverty: A Ten-Year Appraisal.*

A number of analysts, such as Irving J. Lewis, Rashi Fein, and John Iglehart, have examined Federal expenditures in order to assess priorities and program directions (Lewis, 1969; Fein, 1974; Iglehart, 1978). In 1969 Lewis examined the funneling of health resources in the government through an explanation of the budget and commented extensively on the interactions of government and the medical care system. As part of a "national health strategy' for the 1970s, he identified the need for "comprehensive health care for the poor, a check on health care costs, a need for measures of effectiveness and a correlation between insurance and the system itself." In 1974 Fein analyzed the impact of the budget's dramatically reduced support for several major health programs. John Iglehart has reviewed the health budget under the Carter administration in order to assess priorities.

The Bureau of the Budget, and more recently the Office of Management and Budget, publishes the annual Budget *Special Analyses.* For many years, this document included an extensive analysis of health expenditures, including a general overview, trends in national and Federal spending, distribution of health expenditures by category, e.g., hospital and medical care, Federal grants and payments for hospitals and health care in non-Federal facilities, medical research and training; services by population grouping, e.g., the aged, adults, children; and by income status. This material is now included as part of the budget rather than as a separate analysis.

When the Department of Health, Education, and Welfare was formed in 1953, it administered fewer than 70 programs. Most of these programs were social security or public assistance programs rather than health care programs. Among the health programs, health care for the disadvantaged had a low priority. Of a $6.5 billion budget in 1955, for example, health programs amounted to less than $300 million. Federal expenditures accounted for less than 2 percent of the Nation's total health expenditures at that time. By 1968 the Department's responsibilities had extended to over 250 programs and its budget had grown to $40.8 billion (Cohen, 1968).

The dramatic increase in Federal health expenditures after FY 1965 reflected the impact of Medicare and Medicaid, as well as other programs launched in the 1960s (see figures 1 and 2 and tables 1, 2, 5–8 in appendix II). Outlays for both Medicare and Medicaid increased rapidly during the late 1960s. Between FY 1965 and FY 1968, the total health programs in HEW grew from $2.6 billion to $12.5 billion, or from 7 percent to 24 percent of national health expenditures.

Expenditures in the late 1960s began to reflect a dramatic shift in priorities. In FY 1968, Federal health expenditures were $5.8 billion for the aged, $2.5 billion for adults aged 22–64, and $1 billion for children and youths aged 0–21 (U.S. Office of Management and Budget, 1969). Five years later in FY 1973, expenditures were $11.7 billion for the aged, $6 billion for adults, and $2.1 billion for children.• By FY 1979, Federal expenditures were $31.7 billion for the aged, $18.3 billion for adults and $5.2 billion for children (U.S. Office of Management and Budget, 1979).

The Federal budget provides a wealth of information which permits some assessment of the priority accorded the aged, the poor, and children. Particularly relevant to this report, it is more difficult to assess the priorities for the minorities, the chronically ill, or the handicapped because many of the programs serving their needs also serve either the poor or the aged more broadly. Nevertheless, the budget has been a major tool in analyzing trends in Federal health programs.

Other valuable sources of budgetary information are departmental documents (e.g., the Department of Health and Human Services 1981 Budget), the Congressional Budget Office annual reports (e.g., *An Analysis of the President's Budgetary Proposals for FY 1981,* and the *Catalog of Federal Domestic Assistance* that lists over 131 separate programs for health in HEW and over 283 programs in all other areas

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• In that year, expenditures were calculated for indigent and nonindigent population groups. These figures represent expenditures for the indigent population.

of government combined in 1978 (U.S. Office of Management and Budget, 1979).

While each of these documents contains detailed budgetary and programs information, they do not (nor were they intended to) provide policy analysis. A careful comparative examination of these documents, and the expenditures they report over time in relation to health care for the disadvantaged, would be a valuable undertaking. Such a study, however, would not provide information about either the health outcomes of these expenditures or their impact on service utilization. Studies of this type constitute health services research.

The Social Context of Health Policy Development and the Factors Affecting Health Policy in the 1980s

The development of health policy in the 1980s will be affected by multiple social, economic, and political factors, including inflation, the legacy of new federalism policies of the 1970s, the fiscal crisis, the public's perception of the problems, and the growing role of medical care and the influence of medicine.

Inflation

Inflation is the dominant policy issue in 1980. It is likely to have a broad impact on public policy in the years immediately ahead, but its long term consequences for policy will be determined by its persistence or its gradual decline.

Inflation has been a matter of serious concern for over a decade. The yearly inflation rate in the early 1950s was between 1 and 2 percent per year. In the past decade inflation rates have fluctuated widely, but the upward trend has been unmistakable. The yearly inflation rate rose from less than 3 percent in 1965 to over 6 percent in 1969, then fell with the recession to about 3.5 percent in 1971 and 1972. In 1973, however, it shot up to over 8 percent and to over 12 percent the following year. After dropping to below 6 percent in 1976, it rose to 10 percent in 1978, 14 percent in 1979, and is now approaching an annual rate of 20 percent.

Inflation not only affects the individual, but the individual's reaction to public policy. The "taxpayers' revolt" in California is an outgrowth of rapidly rising property taxes (due to inflated housing prices) and rapidly rising government spending. A large factor in the rising costs of State and local government has been the increase in medical care costs, reflected in both Medicare and Medicaid expenditures.

As people face inflation and greater uncertainty about the future, they strive to maximize their own resources and to limit what is taken by the government. Policymakers see inflation devouring more and more of what in years gone by was a fiscal dividend that could be devoted to public needs. Because of inflation, policymakers are unable to increase resources for health care and other social programs. Inflation also has had a devastating impact on government programs serving particularly the aged, the poor, and other disadvantaged groups because the costs of these programs have risen so rapidly. This has been particularly critical for State and local governments. Inflation has also hit employers, employees, and individuals because of the rapid increase in health insurance premiums. Out-of-pocket expenses have also risen rapidly because of the increase in physicians' fees, drugs, and other costs.

New Federalism

The development of new federalism policies in the 1970s gave a strong boost to the role of the States in domestic social programs, including those affecting health care. The new federalism strategy as it evolved in the 1970s was designed not only to decentralize program control to State and local governments, but also to limit Federal involvement in domestic social programs.

As social policies have been significantly decentralized in the last decade, State and local influence and control has been expanded over program priorities, service emphasis, and recipient eligibility in such programs as Community Development Block Grants, Urban Mass Transit Authority, Title XX (Social Security Act), and the Older Americans Act. Because decentralization was employed in the 1970s as a mechanism for curtailing the growth of Federal programs, it essentially transferred the pressures for underwriting program expansion from the Federal to State and local governments. It has also helped to generate fiscal and tax pressures at these levels of government sufficient to initiate taxpayer revolts.

New federalism is a legacy of the 1970s that will continue to be a major factor in the evolution of domestic social programs in the 1980s. The decentralization policy trend of the 1970s has been accompanied by the fragmentation and diversification of policy in most social problem areas (e.g., Medicaid, developmentally disabled) as national policy goals give way to more autonomous and *variable* State and local policy choices across multiple programs, jurisdictions, and authorities. With a myriad of decisionmakers and authorities who act on their own discretion, it is no longer possible to focus with assurance on particular targets or disadvantaged groups for intervention. Under the broadly defined, largely block grant enactments in which Congress has only vaguely specified its intentions, there is increased potential for the politicization of State and local policymaking and program implementation. The resultant ambiguity has provided opportunities for political actors, vested interests, and agencies to actually "create" a large proportion of health and social policies in the implementation and administrative processes (Lowi, 1979).

Redistribution of power among Federal, State, and local officials with new federalism is a major issue. Equally important are: The degree to which new federalism increases politically motivated, rather than need-based, determination of program priorities and allocations, thus augmenting the influence of special interests—especially providers—and the extent to which new federalism engenders extreme program variability, and uncertainty, across States.

Although Medicaid was enacted before the recent movement toward new federalism, this program shares important attributes of later programs, in particular, the considerable policy discretion left to State and/or local authorities. The Supplemental Security Income program initiated in 1974, which replaced the prior Federal-State programs of Old Age Assistance and Aid to the Blind and Disabled, provided a basic income level across States, but it permits State supplementation consonant with a new federalism type of State level discretion.

Multiple levels of government are fundamental to the American Federal system. How these levels are to be related and articulated has been a central political issue in recent American politics. The failure to resolve this issue has produced both "power fragmentation" (Binstock and Levin, 1976, p. 15) and "program fragmentation" (Hudson, 1973, p. 3), and these fragmentations have seriously affected public capacity for effective social intervention.

Studies of the implementation of Federal programs have shown that through their ability to organize and structure their activities, State and local officials are insulated against direct Federal control, both administratively and politically (Pressman and Wildavsky, 1973). To achieve national objectives within diverse local settings, Federal administrators must rely upon the initiative, the ability, and often the willingness of State and local officials. Federal agencies rarely have the time and resources needed to carry out program requirements under the varied legal, political, and socioeconomic conditions that exist at State and local levels (Ingram, 1977).

Efforts to assess the impact of new federalism programs on particular populations, such as the disadvantaged, are made difficult by the general problems of accountability inherent in Federal programs, which are exacerbated by new federalism strategies (Estes and Noble, 1978). Federal reporting requirements rarely permit easy tracking of funding allocations to specific services or populations. The dispersal of policy discretion among States and localities increases sub-Federal, and, in many cases, sub-State autonomy, decreasing Federal capacity to assess the impact of Federal funds—particularly on the population groups to be served, such as the disadvantaged. As the inter-State and intra-State variability is enhanced under decentralization and new federalism policies, it is increasingly important, first, to develop an empirical basis describing what States are doing in programs of interest and, second, to link these to conceptions of outputs for those in need (in this case, the disadvantaged).

The problem has been made even more complex by the emergence of fiscal crisis conditions at various levels of government and the "taxpayer revolts" that have followed. These changes in fiscal conditions, which have created pressures to redefine the funding relationships among Federal, State, and local governments, can be expected to produce new State and local strategies for shifting fiscal responsibilities within programs created or redesigned within the new federalism era.

Even more important, because the benefits provided by these Federal-State programs for the poor are heavily influenced by a State's willingness to underwrite the costs, we can expect mounting pressure for State level policies of retrenchment (cutbacks) with the rise of fiscal constraints on State government. Because the disadvantaged are heavily dependent on State-determined benefits, they are extremely vulnerable in this period of economic flux.

In this decentralized policy context, the challenge will be great for health policymakers seeking to derive a sound national health policy for the disadvantaged, particularly in view of the reality that each level of government will be attempting to shift its fiscal and political responsibility to other levels of government for many of the health programs that vitally affect the disadvantaged.

Fiscal Crisis

"Fiscal crisis" is a term applied to the financial difficulties of a variety of governments in the United States. In its strictest form, fiscal crisis refers to the threat to the fiscal integrity of a government—when it cannot service its debts (as in New York City and Cleveland) or it cannot meet current operating expenses (as in the "cash flow problems" of various States). Both the strict and the wider applications of the term "fiscal crisis" are based upon the tendency for government expenditures to exceed revenue, a tendency that may exist whether or nor deficit spending actually occurs. This tendency is sometimes referred to as "fiscal strain."

O'Connor (1973, p. 221), in his seminal work on the "fiscal crisis of the state," spoke of a "structural gap between state expenditures and revenues." The idea is that there are simultaneous tendencies to an increase in demand for expenditure and a limit to the base for revenue.

Many aspects of these conflicting tendencies have been explored by theorists of fiscal crisis (see O'Connor, 1973; Gordon, 1977; Mollenkopf, 1977). Other students of fiscal crisis have been more empirically oriented, spurred on by the crisis of specific jurisdictions, such as New York City (see Clark, 1977; Sharp, Newton, 1977).

Structurally induced fiscal crises of particular governments are exacerbated by cyclical economic down-turns that translate into fiscal strains on these jurisdictions. For example, during periods of recession, revenues (tax receipts) go down, while demand for social services (welfare, unemployment insurance, etc.) go up due to unemployment creating a revenue gap. More recently, "tax revolts" have brought on fiscal strain, or fiscal crisis, in a number of States (Bowen, Lee, 1979). In part, these "revolts" occurred in the context of and reflected fiscal strain (Puryear, Ross, 1978). Tax and expenditure limits have occurred, however, where fiscal strain was not pronounced: (e.g., in Texas). Moreover, "tax reforms" much different from the Proposition 13 style "revolts" have occurred where such strain did exist (see Avault, et al., 1978; National Institute of Education, 1978, pp. 92–93). Actually, in California there were high taxes, but these reflected increases in population, property values, and personal income as much as or more than the demand for revenues to meet expenditures. And, as is well known, the California State government had a very large budget surplus prior to Proposition 13 (National Association of State Budget Officers, 1979).

Of direct concern are the following tendencies in the areas of health and social services: (1) There is a tendency to escalation of expenditures due, in part, to increases in demand for services, but due largely to escalation in costs of services, especially in the area of health (Department of Health, Education, and Welfare, 1977; Cambridge Research Institute, 1976). Increases have been large in social services as well (Millar, et al., 1977; Wolfe, 1978). There are the limitations on, or decreases in, revenue for such services imposed on the one side by limits to Federal funding under the new federalism and on the other by the "tax revolt" at local and State levels.

In the area of health, Federal Medicaid policies require States to meet their percentage share of total expenditures. Because of the rapid increase in the cost of medical care, these costs have risen far more rapidly than revenue increases, creating serious fiscal difficulties for States and many local governments where they share in State costs. In response, States have reduced the number of beneficiaries by lowering the level of income allowed, reduced the scope of optional services, or reduced the duration of mandated and optional benefits.

In social services, the major factor is a part of new federalism. The shift from categorical grants-in-aid to block grant type revenue sharing, continued in Title XX of the Social Security Act, passed in 1975, had definite negative impacts on funding of social services (O'Donnel, 1978, pp. 17–24). Previous grants-in-aid programs effectively assured that those States that wished could receive unlimited Federal aid to the extent of the State's willingness to allocate matching funds. Title XX imposes by formula a limit to the amount of Title XX Federal funds that each State can receive in a fiscal year. As States have reached their limits, they have undertaken a variety of strategies to obtain additional funds for social services. Overall, this has meant a real limit on Federal funds for social services (Millar, et al., 1977; Feild, et al., 1978).

Thus, while costs are escalating, funding for health and social services is experiencing definite limits. From above, there are Federal limits and attempts to shift costs to States; from below, there are structural fiscal crises and tax revolts. Caught between these tendencies, health and social services are involved in a "fiscal crisis" of their own. Attention has shifted to cost-cutting, to ever more energetic attempts to shift expenditures to other jurisdictions, and to a variety of other measures. Various approaches that may be attempted by the States include the following:

- Decreasing labor costs by freezing (or even reducing) wages, by cutting personnel (directly or through hiring freezes), and by giving increased workloads to personnel retained;
- Decreasing services and reducing budgets;
- Maintaining local health services through increased grants to local government from higher levels of government (e.g., revenue sharing and categorical grants);
- Transfering services or funding to higher (or lower) levels of government;
- Imposing user charges (fee for service) or authorizing copayments to private providers;
- Transfering Federal, State, or local health services to the private sector;
- Reorganizing Federal, State, or local government functions and boundaries to improve efficiency; or
- Reducing the number of service recipients by narrowing eligibility criteria.

Some of the techniques may be tried in conjunction with one another. Some may be applied in one area and not in another.

The Public Perception—The Social Construction of Reality

Today, the mood of the public and the public's perception of what the Federal Government—indeed, any government—can do is dramatically different than it was 20 years ago. The mood seems to be one of distrust of government and government officials, skepticism about the ability of government to deal effectively with complex social problems, active opposition to government efforts to deal with problems (e.g., busing), the feeling that "throwing money at a problem won't solve it," and a desire to cut taxes to show government officials who is boss. The mood is one that is against government regulation and government spending, particularly for programs that serve the poor.

Where do these ideas come from? Why are they so widespread? Do they bear any relationship to the actual functioning of government programs (e.g, the National Institutes of Health, the Social Security Administration)? What do research or the views of academics contribute? Are there examples of how the social construction of reality affects public policies?

Fifteen years ago, Berger and Luckman coined the phrase, "the social construction of reality" to describe the process by which definitions of reality become widely shared and institutionalized as part of the "collective stock of knowledge" (Berger and Luckman, 1966, p. 67). Although socially generated, such knowledge and expert opinion take on the character of objective reality, regardless of inherent validity. This "knowledge," in turn, influences both the perceptions of social problems and ideas on how to deal with them.

Medical care and the role and responsibility of the Federal Government illustrate the concept very dramatically. In 1965 the problem was defined as access to good medical care for the aged and the poor, and the threat of financial castastrophe for the aged and their children if an older person became seriously ill. The answer was seen as Medicare, Medicaid, a variety of outreach programs (e.g, neighborhood health centers, maternal and infant care projects, family planning services), and the development of resources (physician training, biomedical research, hospital construction), all with a large Federal contribution.

Today, the problem is not defined or conceived of as access to care, but high cost. Currently, the answer is not defined as requiring changes in rembursement policies in public and private programs (that would be a form of regulation), but as requiring the stimulation of competition in the private sector and the removal of any and all regulation, including laws that assure the safety and effectiveness of prescription drugs before they are placed on the market.

The social construction of reality applies equally to individuals and groups of people—women, the poor, the minorities, the handicapped, the aged. For all of these population groups, their income and opportunities, their participation in community affairs, their personal levels of gratification, and indeed even their health are largely determined by social forces. Individual differences in inherited social and economic status, in marital status, and in racial and ethnic origins influence their lives, but the major determinants of the standard of living enjoyed or endured by the disadvantaged in our society are national, social, and economic policies, political decisions by all levels of government influenced by the power of the various organized interest groups, and the policies of business and industry. Of particular importance is that society's perceptions of social problem groups, and the policies that flow from them are directly affected by politics and economics. The state of the economy affects how social problems are defined and treated—and how public policies are shaped around perceived social problems. For example, when the economy, is expanding, optimism abounds, and generous resources also expand to deal with social problems of all types (Miller, 1976), even those that are not productivity-linked. But when the economy is contracting, policies tend to favor less costly, more limited (often inadequate) social programs, particularly for population groups that are not thought of as contributing to productivity. The current budget-cutting and the threatened retrenchment of programs for the disadvantaged reflect a growing perception of the limits of our economy and inflation. The form which cost containment strategies will take will be heavily influenced by the heritage of new federalism programs of the 1970s.

The Growing Role of Medical Care and the Influence of Medicine

In the past 20 years the role of medical care has gradually expanded—not only in terms of the numbers of health care professionals and nonprofessionals providing care, the number of institutions and the expenditures for medical care, but in the role that society has assigned to medicine. In recent years medicine, particularly medical care, has assumed responsibility for many problems that in the past were perceived to be moral (alcoholism, abortion), legal (drug abuse), educational (mental retardation, learning disabilities), behavioral (cigarette smoking), or personal (family planning). From birth to death the role of medicine has assumed a larger and larger role in the life of most Americans.

Medical care has grown more rapidly than other service sectors because of the demand for traditional care and because of demands generated by medicine's expanded role. Indeed, medicine has become one of the Nation's largest industries, accounting in 1980 for about 10 percent of national income, with a current expenditure level of over $200 billion annually and 7 percent of total employment with 6.4 million workers. Although the health care system has employed millions of additional workers in the past 15 years and expenditures have risen even more rapidly, it is unlikely that this will continue into the 1980s. Although physician supply will continue to expand, the state of the economy and shifting national priorities make any major policy change unlikely before the mid-1980s. Even the modest proposals for national health insurance put forward by President Carter are likely to be the victims of the efforts to control inflation and balance the Federal budget.

The years since 1965 have been ones of dramatic change in health and health care. Not only has medicine's role been growing, but a number of other important changes have taken place. The implementation of Medicare and Medicaid have had a profound effect on access to care, improving it for both the poor and the aged. The desegregation of hospitals was to markedly change the environment of health care for millions. The sharp decline in mortality (particularly infant mortality and in mortality for cardiovascular disease) reflects changes in income, health care, and behavior. The rapid increase in the use of new technologies and the rapid increase in the costs of medical care and in public expenditure for medical care have been among the significant changes.

With the expanding role of medicine and medical care, the role of government has grown apace. The role of government is of major importance in regulating and financing medical care, in supporting the research that lies behind many of the advances in medical care, in supporting the education and training of health professionals who provide the care, and in adopting policies that permit expansion and modernization of hospitals and other health care facilities. The enactment of the Social Security Amendments in 1965, which included Medicare and Medicaid, was the turning point in terms of the role of government in planning, financing, and regulating health care.

In 1977, 40 percent of all costs of personal health care was paid by government (Federal, State, and local) funds; 30 percent was paid directly out-of-pocket by individuals and their families; 25 percent was paid through private health insurance; while charitable contributions and services provided by industry directly to employees accounted for an additional 2 percent. With increased third party payments, both public and private, costs have been rising rapidly and an increasing percentage devoted to hospital and nursing home care, particularly for the aged.

The total amount of money spent on medical care for the aged rose from $8.6 billion annually in fiscal year 1966 to $31.7 billion in fiscal year 1979, as noted in the previous discussion of expenditures. Inflation accounted for the bulk of this increase (50 percent); increased services for 36 percent; and the increase in the cost of medical care has imposed a special burden on government funds because of the expanded role of the Federal and State governments in financing medical care for the aged. Cost, not access, has become the primary concern of Federal policymakers.

Health care involves not only the expenditures of large sums of money, including public money, but it represents an area of great complexity as well, because of the nature of the health care system. In perhaps no other sector of the economy is there such a mixture of public and private financing and delivery of services. Physicians, pharamacists, and dentists are generally in private practice, which is a profit-making enterprise. By contrast, most hospitals are either nonprofit community hospitals or public institutions. Nursing homes, on the other hand, are amost entirely profit-making institutions, even though almost 50 percent of their income is derived from government funds.

Health services differ not only from the output of material goods, but many other services such as education and social services. The one-to-one relationship between the physician and the patient is a critical element in the entire, complex system. The physician must examine the patient in order to prescribe a course of treatment, recommend a consultation or additional tests, or admit the patient to a hospital or nursing home. Except for dental care and some optometric and pediatric services, most medical care derives from the initial physician-patient transaction.

As medicine's role has expanded and the role of medical care increased, so has the complex interrelationship between government, medicine, and the public. The 1980s will likely witness new stresses and strains as the government, particularly the Federal Government, attempts to constrain the growth in medical care costs.

Health Policies and the Aged—A Case Study

The Needs of the Aged

Older people are becoming more and more important in terms of health policies in the United States. One reason is the sheer increase in their number in recent years. In 1940 there were 9.0 million aged (6.8 percent of the population), by 1965, the year that Medicare and Medicaid were enacted, the number had doubled to 18.5 million aged (9.5 percent of the population). There are now more than 22.5 million aged, and it is estimated that in the year 2000, 31.8 million Americans (10.5 percent of the population) will be age 65 or older.

Older people are dependent on public policies and programs because of their relatively low economic status, their burden of illness and disability, and their need for a wide range of health and social services.

The Social Construction of Reality

It is not easy to generalize about socially shared perceptions of older persons because the aged are many different individuals from many different backgrounds and cultures, living in a variety of different places and under many different conditions. However, our recent study of U.S. policies for the aged reveal a set of dominant perceptions that affect most of their lives. As examined in *The Aging Enterprise* (Estes, 1979), the perception of the aged in the United States is:

- First, that they are, themselves, perceived of as a social problem. Old age is, in itself, seen as a problem for the society to manage.
- Second, old age is perceived of as special and different, as characterized by special needs requiring special programs. This has led to separatism of the aged via public policies.
- Third, old age and its concomitant social problems are seen as resolvable by the application of services at the *individual* level. Because the dominant conception is that services, rather than income or employment, can solve "the problem," inadequate income maintenance, employment, and retirement policies have been formulated.
- Fourth, the services strategy that has been adopted preserves and reinforces the existing social class structure. Three classes of the aged are entitled to some type of government program, as cited by Nelson: the middle- and upper-class (nonpoor) aged; the newly poor in old age (the deserving poor); and the aged who have always been poor (the undeserving poor). The nonpoor aged have the resources to permit relatively easy access to public and private services without the necessity of government intervention. They also receive a disproportionate share of the benefits of the largest Federal programs for the aged (e.g., Social Security, Medicare, and retirement tax credits). Most services policies tend to favor the newly poor in old age, largely because they are thought of as both deserving and deprived. Services have been designed largely to assist the recently deprived aged to maintain their lifestyles, rather than to provide the more crucial life-support services (e.g., income) needed by the poorest aged. The aged who have endured lifetime poverty are assisted largely through inadequate income-maintenance policies, such as Supplemental Security Income (SSI), and through Medicaid, which are highly variable from State to State.
- Fifth, old age is commonly perceived as characterized by inevitable physical decline, presumably occurring with chronological aging. The biomedical model of aging and its detrimental-decline concepts have gained wide acceptance, particularly with society's tendency to conceptualize problems as medical in origin and to look to medicine for solutions. This has encouraged a medicalization of the

problems of the aged, at great cost to both the individual and the society.

- Sixth, the problems of old age in our society are characterized as having reached crisis proportions, as evidenced in testimony on Social Security, Medicare, and the Older Americans Act. Such crisis definitions promote the activities and demands of interest groups for an increasing supply of budgetary resources for the respective services with which they promise to solve "the problem." The result is a wasteful patchwork of often contradictory solutions, none of which is capable of ameliorating the defined problems in the long run.
- Seventh, older people tend to be seen as unproductive and dependent, as a burden on society, and also somehow to blame for the socially defined "problem" they represent. They did not save enough; they are living too long; they use too many health services, thereby contributing to the spiraling costs of government programs, including the costs of Medicare and Medicaid.
- Eighth, given the social construction of reality about the problems of old age in the United States, the perception is that it is impossible to redistribute resources to older people in order to alter their status. Rather, it is only possible (and with great sacrifice of other generations) to hold older people in place, despite the fact that many of our own social policies, such as forced retirement, create new dependency for the middle-class old and exacerbate the dependency of those who were poor prior to old age.

The Economic Status of the Aged

Inadequate retirement income is the most serious problem facing older Americans. A host of income and poverty statistics testify to this fact. The problem was summed up by the Select Committee on Aging, U.S. House of Representatives:

> Although persons above 65 constitute little more than one-tenth of the population, they account for 29 percent of all persons in America receiving an income below $3,200. Currently, the median income of all families headed by a person 65 or over is 43.1 percent lower than the median income for all families; the income of individuals 65 or older is 33.4 percent lower than the median income for all individuals.

Although the number of aged living in poverty declined from 5.5 million in 1959 to 3.2 million in 1977, there has been virtually no reduction in the number of elderly living in poverty during the 1970s. The Social Security amendments enacted during the 1970s should, however, prevent further decline in the economic status of the aged. The economic status of millions of the Nation's elderly has a negative impact on their health status, and it severely limits their access to needed medical care without turning to public assistance programs.

The Burden of Chronic Illness and Disability

Although it is difficult to be precise about the numbers and kinds of persons needing medical and social services, the chronically ill and disabled utilize these services far more than those who do not suffer with such problems. Among the elderly in 1970, 5 percent were residents of institutions, and millions suffer from chronic illness and disability. In 1975 almost half of the noninstutionalized elderly were limited in their activities because of chronic conditions, including 17 percent who were unable to carry on their major activity. Activity limitation is far more common (56 percent) for those 75 years of age and over, in contrast to those 65 to 74 years of age (42 percent) (Kovar, 1977). It is also more common among the poor. Those age 65 and over who are poor had 46.6 days of limited activity per year, compared with 31.2 days for the nonpoor aged.

The problem of those age 75 and older are of particular importance, because this group bears a high burden of illness and disability. They are often poor and without family or other social support systems. Indeed, one-half of the residents of long term care facilities are age 80 or older; the great majority (68 percent) have family incomes of less than $3,000 annually, and most are widowed or never married.

We have previously summarized the impact of chronic illness on the elderly as follows:

> The impact of this illness burden on the quality of life of the aged is enormous. Over 1 million are in nursing homes, over 3.8 million are unable to carry on their normal activities, and at least 11 million are limited in their activities. The problems increase with advancing age. Illness and disability are cited as the major reason that those sixty-five and over are unable to work. Not only do illness and disability restrict the earning capacity of the aged, but the costs of medical care drive many to a state of impoverishment. Poor health is a significant factor in accentuating and deepening the poverty of the aged; in turn, their poverty contributes to their poor health and disability. High medical care costs for the aged reflect their growing numbers, their disproportionate burden of illness, the increasing percentage who are seventy-five years old and older, and the devastating effect of price inflation during the past fifteen years (Lee and Estes, 1979, p. 101).

The Health Care Needs of the Aged and Their Use of Health Services

The added burden of chronic illness and disability among the aged is also reflected in data on the use of health services. In 1975 the aged saw physicians 50 percent more often than did those under 65, and they had twice as many hospital stays per capita and remained in the hospital almost twice as long as younger persons. Still, over 80 percent reported no hospitalization during the year, and over 13 percent did not consult a physician. Wide variations exist in the utilization of medical care by the aged with particular chronic conditions. For example, only 43 percent of the elderly reported to have arthritis had seen a physician about this condition during the year, while 80 percent of the aged with diabetes mellitus, hypertension, and heart disease had done so (Kovar, 1977).

The Impact of Rising Health Care Costs on the Aged

The cost of health care is rising in all industrial societies, and the percentage of the Gross National Product allocated to health services in more developed countries has essentially doubled in recent decades. Older people are particularly concerned about the rapid and continued increase in the cost of medical care, because it is imposing an increasing financial burden on them. In the decade from 1966 to 1976, per capita health expenditures for the elderly rose from $455 to $1,521 annually (Paringer, et al., 1979). Although the most rapid increase was in hospital and physician services (table 4, appendix II) that are covered in part by Medicare, direct out-of-pocket costs rose rapidly because of the cost of prescription drugs, payment of physician fees not covered by Medicare, Medicare (Part B) premiums, Medicare copayments and deductibles, private health insurance premiums, and long term care services. In 1966 direct out-of-pocket costs for medical care for the aged were $237 annually. In 1976 they had risen to $404 annually (table 4, appendix II). In aggregate terms, direct out-of-pocket expenditures for medical care essentially doubled, rising from $4.38 billion in 1960 to $8.71 billion in 1975.

The cost of prescription drugs presents a special problem for the aged. Although the elderly comprise only about 10 percent of the population, they bear the cost of roughly 25 percent of all out-of-hospital drug expenditures—expenses that most older people must meet by out-of-pocket spending. In 1975 the average drug bill for the elderly was more than four times the average drug expense for individuals under 19 years of age and almost two-and-one-half times the bill for persons age 19 to 64.

Current health expenditure data reveal that drugs represent one of the largest out-of-pocket medical expenses for the aged. In 1976 per capita drug expenditures for the elderly were $121 annually. More important than the per capita expenditures is the fact that because of their burden of illness and disability, 10 percent of the aged account for more than 40 percent of all prescription drug charges for the aged. In addition to the problem of direct cost to the aged, it has been suggested that improving access of the aged to appropriate drug use—especially out-of-hospital—can minimize more costly physician visits and hospitalization, as well as limit needless illness and disability.

It was hoped at the time of Medicare's enactment that private health insurance would respond and fill the gaps and permit a better distribution of the costs of care. This hope has not been realized. Private health insurance pays for only about 5.4 percent of the costs of personal health care for the aged. Since 1966, private health insurance has never met more than 5.9 percent of the annual costs of health care for the aged. This does not appear to be a viable alternative for the aged to meet the costs imposed by Medicare's gaps.

Health Care for the Aged: The Growing Role of the Federal Government

Medicare

Medicare is the largest and the most important program designed to provide the aged with access to needed medical care and protection against the high costs of care. Medicare provides protection against hospital costs (Part A) and physicians' services (Part B). Medicare's hospital insurance program pays almost all of the costs of inpatient hospital care through the first 60 days with a modest deductible ($180 at 1980 rates). After 60 days, the patient must pay $45 per day in coinsurance for each day of care. The Medicare hospital insurance (Part A) is financed through a special social security trust fund supported by an earmarked tax on employers and employees. For the aged requiring care in a Skilled Nursing Facility, coinsurance is $22.50 per day from the 21st to the 100th day.

The Supplementary Medical Insurance (Part B) is much less satisfactory in terms of protection. The aged person must pay a monthly premium ($8.70 per month, rising to $9.60 in July 1980) plus an annual deductible ($60 in 1980) if any medical bills are incurred and 20 percent coinsurance for all "reasonable charges" when the physician accepts assignment of the bill to the government. Because of the increasing number of physicians who are billing the patients directly rather than the government, at charges well above those that Medicare considers "reasonable," the elderly are forced to pay more and more out of pocket as physicians' fees increase. For the aged not covered by social security, the monthly premium for hospital insurance (Part A) is $69. This will rise to $79 per month on July 1, 1980.

In 1976, 5.1 million aged had much of their inpatient hospital care costs covered by Medicare and 12.7 million elderly had a portion of their physicians' and related services covered by Part B of Medicare. Total Medicare costs were $17.73 billion in fiscal year 1976 and $20.77 billion in 1977, $24.6 billion in 1978, and $28.9 billion in 1979.

The implementation of Medicare and Medicaid in 1966 was followed by a dramatic increase in the use of hospital services, but little or no increase in the use of physicians' services outside the hospital by the aged. Indeed, the average number of physician contacts by persons aged 65 and over, excluding contacts while a patient is in a hospital, nursing, or other institution, has remained at approximately 6.6 visits per year from 1965 through 1975. There was an increase in the use of physicians' services by the poor aged and a decrease by the nonpoor aged. Hospital utilization, by contrast, increased sharply during the first year (1966–1967) that Medicare was implemented. The hospital discharge rate increased 4.6 to 7.4 percent, average length of stay by 4.1 to 7.8 percent, and days of care per 1,000 elderly by 8.9 to 16.0 percent. Since then, the increase in the number of patients discharged and the decrease in the average length of stay have tended to cancel out each other so that the number of days of hospital care per 1,000 elderly people has not increased substantially (U.S. Department of Health, Education, and Welfare, 1977).

Surgical rates have increased dramatically since the advent of Medicare. In 1965 there were 6,554 operations for every 100,000 people aged 65 and over; in 1975 there were 15,482 operations, an increase of 105 percent. Cataract surgery more than doubled, from 525 to 1,115 operations per 100,000 elderly, and arthroplasty increased from 49 to 145 operations per 100,000 elderly people. Use of prescription drugs has increased even more rapidly during this period.

Although, as noted, utilization of physicians' services outside the hospital has not increased, costs have escalated because physicians have raised prices at a rapid rate during the past decade. Further, more and more physicians refuse to accept "assignment" of the Medicare bill, choosing instead to bill the patient at a price well above the limits that Medicare will pay physicians who accept assignment of their bill for Medicare. Consequently, the older person often bears the total cost of such services because the red tape and level of sophistication required to obtain reimbursement often prevent the older person from seeking the partial reimbursement to which he or she is entitled.

Medicare policy is basically set at the Federal level, without State discretion. However, a locus of discretion within the State lies with the fiscal intermediaries which set the reimbursement levels for the

State. There is an additional consideration with regard to Medicare. State policy choices as to Medicaid buying-in provisions can have major impacts on Medicare expenditures by reflecting the numbers of those actually covered by Medicare (Davis and Schoen, 1978).

Medicare expenditures have been predominantly for hospital and physicians' services. In 1977, 60 percent of all health outlays in the Federal budget were for Medicare (Gibson and Fisher, 1979). Concern has long been expressed about the rising costs of the Medicare program and the failure of attempts to control these cost increases (U.S. Comptroller General, 1976). Medicare expenditures continue to rise rapidly.

Two factors contributing to the increase in Medicare expenditures are rapidly increasing hospital costs and the growth in enrollment of disabled persons and those with end-stage renal disease that followed the 1972 amendments (Gibson and Fisher, 1979). Conversely, Medicare contributed to the spiraling costs of health care (Davis, 1973). Concern with increased hospital costs has stimulated a number of proposals directed toward placing limits on allowing cost increases for Medicare and Medicaid. At the same time, various proposals have been made to extend the coverage of the Medicare program, e.g., outpatient drugs, hearing aids, routine physical exams, etc. (U.S. House of Representatives, Committee on Ways and Means, August 1978).

One significant effect of rising costs has been a rapid increase in the percentage of funds derived from Federal general revenues. For the Medicare program, general revenue contributions rose from 16.4 percent in fiscal year 1974 to 26.4 percent in 1977. The rapid increase in the general revenues comes from the increase in Federal matching funds for premiums paid to the supplementary medical insurance trust fund (Gibson and Fisher, 1979, p. 16). As these expenditures rise, fewer funds are available to meet other needs, including those for long term care or other health care services.

The marked differences in the Medicare and Medicaid benefit structure account for the major differences in program expenditures. Medicare provides broad coverage for inpatient hospital (Part A) and generally adequate, but less comprehensive, coverage for physicians' services. Long term care benefits are, however, limited.

Medicaid

Medicaid is the federally assisted, State administered program that pays for basic medical care for the poor who are aged, blind, or disabled (and eligible for Supplemental Security income—SSI) or who are members of families with dependent children (eligible for Aid to Families with Dependent Children—AFDC). Medicaid currently provides some assistance in paying medical bills for over 21 million poor people. Most of them are children, but 18 percent are over 65 years of age and the payments to providers for their medical care account for 38 percent of Medicaid expenditures. This is due to the disproportionate burden of chronic illness and disability borne by the aged and the high cost of hospital and nursing home care.

A major limitation in the Medicaid program is the existence of wide State variations in coverage, in terms of both services offered and program eligibility. States have the discretion to limit coverage to the categorically needy (excluding the "medically needy" option) and to provide only 6 basic services out of a possible 23 services. The problems of elderly poor resulting from this State discretion include the lack of uniformity among Medicaid programs and the limited range of services provided in many States. As fiscal limitations extend themselves at State and local levels, even the bare minimum eligibility and scope of services standards are likely to be reduced.

The Rising Cost of Medicaid

Medicaid is the largest Federal-State social program. A review of the literature pertaining to Medicaid reveals, however, not only the enormous complexity of the program, but also, and more important, the lack of comprehensive understanding among policymakers, including Governors and State legislative leaders, fiscal managers, and even agency administrators. For example, a recent major investigation of Medicaid concluded that the program is perhaps the least understood of all Federal aid programs (Holahan and Scanlon, 1977).

A number of factors have contributed to the rapid increase in the cost of the Medicaid program. During the period from 1968 to 1976 Medicaid expenditures rose from $3.5 billion to $14 billion. During this time the number of Medicaid eligibles more than doubled—from 11.5 million to 24 million. The number of aged eligible for Medicaid has risen more slowly—from 1.5 million in 1970 to 2 million in 1976. If there had been no increase in the number of recipients, Medicaid costs would have been $6.6 billion in 1976 (Urban Systems Research and Engineering, Inc., 1977).

The aged, and the fact that they bear such a heavy burden of disease and disability, have also contributed to the rising cost of Medicaid. In fiscal year 1978, total Medicaid expenditures were $17.8 billion, including Federal, State, and local government expenditures. Almost 32 percent of Medicaid expenditures ($6.7 billion) were spent on medical care for the aged. Although the Medicaid eligible population declined slightly between 1976 and 1977, payments under the Medicaid program continued to rise to a total of $16.8 billion, or a 14.1 percent increase over FY 1976. Long term care services for the aged, particularly for the Skilled Nursing Facility (SNF) and the Intermediate Care Facility (ICF) constitute an increasing share of total Medicaid costs.

A major factor in the emphasis that Medicaid policies have placed on long term institutional care for the aged, particularly SNF and ICF care, has been the limitations in the Medicare program. Medicare provides up to 100 days of SNF per benefit period, these days must be preceded by at least 3 days of hospitalization. Medicare expenditures actually represented only about 9 percent of Federal spending for nursing home care in fiscal 1977, and long term care represented only 2 percent of total Medicare expenditures.

Medicaid, by contrast, provides either SNF or ICF care services in every State. As a result, Medicaid paid a total of $6.2 billion in Federal and State funds for nursing home care of the aged and disabled in fiscal 1978 (HCFA, Fall 1979) representing more than 50 percent of all public and private expenditures for such care and almost 38 percent of total Medicaid expenditures. In fiscal year 1974 Medicaid expenditures for ICF/SNF care exceeded those for inpatient hospital care. Although ICF care is an optional benefit, it is paid for in every participating State. In 19 States, nursing homes account for the bulk of Medicaid expenditures. Expenditures for ICF care now exceed expenditures for SNF care (rising from only 2.2 percent of total Medicaid expenditures in fiscal year 1969 to 22 percent in fiscal year 1977. Below the level of ICF care is domiciliary or custodial care for which Supplemental Security Income payments to elderly beneficiaries are the main source of payment.

Home-health services are authorized under both Medicare and Medicaid, but together these programs provide minimal funding for noninstitutional service. Medicare is the primary source of payment for home-health services. It provides coverage for home-health visits when they are preceded by a hospital inpatient stay of at least 3 days (Part A) and when they are ordered by a physician for patients who have not been hospitalized (Part B). In both cases, visits are limited to 100 visits per calendar year. Both require that patients be homebound and in need of skilled care, and the services must be ordered by a physician. In 1977 Medicare expenditures for home-health services were $433 million, while Medicaid expenditures were $179 million for home health services.

State discretionary policy is particularly important in relation to long term care services, because State officials have a number of options related to eligibility, scope, and duration of benefits, reimbursement, standards of care, and utilization review. The result is a wide disparity among States in terms of long term care services provided. In fiscal year 1976, for example, State-level Medicaid expenditures for long term care ranged from 66.6 percent of total Medicaid expenditures in Wyoming to only 19.3 percent in the District of Columbia.

A particularly costly policy decision by the States may be the liberal coverage of ICFs. One major study suggests that since 1973 many States have included Intermediate Care Facilities as a mandatory benefit, perceiving these facilities to be a substitute for more costly Skilled Nursing Facility or inpatient hospital services (Holahan, Scanlon, and Spitz, 1977). However, savings effected through this substitution were outweighed by the fact that an increased number of eligible elderly whose health was not sufficiently impaired for care in a Skilled Nursing Facility or a hospital were not eligible for Intermediate Care Facilities.

The shift from State mental facilities to domiciliary facilities, boarding homes, and Intermediate Care Facilities has been observed in earlier studies (U.S. Senate, Special Committee on Aging, 1976; Pollack, 1974; Wolpert and Wolpert, 1976; Joe and Meltzer, 1976; Scull, 1976). Although some of these studies speculate on States' efforts to shift program costs to other Federal or Federal-State programs in order to lighten their own fiscal burden for long term care (Holahan, 1977), there is surprisingly little research to substantiate the role of State policy. There also is a lack of research pertaining to cross-funding source differences.

The Fiscal Burden of Medicaid on State and Local Governments

The allocation of fiscal responsibility among levels of government has been a major political issue since the inception of the Medicaid program (Advisory Commission on Intergovernmental Relations, 1968 Report; Holahan and Scanlon, 1977; U.S. House of Representatives, Select Committee on Aging, 1977; Chulis, 1977; Feder and Holahan, 1977). The fiscal impact of increasing Medicaid cost upon States has been substantiated in major congressional reports and studies since 1968 (U.S. Senate, 1970; U.S. Comptroller General, 1976; Health Care Financing Administration, 1978; Advisory Commission on Intergovernmental Relations, 1968). Between the years 1970 and 1974, the increase in State Medicaid expenditures per capita far exceeded the growth in per capita income. One State, Texas, experienced almost three times the percentage growth in per capita program costs as in percentage growth of per capita income (Holahan, et al., 1977). Data for FY 1976–1977 show that for many States the growth in State Medicaid expenditures per capita continues to exceed the growth in per capita income. Of an eight-State sample studied by the Aging Policies Project, Florida and Pennsylvania Medicaid programs experienced more than three times the percentage growth in per capita income; Missouri and Texas experienced about twice the percentage growth in Medicaid costs as in per capita income. Other States—Washington and Wisconsin—were able to hold their expenditures below the percentage growth in per capita income (Estes, et al., 1980).

The shift in the financing burden resulting from Medicaid cutbacks imposed by State governments has been a source of concern at the local level as well (Koppel and Clark, 1976). Although county governments' responsibilities for Medicaid financing are substantial in some States, the ability of counties to control expenditures in those States is limited. Research pertinent to Medicaid suggests that there is a perceived long-range crisis, not merely a cyclical one, in States' ability to support long term institutional care. In an examination of the effect of the 1974–1975 recession on health care programs, it was found that while there was a correlation between a State's degree of fiscal strain and Medicaid cutbacks, there were "no-strain" or "moderate strain" States, such as Texas, that also imposed cutbacks during this period (Holahan, et al., 1977). Cutbacks in Medicaid payments for long term care will have particularly serious consequences for the elderly poor.

Controlling Medicaid Costs

The literature is replete with studies pertaining to health care costs and expenditures (Gibson and Fisher, 1979; U.S. Comptroller General, 1976; Cooper and Worthington, 1973). The studies most relevant to the Commission's interest are those of the Urban Institute which suggest that efforts to reduce Medicaid expenditures should address two exogenous sets of factors responsible for the growth in Medicaid expenditures: first, factors related to States' economy/fiscal condition; and, second, factors related to the substitution of medical care for social services and programs. These studies found that:

- The number of Medicaid recipients is growing much faster than the population in general (e.g., Medicaid recipients increased by 26.6 percent between 1972 and 1975, in comparison to a 2.4 percent increase in total population). This rapid growth in the Medicaid population was linked to the economic conditions (e.g., unemployment, economic growth, inflation) in the States.
- Medicaid has assumed the burden of providing needed services not related primarily to health care. The prime example is coverage of Intermediate Care Facilities. The lack of Federal subsidies for appropriate housing and social service programs for the aged has been cited as an explanation for the expansion of the nursing home sector under Medicaid.
- State cutbacks in Medicaid programs between 1974 and 1975 could not be attributed simply to fiscal strain. Instead, States were

responding to more than short term fiscal crisis and there was a perceived long range crisis in States' abilities to support long term care.

In 1977, 14 States instituted some form of reduction or temporary cutback in their Medicaid programs, and a number of States have set limits on physician reimbursement rates substantially below those authorized under Medicare. Recent summaries of Medicaid cutbacks have highlighted three major approaches adopted by States to control costs: (1) increased limits and restrictions on optional and basic Medicaid services; (2) increased cost-sharing by patients for basic and optional services; and (3) lowered reimbursement fee levels for services to ambulatory patients (Davis and Schoen, 1978).

A complex interaction between structural and policy variables affects a State's decision to adopt specific cost control measures; ultimately, however, political considerations are the most important (Holahan and Stuart, 1977). Stuart and Stockton (1973) have observed that most forms of utilization control are subject to severe shortcomings, including ambiguity of purpose, organizational inefficiencies, and the presence of undesirable or unanticipated side-effects. Holahan, Scanlon, and Spitz (1977) found that limitations on mandatory benefits and elimination of optional benefits were the major cost containment efforts characterizing selected States during the 1974–1975 recession. The point is that the Federal designation of mandatory and optional services assumes rationality. However, the consequence of such arbitrary categorization of Medicaid services in the context of States' perceived fiscal crisis may be quite contrary to any rational long term strategy.

There is no definitive research on the most effective cost containment approaches, but limitations on covered benefits under Medicaid have been the most frequently employed cost control measure used by States. It has been argued, however, that this not an effective cost containment strategy. For example, one likely consequence of restrictions on physician visits is an increase in the use of hospital outpatient services, unless these are similarly restricted. In many cases, services rendered in outpatient departments are more costly than similar services in physicians' offices (Spitz and Holahan, 1977).

The area of reimbursement is a critical policy area in providing incentives and/or disincentives for efficient management of the Medicaid program. Reimbursement schemes for inpatient, outpatient, physician services, and long term care facilities are enormously varied across States. Limitations on physician reimbursement are an attractive cost control measure for States and represent a key area of State discretionary power. While the options available to States for controlling the level of physician fees are known, there are no certainties that the effects of such action will be desirable.

Social Support and Social Services for the Aged

Families, friends, voluntary associations, churches, and other institutions provide most of the social support systems and social services needed by the aged. This is particularly true of those in the upper and middle classes, who are not rendered poor by retirement and inadequate private pensions and social security retirement benefits.

The Older Americans Act, enacted in 1965 but significantly modified in the 1970s, was originally designed to support the development of community services to meet the needs of all of the aged. Three programs—area planning and social services, nutrition, and multipurpose senior centers—are of potential importance in filling gaps in the continuum of long term care services. This potential has not been realized because appropriations for these Title III programs have been severely limited in relation to the needs, with total FY 1980 appropriations for these and all other Older Americans Act programs approximately $600 million. A far larger program, Title XX (social services) of the Social Security Act, has also been of limited benefit to the aged.

Title XX Services

Title XX of the Social Security Act provides a range of social and health services to populations in need in the 50 States. Enacted in 1974 as part of the new federalism strategy, Title XX (P.L. 93–647) consolidated two social services programs; provided the States broad discretion in achieving national goals; and set a limit on Federal matching funds. That restriction was to limit severely future program growth. Estimated expenditures under Title XX in FY 1978 reached $3.7 billion, of which $2.5 billion was the approximate Federal share. In addition to goals which call for the maintenance of economic self-support and for self-sufficiency, Federal mandates seek to direct Title XX activities toward preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care (Feild, et al., 1978). Many Title XX services have been conceived in more or less explicit terms as means to enhancing the long term care alternatives of particular vulnerable populations, including the aged and the handicapped young (Joe and Meltzer, 1976; Schram and Hurley, 1977).

Title XX represented a significant break with former Federal categorical efforts to provide social and health services. Virtually all Federal services were eliminated, service eligibility guidelines were broadened, and the locus of policymaking was considerably decentralized. The result has been a special revenue sharing program in which States and localities have been given considerable discretion in defining service priorities and designating populations to receive services (Gilbert, 1977; Gilbert, et al., 1979; Terrell, 1976).

Considerable variations exist in Title XX programs. The maximum income levels to which services are offered, as a percentage of State median incomes, varies greatly among the States. The State standards range from 60 percent to 115 percent. This means, for example, that in Texas only persons earning below 60 percent of the State median income are eligible for services, while in California and Pennsylvania persons with incomes higher than the median may qualify. Five States use this standard for most or all services, while the others apply varied standards to different services. In addition, States vary in terms of the range of services to which this maximum is applied.

States vary as well in terms of the nature and mix of the services that they deliver under Title XX (Gilbert, et al., 1979). A 1976 taxonomy prepared for the Department of Health, Education, and Welfare reported 1,313 services being provided under this title and suggested 41 categories be used to group them for reporting purposes. Within this list are at least 14 service categories that have important implications for long term care. Virtually all of these service categories have implications for the disadvantaged.

The extent of State-level Title XX commitments to specific services has changed in important ways in the past several years. For example, total expenditures for home-based services increased by more than $100 million between FY 1976 and FY 1978, an increase of 26.4 percent in 3 years. By contrast, expenditures for health services dropped by $55 million or 36.1 percent. Adult day care and home/congregate meals both grew modestly, or by around 6 percent. Fee patterns are also changing—States in FY 1968 were setting fees at lower levels of median income than in FY 1976. States also are starting to let localities set fee levels below State maximums, especially in State-supervised systems. These factors affect the poor most adversely. Data from the Urban Institute also suggest that administrative costs of services have been increasing both in absolute terms and as a percentage of total expenditures. With a ceiling operative on Title XX expenditures, this has meant reduced services (Feild, et al., 1978). For States whose spending has approached their ceiling, defined by their share of the "capped" Federal appropriation, providing the same level of services or managing demands for more services has been an increasing problem, despite the recent modest increase in the ceiling.

The existence of the $2.5 billion (now $2.9 billion) annual ceiling on Title XX expenditures has provided incentives to States to devise means to generate or tap other funds to support services, to be increasingly selective in and to cut back services included in their State plans. The resource limitations and service selection issues appear to be closely related (Millar, et al., 1977). States have made and are continuing to make policy adjustments that are likely to have a significant impact for the disadvantaged both on service provision and on the growth of other Federal programs. The result clearly seems to have been diminished Federal control over State social services programs.

Several State strategies for coping with an increasing demand for services have been identified (Millar, et al., 1977). These strategies are used in various ways by different States and include ending program expansion, reordering service priorities, changing client groups served, reducing services to absorb administrative costs, and using other funding sources. Of particular relevance to Federal health policymakers, Millar's work (1977) suggests that intertitle transfers are a major strategy utilized by States under conditions of fiscal restraint and that increased Federal spending, particularly under Medicaid, is a likely consequence.

The Older Americans Act

Title III of the Older Americans Act provides a range of social and health services to older persons in the 50 States. Considerable variations exist in Title III service emphasis. Among the range of services offered under Title III, three are most directly related to health care: home-health, day care, and medical services.

In addition to broad options and service emphasis, States have considerable discretion in defining the population criteria by which funds are allocated to local areas and in specifying segments of the elderly population that receive service priority (Binstock and Levin, 1976). While the Older Americans Act defines eligibility for services as universal for all elderly, debate has continued regarding the value of concentrating the limited resources of Title III on those elderly persons most in need, especially the poor and frail. Since these groups are the most likely to require long term care services, State and local policy choices regarding targeting of services and populations have important consequences for the delivery of health-related services to the most disadvantaged.

Research by the Aging Policies Project, University of California, San Francisco (Benjamin, et al., 1978), reveals that in most States allocation of funds to the planning and service (broad local) areas conforms closely to the distribution of elderly within the State; in about half of the States allocations conform also to the spread of low-income elderly. Along with the geographical allocations of funds to substate areas, State Units on Aging also develop State policy regarding groups to be targeted by local services. Some have policies that direct area agencies to give priority to isolated, frail, and at-risk elderly. Others emphasize targeting to low-income elderly without qualification.

Income Support for the Aged

The most important Federal programs for the aged are those providing income and financial support. Social security has become increasingly important as the mainstay of retirement income for the vast majority of the Nation's elderly. This has been particularly important because of the mandatory retirement policies of government, business and industry, and because of the inadequacy of private pensions. Almost 16 million retired workers received social security retirement benefits in 1977, and without it 60 percent of elderly families would be poor (Ball, 1978; Lee and Estes, 1979). Even with social security benefits, over 4.9 million aged (30.6 percent) are poor by government standards. The number is reduced to 3.9 million (35.5 percent) when other government programs, such as Supplementary Security Income (SSI) are added. Although these figures appear impressive, the relative financial status of the aged, compared with the financial status of those under 65, has changed very little in 25 years (Clark, et al., 1978).

The SSI program is important in long term care, because it is a source of income for the aged poor and because of its relationship to Medicaid eligibility and domiciliary care. The law provides automatic Medicaid eligibility for SSI beneficiaries (aged, blind, and disabled) unless States adopt more stringent standards based on their 1972 Medicaid eligibility. The result has been that 28 States make Medicaid eligibility automatic for all persons eligible for SSI; 7 States use SSI criteria in determining eligibility but require separate applications for Medicaid; and 15 States use different criteria in determining eligibility and require separate applications. The lack of coordination between SSI and Medicare has tremendously complicated the administration of Medicaid eligibility for the aged, blind, and disabled. And it is the beneficiaries who suffer. The law also permits States to provide additional payments to SSI beneficiaries to cover the costs of congregate housing or domiciliary care. Because States vary in their coverage of institutional settings (both the types and numbers of categories) and in the levels of supplementation, SSI policies may affect Medicaid caseloads and expenditures, as well as the development of particular segments of long term care services.

Currently 34 States supplement the Federal minimum payment for persons residing in congregate or protective living arrangements, arrangements including board and care homes, personal care facilities, and facilities for the mentally retarded. If the State elects the Social Security Administration to administer the program, the State supplement may be limited to a flat amount above the Federal payment, based on variants in living arrangements and geographic areas.

The overlap between the SSI population in general and those residing in medically reimbursed facilities (i.e., Skilled Nursing Facilities, Intermediate Care Facilities) has not been well documented, but evidence suggests that many residents of SSI domiciliary facilities are similar in number and in kinds of diagnoses to residents in more medically oriented facilities like skilled nursing homes. The SSI populations, while having similar chronic conditions and health maintenance needs, appear to be more functionally independent. However, the line between SSI and Medicaid populations is not well drawn and the ultimate place of residence—SNF, ICF, or other domiciliary care facility—may be governed as much by funding source as by medical or other considerations.

Although it is next to impossible to obtain complete data on how much Federal and State SSI money is spent on domiciliary care, a recent Social Security Administration estimate places the total figure at approximately $300 million annually, of which $120 million was Federal and $180 million State supplementation. States supplement a uniform minimum at different levels according to State discretion. States also develop their own categories of living arrangements within broad Federal guidelines, paying different amounts for various living arrangements.

The Policy Process and Interest Group Influence

An important element in the failure of domestic social programs, including those affecting health, is the role and influence that pluralism in American politics provides for special interests in the enactment and implementation of legislation. The ambiguous mandates in much legislation permit continued special interest influence in all processes of program implementation. Pluralist theory holds that competition of multiple special interests results in policies and priorities that are in the national interest. We do not agree. We find the observations of David Broder, one of America's most distinguished political reporters, far more accurate. Broder observed: "There is no 'free market' in the political influence game. Some interests are far more powerful than others, so powerful that they can almost rig the game to assure a favorable outcome to themselves" (Broder, 1972). The dominance of special interest and interest group bargaining in determining social policies has had important consequences for the aged and for health policies.

The decentralization of responsibility, with broad discretion in program implementation provided to States and localities in Medicaid, Title XX, and other new federalism programs, has meant that choices concerning program priorities, service emphasis, and eligibility often occur in the less visible implementation processes, rather than in the more visible (and more publicly accountable) legislative processes. This permits the interest groups to exert their influence at every step of the implementation process, and it tends to hide the facts of power from those over whom it is exercised.

The particular consequences of this policy process are most severe for the disadvantaged of all ages because the health, income, and social services policies that affect them most are variably determined within the States, and significantly conditioned by State and local political and economic vicissitudes. More important, it will be difficult to track the effects of the multiple, changing, and variable discretionary State policy choices in cost containment and program cutback efforts across the States. Further, their effects on the disadvantaged are likely to be most severe because of their relative powerlessness in the policy process just described.

Creating a Continuum of Effort

Responsibility for the pursuit of health and for care of the ill is a cooperative venture involving government, the health professions, business and industry, voluntary health organizations, and, particularly, families and individuals. The health of the aged, no less than that of the young and middle-aged, is dependent on how well the various groups work together toward agreed-upon goals. Although emphasis has been placed on the role of medicine and the role of government in health care, it is individuals and families who are primarily responsible for health promotion and who treat from two-thirds to three-quarters of all episodes of illness and injury in the United States. The aged, perhaps because of their frequency of symptoms, are very much a part of this self-care system.

At an individual level, choices relating to health revolve around efforts to remove personal or behavioral barriers to health—smoking, drinking, reckless driving, physical inactivity, improper diet, and poor sanitary or hygiene habits. These issues are variously labeled as lifestyle problems, behavioral problems, and individual problems. They are individual problems, however, only if the individual alone can solve them. In most cases individuals need help in solving these problems, because they have their genesis in social, economic, and cultural patterns, rather than purely in the behavior of the individual. Individuals need information and skills; they need protection from environmental hazards; they need incentives and resources in order to alter their behavior. Most of all, they need the freedom to act in what they consider to be their own best interest.

At a governmental level, policy choices revolve around attempts to remove social and environmental barriers to health—poverty, unemployment, lack of educational opportunities, poor nutrition, environmental and occupational hazards, unequal access to health care, and the high cost of health care. In an ideal sense government should be involved in doing for individuals only what they cannot do for themselves.

Practicing health professionals, particularly physicians, sit at midpoint on this continuum. Once an individual decides to seek advice for a health problem, the threshold is crossed into the health care system. It is then the physician who has to deal with the symptoms, diseases, and associated problems that the individual decides require skilled professional management. Physicians cannot, however, limit their activities to care of the sick. They must carefully examine the role of medicine and its emphasis on disease, acute care, modern hospitals, and advanced technology, as well as on professional and financial rewards for nonprimary care practitioners. Why has medicine accorded a low priority to health care services, particularly long term care, needed by the aged and disabled? Why does medicine give lower status to professionals who provide primary care and work in long term care institutions?

Medicine's view of its function have a profound impact on the views and actions of society. Medical care generally is equated with improved health and well-being. More and more resources are being invested in its development. The number of social and behavioral disorders that are included within the jurisdiction of medicine and its practitioners is increasing, lending support to the claim that American society is being medicalized. As a result of the policies that flow from this perspective, aging is being medicalized with extremely negative consequences, both for the aged and for the costs of health care. The deleterious results of this policy emphasis have been: (1) a failure to deal with the basic income, housing, and nonmedical social support needs of the aged that might prevent, delay, or reduce the need for medical services; (2) high costs, which have had a major impact on public expenditures at the State and Federal levels, thereby limiting the availability of funds for other needs; and (3) gross inequities among States in eligibility for services and in the scope and duration of services provided.

Prospects for the Future

Policies affecting health care for the aged and other disadvantaged groups reflect the values of the medical profession and the profession's influence on public policy. Medicare emphasizes acute care, particularly hospital care. The systems of reimbursing physicians and hospitals have had a major impact on rising medical care costs, and they are increasingly pricing the aged and the poor out of the mainstream of medical care. Medicaid policies, because the poor are accorded a low priority, have been left largely in the hands of the States, thus creating great inequities in access to and quality of services.

Long term care has been medicalized, because this was the only avenue open to support the development of needed services. In the process, however, long term care has been accorded a low priority, because physicians and hospitals find it less prestigious and economically rewarding than acute care. Institutional care has been emphasized at the expense of community and home care services. Nursing homes have been required to perform multiple functions—custodial care, acute illness care, rehabilitation, chronic care, and terminal care—without the resources to perform these tasks. Alternative policies for income maintenance and housing have not been adequately considered, because the medical model has been so dominant and so costly.

This case study of health policy and the aged illustrates the vulnerability of the aged and other disadvantaged groups to the capriciousness and complexity of current Federal health policies. These public policies have serious consequences for society's disadvantaged because of their emphasis on State discretionary policies, the role of the individual, and the private sector.

In this environment of inflation and perceived fiscal crisis, we expect an exacerbation of the already existing and serious inequities among States in the eligibility and scope of services available to the most disadvantaged.

What is called for is a major reexamination of Federal and Federal-State policies affecting the health and social needs of the disadvantaged. Of major importance are income maintenance, housing, medical care, and social services policies. A basic question that must be asked is whether or not particular health policy goals and priorities (e.g., those affecting the most disadvantaged) should be national in determination rather than largely at the sufferance of State or local politics. A systematic examination of the many State policies affecting the delivery of medical care for the poor and long term care services for the aged is required in order to determine what the current "national" policies are and to define the alternatives and options. The goals of such studies should be to distinguish those responsibilities that are logically State and local in nature from those that are so significant and moral in impact that they require definitive national policy.

ACHIEVING EQUITY OF ACCESS TO THE AMERICAN HEALTH CARE SYSTEM: AN EMPIRICAL LOOK AT TARGET GROUPS

Lu Ann Aday*

Introduction

"Is there equity in the American health care system?" In particular, are women, the poor, ethnic minorities, and the handicapped able to obtain medical care when they need it? This is a central question to be addressed by this conference. Understanding the current profile of needs and access for these groups should permit better-informed solutions to the particular problems they may encounter in gaining entry to the American health care system.

The discussion that follows draws on the findings from a 1976 national survey of access to medical care to examine the existing patterns of care for many of these and other groups in an effort to provide empirical input for decisionmaking concerning who should be the special focus of any efforts to insure a more equitable system of health care delivery in this country.

Statement of the Problem

In a framework for the study of access to medical care developed by the Center for Health Administration Studies at the University of Chicago, access is defined as "those dimensions which describe the potential and actual entry of a given population group to the health care delivery system" (Aday et al., 1980). Characteristics of the delivery system itself, such as the availability and distribution of health care providers and facilities, for example, and characteristics of the population itself, such as their age, health status, whether or not they are insured or have a regular source of medical care, reflect the probable or potential levels of access to medical care while utilization and satisfaction measures may be considered indicators of actual or realized access to services.

A special case of access which is of particular interest is the problems people experience in obtaining care once a need is perceived. The greatest "equity" of access is said to exist when need, rather than structural or other individual characteristics, determines who gains entry to the health care system. To the extent that having a family doctor, insurance coverage, or actual utilization is a function of the person's general physical health or of particular presenting complaints, then an "equitable" system of health resource allocation is said to exist.

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Inequity is suggested, however, if services are distributed on the basis of demographic variables such as race, family income, or place of residence.

In the findings to be presented here potential and realized access indicators for different age, sex, race, income, and residence groupings will be examined, adjusting for the variant needs of each so that the inequity due to other population or health care system characteristics can be more clearly identified. The number of severely handicapped individuals available for analysis in this data set are quite small. Hence, they are not singled out for discussion here. They could, however, be expected to be concentrated among the elderly and low-income groups for which findings are presented.

Before presenting the recent national survey data on the access profiles for these groups, however, a summary of the literature describing the historical patterns of variation by age, sex, race, income, and residence will be examined.

Age

In general, the relationship between the volume of physician visits and age is best described as "U-shaped." Old people and the very young tend to use the most services. The elderly tend to have a higher prevalence of chronic diseases and the young a greater tendency to have care for general preventive reasons or in response to acute illness episodes. The U-shaped use curve for physician visits is reversed for dental care, however, with the youngest and oldest groups least likely to see a dentist (Aday and Eichhorn, 1972). There is evidence on many dimensions of care that the elderly tend to be less dissatisfied than young people, however (Andersen, et al., 1971).

Medicare, enacted in the mid-1960s, is credited with substantially increasing the access of the elderly to the health care system. There is evidence, however, that the Medicare program, because of its emphasis on deductibles and coinsurance has worked more to the advantage of the middle-or high-income than the low-income elderly, for whom financial barriers still exist (Davis and Reynolds, 1975; Aday, et al., 1980). Some services required by the elderly, such as drugs, dental care, and eyeglasses, for example, are still not covered by Medicare. While a greater proportion of the elderly's total medical care expenses are paid by third parties, the per capita out-of-pocket expenditures may still be higher than those of other age groups (Health Resources Administration, 1978).

Sex

As with age, variations in access to care by sex have in large measure been attributed to variant types of need for care on the part of males and females. Women have traditionally been more likely to have a regular source of medical care than have men. This is due primarily to women's need for obstetrical services during the childbearing years. (Eight percent of the women in the 1976 national study with a regular source of care reported it to be an obstetrician-gynecologist specialist.) Women have also tended to be higher utilizers of dental services than males. Levels of satisfaction with the health care in general they receive have not usually varied in a strong or consistent way for males compared to females (Aday and Eichhorn, 1972; Aday, et al., 1980).

There is a great deal of discussion in the current literature concerning how the different sex roles for males and females in this society give rise to variant types and levels of illness for men and women, however (Nathanson, 1975; Nathanson, 1977; Verbrugge, 1976), and that the design of programs to insure the most equitable access to care for each should take into account the unique health care needs and roles they play, respectively, in the social structure (Lewis, 1976; Waldron, 1976).

Income

In the past, high-income people had much better rates of potential and realized access to medical care than did the poor. There is evidence that this gap has narrowed considerably over the past 25 years—particularly in terms of overall physician contact rates and the use of services when the need arises (Bice, et al., 1972; Wilson, et al., 1977). The literature shows that substantial gaps between the poor and nonpoor still exist for dental care, however (Aday, et al., 1980), and that many of the mental health care needs of the poor may be unmet (Rosen, 1977). Further, concern is expressed that the "marginal poor" may not be able to afford to purchase insurance on their own but are not poor enough to qualify for the income-eligibility-based Medicaid program (Skinner, et al., 1978). The low-income continue to be substantial utilizers of hospital outpatient departments and emergency rooms for primary medical care needs (Salon and Rigg, 1972) and increasing concern is being expressed about the necessity for new modes for the organizing and integrating of the care provided in low-income neighborhoods (Dutton, 1978; Okada and Sparer, 1976a; Okada and Wan, 1978; Orso, 1979).

Race

As with income, many of the traditional inequities by race seem to have disappeared over the past 25 years. Whereas, in the past nonwhites were much less likely to have seen a doctor in the year than were whites, now there appear to be no differences in the rates they seek care when the need arises. Dental access differentials remain substantial, however (Aday, et al., 1980; Garcia and Juarez, 1978; Okada and Sparer, 1976b; Okada and Wan, 1979). There is evidence also that pockets of inequities exist for minorities in certain regions of the country—the rural South, for example (Greene et al., 1979; Greene and Salber, 1979; Miners, et al., 1978). As with low-income people, increasing attention is being directed to new models of health service delivery organization to improve the access of racial and ethnic minority groups (Cotterill and Eisenberg, 1979; Dutton, 1979; Holahan, 1975; Okada and Sparer, 1976a).

Residence

In the past, rural farm residents have generally had the lowest rates of realized access for physician and dental services compared to urban dwellers or people who lived in rural areas, but not on farms. They may be more likely than city residents to identify a place they would go to for care should the need arise, but they also have to travel long distances or wait a long time before being seen once there. The proportion of rural farm people with insurance coverage has also tended to be low, compared to others (Aday and Eichhorn, 1972; Kennedy, 1979).

Urban inner-city residents are another group which has traditionally experienced problems in obtaining convenient, high quality, reasonably priced care when they need it. The problems noted earlier for low-income and ethnic minorities with respect to having a routine and appropriate point of entry to the health care delivery system reflect the focus of health care reorganization policy efforts at the present time for inner-city areas as well (Skinner, et al., 1977).

The preceding overview provides an idea of the traditional profile of access to medical care for selected age, sex, race, income, and residential groupings. In the analyses that follow, the recent national data on the variation that persists for these groups, controlling for need and other inequitable factors, will be examined.

The Data

The primary data set on which the findings to be presented are based is a household survey of the United States population conducted in late 1975 and early 1976 by the Center for Health Administration Studies and the National Opinion Research Center (CHAS-NORC), the University of Chicago.

The 1975–76 study is the fifth in a series of national household surveys of health care utilization and expenditures conducted by the Center for Health Administration Studies. The previous four surveys—in 1953, 1958, 1964, and 1971—emphasized estimates of families' total health care experiences and costs while the most recent study concerned individuals' *access* to the health care system and problems they encountered in obtaining care when they needed it.

In the 1975–76 study, interviews were conducted in 5,432 households representing the noninstitutionalized population of the United States. A random adult and child under 17 years of age (if one lived in the household) were selected from each household, yielding a sample of 7,787 individuals. The overall response rate for the survey was 85 percent. In addition to a probability sample of the noninstitutionalized population, there was also supplementary sampling of persons experiencing episodes of illness, non-SMSA southern blacks and Spanish heritage persons living in the Southwestern States. These groups were thought to have special problems of access and, hence, oversampling was done to insure that a sufficient number of cases would be available for analysis. All of the tables reported here are based on weighted distributions to correct for the oversampling of these groups and to allow estimates to be made for the total noninstitutionalized population of the United States. The sampling errors associated with estimates for the minority samples are, in some cases, still quite high, however. Sampling (standard) errors are, therefore, reported in the tables so that the data can be more appropriately interpreted. In general, in discussing the findings, differences that are equal to or greater than at least two standard errors of the difference between the groups being compared (i.e., $p \leq .05$ that—difference occurred by chance) are emphasized.[1]

Multiple Classification Analysis (MCA) was used in analyzing the findings reported here (Andrews, et al., 1973). MCA is similar to dummy variable regression except that deviations are expressed for each category of the predictor (independent) variable as a deviation from the grand mean of the dependent variable. MCA is particularly useful when the predictor variables of interest are categoric and are intercorrelated (as is the case with the population characteristic breakdowns to be examined here). MCA permits the net effect of each predictor variable to be estimated, controlling for differences in other correlated variables in the model. Adjustments can be made for these nonmetric, categorical predictors and for metric (continuous, interval-level) covariates. In the analyses that follow, MCA is used to control for other equitable and inequitable factors that might account for differentials in the access scores for the subgroups being examined. The equitable factors refer primarily to need correlates. For all of the access measures examined, need measures were entered as metric covariates to adjust for differences in the categorical predictors (population subgroups of interest) due to this equitable factor. Perceived health, the sample person's worry about his or her health, and a log transformation of the number of disability days experienced during the year, not including hospital days, were used for all except the dental access measure. For that indicator whether or not the person experienced a toothache or bleeding gums during the year were entered as the need correlates. Age and sex may also be considered "equitable" control variables because of their strong association with the need measures. Family income, race, place of residence, and structural factors, such as the average time people have to wait in a doctor's office before being seen or the cost to them of the visit, refer to inequitable system or individual characteristics that may ultimately impact upon access. Adjusted percentages for any particular subgroup in the tables presented reflect adjustments for all of the other (equitable and inequitable) factors shown in the table and the need measures detailed above.

The betas reported in the tables measure the ability of a predictor to explain variation in the dependent variable after adjusting for the effects of the other predictors in the model. The betas indicate the relative importance of the various predictors. The R^2 represents the proportion of variation in the dependent variable explained by the additive effects of all the predictors in a particular model.

Definitions of the variables used in the analysis are detailed below.

Race

Rural southern blacks are blacks who reside outside SMSAs but within the Southern States; the *Spanish heritage, Southwest* group were persons residing in the Southwestern States (Arizona, California, Colorado, New Mexico, and Texas) who had Spanish surnames or who were from families in which the head or spouse spoke Spanish as a child. *Urban blacks* are actually all other nonwhites besides those in the rural southern black group. A small proportion (around 2 percent) do not actually reside in urban areas. The *majority whites* are all those who are not in any of the other three racial groups.

Poverty Level

The poverty level cutting points were based on a table of "Poverty Cutoffs" for 1975, published in *Current Population Reports,* Series P-60, No. 103 (September 1976), adjusted for family size, sex of the family head, and farm-nonfarm residence. The income levels provided in table 16 of that report were multiplied by 1.25 to include more of the marginal poor in the "poverty level" category.

Residence

A *rural farm resident* is one who resides in a place described as a farm (based on Census definition as a guide) by interviewer and which is outside an SMSA or unincorporated area within an SMSA that is in a county in which more than 50 percent of the population is defined as rural by the Census. *Rural nonfarm* people are residents of rural areas (defined above) who do not reside on farms. *SMSA, central city* residents live in the central cities of Standard Metropolitan Statistical Areas (SMSAs). *SMSA, other urban* dwellers are those who live in the suburbs of the SMSA. *Non-SMSA urban* refers to places that are not farms and which are in incorporated areas of 2,500 or more outside SMSAs.

Regular Source of Medical Care

Respondents were asked, "Is there one person or place in particular you usually go to when you are sick or want advice about your health?" Those respondents who said they had some place they usually went to for medical care were asked, "Is that a medical doctor, an osteopath, a chiropractor or what?" Respondents who reported they saw a medical doctor or osteopath were queried further: "Is there one doctor in particular you usually see at (PLACE)?" In 1976 respondents who said they used medical doctors (M.D.s) or osteopaths and said "yes" to the question concerning whether they saw "one doctor in particular" were characterized as having a "particular doctor" care source.

Persons who reported having a regular source of care were asked, "Where do you usually go—to a doctor's office, a clinic, a hospital or some other place?" The responses for a hospital (OPD or ER) are reported here.

Respondents with a regular source of care were asked about how long they usually had to wait to see the *doctor,* once they got there. This referred to time he or she waited before seeing the doctor, including any time he/she waited in an examining room before the doctor came to see him/her.

Insurance Coverage

People were said to have *private coverage* if they reported that they bought a policy directly themselves or if health insurance was provided through place of work or other group membership (Grange, Farm Bureau, Medical Society, group retirement plan, etc.). *Public coverage* includes those who had either Medicaid, Medicare, or other reduced price form of care and no private coverage. The *uninsured* are those who had neither of these forms of coverage.

Doctor Visit in the Year

A physician visit includes seeing either a medical doctor or osteopath or his nurse or technician at the following sites: patient's home; doctor's office or private clinic; hospital outpatient department or emergency room; industrial, school, camp, or college health service; or any other clinic such as a board of health clinic or neighborhood health center. The variable reported here refers to the proportion of the sample who did not have at least one contact of this kind with a physician during the survey year.

Dentist Visit in the Year

Sample people were asked whether they had visited a dentist within the 12 months preceding the interview. This question was not asked about infants, however.

Dissatisfaction with Most Recent Medical Visit

People who had a visit to a physician within the survey year were asked how satisfied they were with various aspects of their most *recent* visit—completely, mostly, moderately, slightly, or not at all satisfied. People who were "completely" or "mostly" satisfied were characterized as being "satisfied" with that aspect of the visit. All others were classified as being "dissatisfied." Satisfaction levels with the cost and office waiting time on that visit are reported here. Only people who paid something out-of-pocket for their most recent visit were asked how satisfied they were with the cost of that visit. Proxy respondents who accompanied the sample person reported how satisfied they were with the care the person received during that visit to the doctor.

Infants under 1 year of age are not included in the analyses to follow.

Findings

Tables 1–6 deal with indicators of potential access, especially the organization and financing factors which may impact on whether or not care is eventually sought. Tables 7–10 refer to both objective (utilization) and subjective (satisfaction) indicators of realized access.

The statistical procedure used described earlier—Multiple Classification Analysis—factors out the effect of the other variables identified in the table for any particular population group. For example, the estimates reported for race control for income differences among the respective racial groups as well as for any differences in their age and sex distributions and where they live. Other statistics reported in the tables provide information about how accurate and/or important the results for any given population characteristics—age, sex, race, etc.—may be in understanding its relationship to the access indicator being examined. The numbers in parentheses in the tables—the standard errors—indicate the range of accuracy for any particular access measure. Because of the inevitable errors associated with drawing a sample rather than interviewing the entire population or conducting a census to obtain information, it is more appropriate to specify a range of values for estimates obtained through a survey such as the one reported here. Any findings for the groups reported in the tables are then more accurately interpreted as the percentage figure plus or minus its sampling error, e.g., according to table 1, 14 percent ± 3.5 percent, that is, from 10.5 percent to 17.5 percent of the Spanish heritage, Southwest group had no regular source of care. We can be confident that about two-thirds of the time the "true" value for this group falls within this range and 95 percent of the time the estimate would be contained in the range specified by two standard errors around the estimate, i.e., 14 percent ± 7.0 percent. Sampling errors can also be computed for the *difference* between two groups (e.g., poor and nonpoor) using the following formula:

$$\begin{matrix}\text{standard error}\\\text{of difference}\end{matrix} = \sqrt{\begin{pmatrix}\text{standard error for}\\\text{group 1}\end{pmatrix}^2 + \begin{pmatrix}\text{standard error for}\\\text{group 2}\end{pmatrix}^2}$$

Ninety-five percent of the time groups would "truly" differ if the difference between them were equal to or greater than two standard errors of the difference. This is the criterion used in deciding which differences to emphasize in the discussion that follows. The betas shown in the tables indicate how important a particular characteristic is in influencing the access indicators after taking into account all the other characteristics in the table. A higher beta means the factor (e.g., age) is a more important determinant of that aspect of access than are those with lower values. The R^2 provides an indication of what percent of the variation in the access measure is explained by the factors looked at here. A low value means that other aspects may need to be taken into account in understanding what influences this particular type of access experience.

In discussing the findings for tables 1 through 10, those factors which seem to be most associated with the access measure (have the highest betas) will be emphasized initially. Groups with scores that differ at least two standard errors of the difference will be noted and the relative amount of variance explained by the variables considered here discussed. Other factors which it may be relevant to take into account in further analyses of this access dimension will be cited.

According to table 1, age is the most important predictor, of the several considered here, of whether or not a person has an identifiable point of entry to the health care system. Young children are much more likely to have a regular place they go to for care than are young adults and those in the older-aged categories. As has been the case traditionally, men are less likely to report one place or provider they usually go to for care than are women.

Adjusting for other factors there appears to be no significant difference among the racial groups with respect to having a regular source of medical care or not. Income continues to be an important predictor of whether or not people have a place they can identify as one they go to routinely when they need care, however. More poor than those whose incomes are above the poverty level do not have a regular medical provider. Residents of large urbanized SMSA areas are more likely to have no routine point of entry to the system—particularly compared to rural farm people.

Only 5 percent of the variance in this indicator of potential access is explained by the model analyzed here, suggesting that other factors may help account for whether or not people have a regular source of care. Other analyses have suggested that whether or not a person has third-party insurance coverage is a particularly important determinant of whether they have a relationship with a regular medical care provider (Aday, et al., 1980).

Table 2 looks at the impact of the various equitable and inequitable factors—for those who do have a regular source of care—on whether they usually see one particular doctor when they go. It is apparent that race is a particularly important determinant of the particular model of care people use routinely. Urban blacks are much less likely to have a relationship with a single family doctor. This effect exists independent of income differences among the respective racial groups.

Though the elderly, as we saw earlier, may be less likely to have a regular source of care than the very young, once they do, they are more apt than are children to have a single physician they see when they go. There is no difference in the rates at which males and females see one doctor regularly when they go for care. There is a tendency for the poor and residents of SMSAs not to have a single provider as their regular source of medical care.

Once again, only a small percent of the variance (5 percent) in this model is explained by the variables considered here.

Table 3 provides further detail on the profile of care for different target groups. Clearly the fact that such a large proportion of urban blacks use hospital emergency rooms and outpatient departments helps to explain the finding in table 2 that they are not as apt to identify a single physician as their regular family doctor. Though not reported in this particular table, around 1 percent of the U.S. population uses publicly-supported clinics as their regular source of medical care. The percentages are higher for minority groups—especially urban blacks and Spanish heritage persons in the Southwest, of whom 4 percent and 5 percent, respectively, report using such facilities. The proportion of majority whites using public clinics as a routine source of primary care is miniscule—fewer than 1 percent.

Young children tend to use hospital emergency rooms more often than do the elderly. There are no significant differences in the rates at which men and women use this type of facility for routine medical care. Poor people and inner-city residents tend to make greater use of hospital ERs or OPDs than do the well-to-do or people who live outside the inner cities of large urban centers.

Approximately 9 percent of the variance in where people routinely go for medical care is explained by the variables considered here.

Where one lives appears to be the best predictor of how long people may have to wait for care (table 4). Even though, as we have seen earlier, inner-city residents are less likely to have a routine source of care, or if they do, it is more apt to be a hospital outpatient department or emergency room than is the case for people who live in rural areas, especially. It is this latter group that may still have the longest waits before getting in to see the physician. The large patient loads of rural solo providers and an informality about scheduling appointments in advance to see patients undoubtedly keeps account for this finding.

The differences by age and sex are not statistically significant. The findings for rural residents and inner-city populations are mirrored in the waiting times reported by urban and rural southern blacks. Poor people, in general, average much longer waiting times than do the nonpoor.

Much of the variance in this indicator remains unexplained. The relative variation among subgroups reported here does point to certain target populations, e.g., rural farm dwellers and rural southern blacks, who may be at a disadvantage, relative to others, in terms of the convenience they experience in obtaining care, however. Other analyses suggest that whether or not appointments are arranged in advance for a visit is an especially important determinant of how long people actually wait to be seen, once there, however (Aday et al., 1980).

Table 5 shows the groups which at the present time are most apt to have no form of third-party coverage. Family income continues to be a very strong predictor of whether or not a person has health insurance. Almost three times as many of the poor compared to the nonpoor have no form of coverage against the potentially high cost of illness.

Even controlling for income differences, over one-fourth of the Spanish heritage population have no health insurance coverage. The relationship of residence to insurance coverage is not significant, controlling for other factors. The "universal" coverage provided the elderly by Medicare is reflected in the fact that no people 65 years or older are reportedly "uninsured." There are no significant differences, controlling for other factors, in the insurance coverage status for males and females.

Around 10 percent of the variance in insurance coverage status is explained by the model examined here. Where one works and the nature of this employment are apt to be other important determinants of whether or not a person is insured, since, for many people, health insurance benefits are available through their job.

As might be expected, income status is a good predictor of whether one has publicly subsidized insurance coverage benefits (Medicaid, Medicare, or other reduced price form of care) (table 6). Urban blacks are more likely to have this form of coverage than are any of the other racial groups.

Approximately 35 percent of people 65 and over have public coverage only—reflecting the importance of Medicare to this age group, which is less likely to purchase private health insurance on their own or to have it through their jobs, since such a large proportion of the elderly are, of course, retired or not working. There is no significant difference in the rates of public coverage reported by males and females nor by place of residence.

Over 20 percent of the variance in this indicator is explained by the variables examined here. Age, race, and income are strong predictors of whether or not public third-party coverage is the primary source of protection against the potentially high cost of serious illness.

Even adjusting for variant levels of need, it is apparent from table 7 that young children are most likely of any age group to have seen a doctor at least once in the year. Males are much less likely than females to have seen a physician—as has generally been the case in the past.

The noncontact rates for rural southern blacks, the Spanish heritage population, and the poor remain high—compared to other racial groups and the nonpoor. Though the income differential in access has certainly narrowed over time, some inequity does remain along this dimension. The proportion of the rural farm population not having seen a physician similarly is somewhat high compared to the national average.

Fourteen percent of the variance in physician contact rates is accounted for by the factors considered in this model.

As was suggested earlier in a review of the profiles of dental care for different age groups, it is the very young and the very old who have the lowest rates of dental contact (table 8). Males continue to see a dentist less often than females.

The dental noncontact rates is high for all minority groups compared to majority whites. Rural southern blacks in particular are much less likely to have seen a dentist at all in the year as have Spanish heritage people residing in the Southwestern States. Income continues to be a strong predictor of whether or not dental care is sought and SMSA residents appear to more likely have seen a dentist in the year compared to those who live outside SMSAs.

The variables examined here account for 11 percent of the variation in dental contact rates.

The most important predictor of whether or not a person is satisfied with the out-of-pocket cost of medical care is, as we might expect, the cost of the visit itself (table 9). The level of dissatisfaction is more than twice as high for those who paid $25 or more for the visit compared to those who paid $10 or less. Poor people are also more dissatisfied than are the nonpoor.

Parents of young children tend to be unhappier with what they have to pay for their care than is true for the other age groups. There is little or no systematic variation by sex. Nonwhites tend to be unhappier with the cost than are whites.

Eight percent of the variance in satisfaction with the out-of-pocket cost of care is explained by the cost itself and the other factors examined here.

People who have to wait more than half an hour before being seen by their doctor are much more dissatisfied than those who are able to see the provider in half an hour or less (table 10).

As was the case with satisfaction levels for the cost of the recent visit, parents of young children tend to express more dissatisfaction about the time they had to wait to obtain care than is true for the elderly, for example. Urban blacks tend to be unhappier with the time they have to wait than are majority whites.

The length of time the person waits to see the doctor and other factors considered in this model account for 12 percent of the variance in levels of satisfaction with this aspect of care.

Summary and Conclusions

The preceding analyses have presented data on how potential and realized access rates vary for selected age, sex, race, income, residence, and other target groups. Table 11 summarizes the results of the analyses reported in tables 1–10.

What are the implications regarding current profiles of access that may be drawn from the findings reported here for these different groups?

Age

Age remains a good predictor of both potential and realized access rates. There are well-documented variations in the patterns of care, as one might expect, for the very old and the very young. Because the elderly have been a special target of major health policy initiatives during the past 20 years via the Medicare program, let us focus on their access profiles in particular in the light of the data just presented.

The elderly do not compare that unfavorably to the national average in terms of the proportion of them that report having a regular source of medical care. Around 11 percent (2 million elderly) do not. The fact that this number of elderly do not have a regular place to go for care may still be interpreted as a problem, since this is a group which tends to require the services of a physician for illness-related care on a more regular basis than do the young. Most of the elderly who have some place they do usually go do have one doctor that usually sees them when they go. The vast majority of the elderly go to private doctors' offices rather than hospital outpatient departments or emergency rooms or public clinics. The impact of Medicare is reflected in the fact that almost no one 65 years of age or over is "uninsured," although more than a third of the elderly do report that Medicare is their *only* form of third-party coverage. About one-fifth of the elderly (over 4 million people) did not see a physician at all in the year. The number not seeing a dentist is much higher (almost 14 million individuals), primarily reflecting the lower dental care need for this age group—particularly compared to young children 6–17 years of age. Levels of dissatisfaction expressed by the elderly tend to be somewhat lower than that registered by parents of young children about their child's health care, for example.

In sum, the general access measures cited here do not suggest that there are substantial potential or realized access problems for the elderly at the present time. There are potential financial problems that result (especially for the elderly who are only covered by Medicare) from not being fully insured for some services that should be mentioned, even though they are not addressed directly in the general access findings reported here.

While a greater proportion of the elderly's expenses are paid by third parties, their per capita out-of-pocket expenditures are considerably higher than those of any other age group. This happens because their total expenditures are high and some services such as drugs, dental care, and many appliances, such as eyeglasses, are not covered by Medicare (Health Resources Administration, 1978). A related problem is the limited coverage of Medicare for long term illness and nursing home care. Medicare currently limits coverage to 90 consecutive days in the hospital and nursing home coverage is provided for 100 days, but only if preceded by a stay in an acute hospital. Consequently, it is possible for elderly persons with extended illnesses to exhaust Medicare, supplementary insurance coverage, and whatever personal reserves they have, and subsequently become dependent on Medicaid and welfare. These financial problems, while not highlighted in this study, do indicate the need for supplementary third-party financing for catastrophic and long term cost of illness experienced by the elderly.

Sex

As has been the case traditionally, women are more likely to report having a regular source of care and higher physician and dentist contact rates in general. There are no substantial sex differences controlling for need and other factors for the other indicators examined here.

Women do, however, have special health care needs associated with their childbearing responsibilities—prenatal care and gynecological-related screening for cervical and breast cancer, for example. Though the vast majority of women do see a physician during the first 3 months of pregnancy, there is evidence that low-income women may still be less apt to do so. Further, though over half of the adult women in this country have a pap smear or breast examination at least once a year, low-income females and those who are poorly educated are less likely to have these (Aday et al., 1980). As noted earlier, there is also concern expressed that women may have to see more than one type of physician in order to have their total health care needs met (obstetrician-gynecologist in addition to an internist or GP, for example). These unique health care problems of women and their implications for the type and frequency of contacts with the health care system then should be taken into account in evaluating women's overall medical care access.

Race

The gaps between whites and nonwhites with respect to both potential and realized access indicators have narrowed considerably over the past 25 years. The preceding analyses suggest that racial inequities do persist along certain access dimensions, however, even when income differences are controlled. Urban blacks are much more likely than other groups to use hospital emergency rooms or outpatient departments as their regular source of care and, hence, much less likely to have a regular family doctor they would go to should the need arise. They and rural southern blacks tend to average long waits before being seen when they go for care. A large proportion of the Spanish heritage have no form of public or private coverage and a large number of urban blacks have only publicly subsidized health insurance (Medicaid, Medicare, or other reduced price form of care). The realized access rates for physician and dentist services remains low for the Spanish heritage and rural southern black population groups in particular. Nonwhites tend to be more dissatisfied than whites with the cost of care and urban blacks are unhappier than majority whites with the average time they have to wait to see a doctor when they go.

Income

As with the race variable, though the access gaps by income have narrowed considerably, income remains an important determinant of whether or not a person does have a regular source of care, if so—what kind, whom they see there, and how long they may have to wait, on average, when they go; whether or not they are insured and how (public or private); whether or not they have actually seen a doctor and particularly a dentist in the year; and whether they are satisfied with the cost of their medical care.

Residence

Where one lives continues to influence one's potential and realized access rates. Inner-city residents, for example, make extensive use of hospital outpatient departments and emergency rooms as their regular source of medical care. Rural farm dwellers, who most often see GP solo practice providers, report particularly long waits at their regular source of care and low physician contact rates overall. In general, people who live in large urban centers (SMSAs) are more apt to have seen a dentist than those who reside in other areas.

In summary, though many medical access inequities have narrowed, great possibilities would seem to exist through various health care reorganization strategies for continuing to improve the potential and realized access to general health care services. System reorganization approaches such as enrolling groups of individuals in Health Maintenance Organizations or converting the fragmented services of hospital outpatient departments to comprehensive, family centered group practice models could help to reduce the inconvenience and dissatisfaction which the poor and ethnic (especially urban and rural southern black) minorities now frequently experience in obtaining care through existing arrangements. Encouraging physicians and patients to set up appointment systems to reduce the queues for care in big city outpatient departments and overcrowded solo general practitioners' offices in the rural South could bring about improvements in access, as would efforts to insure that patients are able to have one provider they can identify and relate to as *their* family doctor.

Major financing initiatives (Medicare and Medicaid) have been credited with reducing many of the historical inequities—by race and income in particular—over the past two decades. There is evidence that the relative status of certain groups could still be enhanced if more universal third-party financing were available. Ethnic minorities—especially the Spanish heritage population—have lower rates of third-party coverage than do the majority white population. Educational and occupational status differences help explain these differentials. Poorly educated ethnic minorities are less likely to be in jobs that provide such coverage. Further, the marginal working poor are still not "poor" enough to qualify for Medicaid. Special attention should, it seems, be devoted to those groups that "fall between the cracks" of existing third-party schemes in designing new Federal financing initiatives. There is evidence that financial barriers significantly affect individuals' potential and realized access and how satisfactory they consider their experience in obtaining care to be. Options which focus on providing coverage to those persons who currently have no protection against the potentially high cost of illness and the integration of these financing mechanisms with models of service delivery which attempt to contain the cost and insure the quality and convenience of care to consumers are needed to reduce the persisting inequity.

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TABLE 1

Potential Access Barriers: Percent With No Regular Source of Medical Care
For Selected Target Groups
Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WITH NO REGULAR SOURCE OF MEDICAL CARE	
AGE		
1-5 years	4%	(1.1)
6-17	8	(1.0)
18-64	15	(0.6)
65 and over	11	(1.3)
BETA		.12
SEX		
Male	15	(0.6)
Female	10	(0.6)
BETA		.08
RACE		
Majority White	12	(0.6)
Urban Black	14	(1.5)
Rural Southern Black	12	(2.3)
Spanish Heritage, Southwest	14	(3.5)
BETA		.02
POVERTY LEVEL		
Nonpoor	11	(0.5)
Poor	17	(1.1)
BETA		.08
RESIDENCE		
SMSA, central city	15	(0.8)
SMSA, other urban	13	(0.8)
NonSMSA urban	9	(1.3)
Rural nonfarm	10	(1.0)
Rural farm	6	(1.5)
BETA		.08
National Average	12%	(0.5)
R^2		.05

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 2

Potential Access Barriers: Percent With Regular Source of Medical Care Who Do Not See Particular Doctor
For Selected Target Groups
Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WITH REGULAR SOURCE OF MEDICAL CARE WHO DO NOT SEE PARTICULAR DOCTOR	
AGE		
1-5 years	11%	(1.5)
6-17	9	(1.0)
18-64	9	(0.6)
65 and over	4	(0.9)
BETA		.06
SEX		
Male	10	(0.6)
Female	9	(0.6)
BETA		.02
RACE		
Majority White	7	(0.5)
Urban Black	24	(2.2)
Rural Southern Black	6	(1.7)
Spanish Heritage, Southwest	9	(3.5)
BETA		.16
POVERTY LEVEL		
Nonpoor	8	(0.5)
Poor	11	(0.8)
BETA		.04
RESIDENCE		
SMSA, central city	11	(0.8)
SMSA, other urban	10	(0.8)
NonSMSA urban	7	(0.9)
Rural nonfarm	7	(0.8)
Rural farm	6	(1.5)
BETA		.06
National Average	9%	(0.5)
R^2		.05

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 3

Potential Access Barriers: Percent Who Use Hospital Emergency Room Or Outpatient Department As Regular Source of Care For Selected Target Groups Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WHO USE HOSPITAL EMERGENCY ROOM OR OUTPATIENT DEPARTMENT AS REGULAR SOURCE OF CARE		
AGE			
1-5 years	9%	(1.5)	
6-17	7	(0.8)	
18-64	7	(0.5)	
65 and over	5	(1.1)	
BETA			.04
SEX			
Male	8	(0.8)	
Female	6	(0.5)	
BETA			.03
RACE			
Majority White	5	(0.5)	
Urban Black	26	(2.9)	
Rural Southern Black	6	(1.7)	
Spanish Heritage, Southwest	4	(2.4)	
BETA			.23
POVERTY LEVEL			
Nonpoor	6	(0.5)	
Poor	11	(1.0)	
BETA			.08
RESIDENCE			
SMSA, central city	10	(1.0)	
SMSA, other urban	6	(0.6)	
NonSMSA urban	5	(0.9)	
Rural nonfarm	7	(0.8)	
Rural farm	5	(1.5)	
BETA			.07
National Average	7%	(0.4)	
R^2			.09

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 4

Potential Access Barriers: Percent Who Wait More Than 30 Minutes In Office To See Regular Source Of Care For Selected Target Groups Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WHO WAIT MORE THAN 30 MINUTES IN OFFICE TO SEE REGULAR SOURCE OF CARE		
AGE			
1-5 years	30%	(2.3)	
6-17	37	(1.7)	
18-64	37	(1.0)	
65 and over	35	(2.4)	
BETA			.04
SEX			
Male	35	(1.3)	
Female	37	(1.0)	
BETA			.02
RACE			
Majority White	35	(1.0)	
Urban Black	40	(3.3)	
Rural Southern Black	44	(3.8)	
Spanish Heritage, Southwest	34	(5.4)	
BETA			.04
POVERTY LEVEL			
Nonpoor	35	(0.8)	
Poor	42	(1.7)	
BETA			.06
RESIDENCE			
SMSA, central city	32	(1.6)	
SMSA, other urban	32	(1.2)	
NonSMSA urban	43	(2.1)	
Rural nonfarm	40	(1.7)	
Rural farm	47	(3.4)	
BETA			.11
National Average	36%	(0.8)	
R^2			.03

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 5

Potential Access Barriers: Percent With No Insurance Coverage For Selected Target Groups Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WITH NO INSURANCE COVERAGE		
AGE			
1-5 years	13%	(1.5)	
6-17	11	(1.0)	
18-64	13	(0.6)	
65 and over	0	(0.0)	
BETA			.12
SEX			
Male	15	(0.6)	
Female	11	(0.6)	
BETA			.00
RACE			
Majority White	10	(0.6)	
Urban Black	12	(1.5)	
Rural Southern Black	11	(2.3)	
Spanish Heritage, Southwest	28	(5.4)	
BETA			.11
POVERTY LEVEL			
Nonpoor	8	(0.5)	
Poor	23	(1.2)	
BETA			.19
RESIDENCE			
SMSA, central city	12	(0.8)	
SMSA, other urban	10	(0.8)	
NonSMSA urban	8	(1.3)	
Rural nonfarm	12	(1.0)	
Rural farm	14	(2.0)	
BETA			.05
National Average	11%	(0.5)	
R^2			.08

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 6

Potential Access Barriers: Percent With Public Insurance Coverage Only For Selected Target Groups Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WITH PUBLIC INSURANCE COVERAGE ONLY	
AGE		
1-5 years	12%	(1.5)
6-17	8	(1.0)
18-64	6	(0.5)
65 and over	35	(2.0)
BETA		.28
SEX		
Male	10	(0.6)
Female	10	(0.6)
BETA		.01
RACE		
Majority White	9	(0.6)
Urban Black	21	(2.0)
Rural Southern Black	12	(2.3)
Spanish Heritage, Southwest	12	(3.5)
BETA		.12
POVERTY LEVEL		
Nonpoor	6	(0.4)
Poor	25	(1.2)
BETA		.27
RESIDENCE		
SMSA, central city	10	(0.8)
SMSA, other urban	10	(0.8)
NonSMSA urban	8	(1.3)
Rural nonfarm	11	(1.0)
Rural farm	8	(2.0)
BETA		.03
National Average	10%	(0.5)
R^2		.22

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 7

Realized Access (Utilization): Percent With No Doctor Visit in Year For Selected Target Groups Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WITH NO DOCTOR VISIT IN YEAR		
AGE			
1-5 years	13%	(1.5)	
6-17	29	(1.6)	
18-64	24	(0.9)	
65 and over	22	(1.7)	
BETA			.09
SEX			
Male	28	(1.0)	
Female	21	(0.9)	
BETA			.08
RACE			
Majority White	24	(0.9)	
Urban Black	22	(2.0)	
Rural Southern Black	29	(3.0)	
Spanish Heritage, Southwest	30	(5.4)	
BETA			.04
POVERTY LEVEL			
Nonpoor	22	(0.6)	
Poor	30	(1.2)	
BETA			.07
RESIDENCE			
SMSA, central city	24	(1.2)	
SMSA, other urban	22	(1.1)	
NonSMSA urban	26	(1.9)	
Rural nonfarm	24	(1.5)	
Rural farm	30	(3.1)	
BETA			.05
National Average	24%	(0.7)	
R^2			.14

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 8

Realized Access (Utilization): Percent With No Dentist Visit In Year For Selected Target Groups Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT WITH NO DENTIST VISIT IN YEAR		
AGE			
1-5 years	71%	(2.3)	
6-17	36	(1.7)	
18-64	52	(1.1)	
65 and over	64	(2.0)	
BETA			.20
SEX			
Male	54	(1.1)	
Female	48	(1.1)	
BETA			.06
RACE			
Majority White	48	(1.1)	
Urban Black	62	(2.5)	
Rural Southern Black	70	(3.5)	
Spanish Heritage, Southwest	65	(4.6)	
BETA			.12
POVERTY LEVEL			
Nonpoor	48	(0.8)	
Poor	64	(1.3)	
BETA			.13
RESIDENCE			
SMSA, central city	47	(1.4)	
SMSA, other urban	49	(1.4)	
NonSMSA urban	54	(2.1)	
Rural nonfarm	56	(1.7)	
Rural farm	6	(3.4)	
BETA			.07
National Average	51%	(0.8)	
R^2			.11

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 9

Realized Access (Satisfaction): Percent Dissatisfied With Cost Of Most Recent Medical Visit
For Selected Target Groups
Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT DISSATISFIED WITH COST OF MOST RECENT MEDICAL VISIT		
AGE			
1-5 years	45%	(3.3)	
6-17	36	(2.4)	
18-64	36	(1.7)	
65 and over	35	(3.2)	
BETA			.06
SEX			
Male	36	(1.7)	
Female	38	(1.3)	
BETA			.02
RACE			
Majority White	37	(1.3)	
Urban Black	40	(5.4)	
Rural Southern Black	41	(6.3)	
Spanish Heritage, Southwest	34	(8.6)	
BETA			.02
POVERTY LEVEL			
Nonpoor	36	(1.3)	
Poor	45	(2.5)	
BETA			.07
OUT-OF-POCKET COST OF MOST RECENT MEDICAL VISIT			
$1-10	26	(1.5)	
$11-24	43	(1.7)	
$25 or more	58	(2.5)	
BETA			.25
National Average	37%	(1.0)	
R^2			.08

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 10

Realized Access (Satisfaction): Percent Dissatisfied With Office Waiting Time On Most Recent Medical Visit
For Selected Target Groups
Adjusted For Other Equitable and Inequitable Factors†—1976

TARGET GROUPS	PERCENT DISSATISFIED WITH OFFICE WAITING TIME ON MOST RECENT MEDICAL VISIT		
AGE			
1-5 years	33%	(2.3)	
6-17	26	(1.9)	
18-64	28	(1.2)	
65 and over	21	(2.0)	
BETA			.06
SEX			
Male	26	(1.2)	
Female	28	(1.2)	
BETA			.02
RACE			
Majority White	26	(0.9)	
Urban Black	34	(3.2)	
Rural Southern Black	31	(4.7)	
Spanish Heritage, Southwest	28	(6.2)	
BETA			.05
POVERTY LEVEL			
Nonpoor	26	(0.9)	
Poor	29	(1.6)	
BETA			.02
OFFICE WAITING TIME ON MOST RECENT MEDICAL VISIT			
30 minutes or less	16	(0.9)	
More than 30 minutes	47	(1.7)	
BETA			.33
National Average	27%	(0.7)	
R^2			.12

† Scores for any particular group are adjusted for other target group characteristics. Equitable factors refer to age, sex and need. Inequitable factors are the other target group characteristics shown in the table. Numbers in parentheses are the standard errors of these estimates.

TABLE 11

Summary of Findings on Potential and Realized Access Indicators For Selected Target Groups*

ACCESS INDICATORS	TARGET GROUPS Age	Sex	Race	Poverty Level	Residence	Other
POTENTIAL						
Percent with no regular source of care	+	+	0	+	+	NA
Percent with regular source of care who do not see particular doctor	+	0	+	+	+	NA
Percent who use hospital emergency room or outpatient department as regular source of care	+	0	+	+	+	NA
Percent who wait more than 30 minutes in office to see regular source of care	0	0	+	+	+	NA
Percent with no insurance coverage	+	0	+	+	0	NA
Percent with public insurance coverage only	+	0	+	+	0	NA
REALIZED						
Utilization						
Percent with no doctor visit in year	+	+	+	+	+	NA
Percent with no dentist visit in year	+	+	+	+	+	NA
Satisfaction						
Percent dissatisfied with cost of most recent medical visit	+	0	+	+	NA	+ actual out-of-pocket
Percent dissatisfied with office waiting time on most recent medical visit	+	0	+	0	NA	+ actual office waiting time

*Symbols in table may be interpreted as follows:

+ Statistically significant relationship with access indicator
0 No statistically significant relationship with access indicator
NA Not applicable—not examined for particular access indicator

These results assume that the findings for any particular target group control for the other characteristics listed and need (e.g., findings for racial groups adjust for age, sex, income, place of residence and health level differences among them).

ENDING DISCRIMINATION IN HEALTH CARE: A DREAM DEFERRED

Sylvia Drew Ivie*

Introduction

Discrimination against minorities in the health care system is a problem with deep historical roots. Separate but "equal" facilities, thought by many to have vanished years ago, continue to be a problem today. Even the advent of major Federal health financing programs such as Medicare and Medicaid have failed to accomplish their stated purposes of bringing minorities, particularly the poor, into the mainstream of the American health care system.

Forty-five million Americans still are without adequate access to health care.[1] A disproportionately large number of these 45 million are minorities. Although frequently studied, little has been done to address this national disgrace.

This paper is divided into three parts. The first section documents the health status of minorities, especially the gaps in health status between minorities and white Americans. The second section describes the factors that have led to this unacceptable health status. The third section recommends a number of changes to improve minority health status, with special emphasis on the failure of the Federal Government to perform its legal obligations.

Minority Health Status

Birth and Infancy

In America minority children have less chance of being "well born" and less chance of living a long life, free of disease and disability, than do white children.

Decreases in infant mortality are taken as a sign, indeed almost a symbol, of how far the country has come in providing health care to all its people. But, unfortunately, that symbol is tarnished. There has been progress made in reducing minority infant mortality rates, but not nearly enough in a country which spends more money on health care than any other on earth.

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I gratefully acknowledge the invaluable assistance of my colleagues at the National Health Law Program, Geraldine Dallek, David Chavkin, and Lucien Wulsin in the revision of the initial draft of this paper.

[1] "Are Neighborhood Centers Providing Services Efficiently and to the Most Needy?" Comptroller General Report to Congress (Wash., D.C.: GAO TRD-77-124, 1978.

Data indicate that the gap between white and black infant mortality rates has actually increased over the past 27 years.[2] Black infants are nearly twice as likely to die before their first birthdays as white infants. The death rate in 1977 for black infants (23.6 per 1,000 live births) was nearly double that for white infants (12.3 per 1,000) and about the same as that for white infants 25 years ago.[3]

The inability of this Nation to address the issue of newborn minority deaths is nowhere more evident than in Washington, D.C. D.C. General is the city's poor people's hospital. Located in southeast Washington, it is the primary provider of care for poor blacks living in Wards 7 and 8, east of the Anacostia River. Fully three-quarters of the women delivering their babies at D.C. General have high-risk pregnancies. The hospital's infant death rate during 1977 and 1978 far exceeded (in one instance tripled) that of any other D.C. hospital; in these 2 years, one-quarter of the city's newborn babies who died had been born at D.C. General—almost all were black.[4]

Across the Nation, in Oakland, California, an infant born of poor black parents in one section of the city is more than six times as likely to die as an infant born of well-to-do, white parents living only a few miles away in another part of the city.[5]

The high black infant mortality rates in Washington, D.C., and Oakland, California, are not aberrations—in every part of this Nation, black newborns die before they have a chance to live, at a rate far exceeding that of white newborns.[6]

Nor are blacks the only minority in America to suffer from high infant mortality rates. The second largest minority in America consists of persons of Spanish origin. There are cavernous gaps in the amount of health data available for this population and its subgroups (persons of Mexican, Puerto Rican, Cuban, Central or South American origin as well as "other Spanish," primarily from Europe).[7]

Nevertheless, some studies and statistics, while not definitive, give credence to the fear that infant mortality among segments of the Hispanic community may be as high as in the black community.

Nearly 1 in every 200 births in the United States occurs at Women's Hospital, a part of the Los Angeles County Public Hospital system. Eighty-five percent of the babies delivered at the hospital are

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[2] *Health, United States,* 1979, DHEW Pub. No. (PHS) 80–1232, p. 12.

[3] *Id.*

[4] Susan Okie, "Keeping the Babies Alive," *The Washington Post,* June 18, 1980.

[5] California Department of Health Services, *Report to the Legislature Pursuant to House Resolution Number 70,* Jan. 16, 1979, p. 92.

[6] *Health, U.S.,* 1979, *op. cit.* pp. 92–93.

[7] There is no consensus over the proper name for persons in the United State of Spanish origin. See David E. Hayes - Bautista, "Identifying 'Hispanic' Populations: The Influence of Research Methodology Upon Public Policy," *Amer. J. of Public Health,* April 1980, Vol. 7, no. 9, pp. 353–56. For purposes of this report, the term Hispanic will be used to describe persons of Spanish origin from third-world countries.

Hispanic. In 1978 the perinatal mortality rate at the hospital was 25/1,000 live births, nearly double the perinatal mortality rate for the State of California (14.2 per 1,000).[8] Indeed, statewide, the infant mortality rate among the Hispanic population is higher than that of the population as a whole.[9]

The infant mortality rate among the migrant population is 25 percent higher than the national rate. One study of migrant workers in Wisconsin found that of the 145 women surveyed, 35 or 15 percent had experienced one or more children dying after birth.[10]

In south Texas in 1970, 43 pecent of all "Mexican Americans" lived at or below the poverty level. A study by the University of Texas at Austin determined that 50 percent of the 2,000 children born in Brownsville in south Texas were born outside a hospital "without professionally supervised prenatal, child delivery, or postnatal care."[11] These children were poor and Hispanic. While no data was available on their health status, the researchers felt that the circumstances of their birth would be at least "partly responsible for infant deaths and birth-related defects of children in the area."[12]

The past reductions in infant minority mortality have been promising. Nevertheless, in this area, nonwhites still lag one whole generation behind whites, and minority infant death rates in America are triple the infant death rate of Sweden. We still have a long way to go, and the future looks more despairing than the past. The recent Supreme Court decision upholding the constitutionality of the Hyde Amendment, combined with the continued inability of poor minority women to obtain prenatal care and omnipresent State Medicaid cutbacks, hold little promise that, at least in the near future, all American children regardless of race or national origin will start off life with equal health.

Minority Children

As America entered its third century, one out of every four children in this country lived in poverty.[13] During the 1960s the proportion of children in poverty declined, but since 1970 progress in this area has been halted.[14] A disproportionate number of these poor children are minorities. In 1974 children in black families were three and a half

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[8] Nancy O'Donnell, Perinatal Regionalization Project, Testimony before the L.A. County Board of Supervisors, Nov. 30, 1979.

[9] Chicano Health Institute of Students, Professors and Alumni, *The California Raza Health Plan*, Oct. 1979, p. 34.

[10] Doris Slesinger, *Health Needs of Migrant Workers in Wisconsin*, Dept. of Rural Sociology, University of Wisconsin-Extension, July, 1979.

[11] The Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, *The Health of Mexican-Americans in South Texas*, 1979, p. 131 (hereafter cited as *Health of Mexican-Americans in South Texas).*

[12] Ibid. p. 132.

[13] National Council of Organizations for Children and Youth, *America's Children 1976: A Bicentennial Assessment*, p. 15.

[14] Ibid., p. 18.

times as likely to be officially poor as were white children; in that year 41 percent of all black children lived in families below the official poverty standard.[15] In 1970 Hispanic children were twice as likely to be officially poor as were white children.[16]

And with poverty comes disease and death. Minority children between the ages of 1 and 4 die at a rate 70 percent higher than white children; between 5 and 9, minority children die at a rate 40 percent higher.[17] Low birth weights substantially increase the likelihood of birth defects, including cerebral palsy and mental retardation. Minority women are more than twice as likely to give birth to low birth weight children.[18] One study has concluded that for every three infants who die, another two are born with such severe handicaps that institutionalization is required.[19]

A just society provides every person with an equal opportunity to thrive. In the area of health, America is failing to provide this opportunity to poor minority children. Minority children suffer from avoidable disease, lack access to health resources, and are far more likely than their white counterparts to enter adulthood in poor health.

The nutritional status of children plays a dominant role in their overall health and development. Yet, one out of three black children have low hemoglobin levels and other nutritional deficiencies, a rate twice as high as that of white children.[20] While less data is available on the nutritional status of Hispanic children, one Texas study of migrant children found that they suffer from high rates of vitamin A, vitamin D, iron, and calcium deficiency.[21]

Poor minority children grow in an environment which often places their health in jeopardy. The continued prevalence of lead poisoning is an indictment of this Nation's commitment to improve the conditions under which poor, particularly minority, children live. Every year, ingestion or inhalation of lead results in 300 to 400 deaths and mental retardation or central nervous system damage in 6,000 children. In neighborhoods with deteriorated housing, 25 percent of the children ages 1 to 6 have been found to have elevated lead levels in their blood and teeth.[22]

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[15] Ibid.

[16] Ibid.

[17] Children's Defense Fund, *Doctors and Dollars Are Not Enough*, 1976, p. 9.

[18] DHEW, *Health Status of Minorities and Low-Income Groups*, 1980, Pub. No. (HRA) 79-625, pp. 61-62.

[19] Robert Goldenberg, M.D., "Infant Mortality: Handicapping Conditions in Alabama." Unpublished manuscript, 1980, p. 3.

[20] Children's Defense Fund, *op. cit.*, p. 10.

[21] Larson, Massòth, and Chase, a "Nutritional Status of Children of Mexican-American Migrant Families." *Journal of American Dietetic Association*, 1976, 29(6), pp. 675-84, as cited in Stanley Lopez Padilla, M.D., "Frequently Encountered Health Problems in the Raza Community," presented at the Second Annual California Raza Health Planning Conference, Sacramento, Ca., May 29-June 1, 1980.

[22] DHEW, *Healthy People*, The Surgeon General's Report on Health Promotion and Disease Prevention, 1979. PHS Publication No. 79-55071, pp. 39-40.

Poverty-related problems—inadequate prenatal care, poor nutrition, and lead poisoning—lead to mental retardation among poor minority children. According to the American Academy of Pediatrics, three-quarters of the Nation's mentally retarded children live in slums.[23]

The simplest and most effective means of protecting children from certain disease is to immunize them. Here, too, we are failing. During the last decade, immunization levels among young children have declined. As of 1978, 463,000 children had not received any DPT doses and nearly 1 million had not received polio vaccine doses. Minority children are immunized less than poor children, and while immunization levels have declined for all children, minority children have been most affected: less than half of nonwhite children between the ages of 15 and 19 were fully immunized for polio in 1974.[24]

Nonwhite children continue to suffer from high rates of communicable disease. In an Hispanic community in California, children display four times as much amoebic dysentery, twice as much measles and mumps, and 1.4 times as much hepatitis as Anglo children.[25] Of particular concern is the high level of tuberculosis among Hispanic children. According to the American Lung Association of Los Angeles, "perhaps the most revealing and serious indicator of the acute problem facing Hispanics in TB control is the number of reported cases in children 5 years old and under."[26]

Upper respiratory diseases and otitis media (middle ear infections) appear to be particularly prevalent among Hispanic[27] and Native American[28] children. Untreated ear infections can and do lead to a high incidence of hearing disability among poor minority children.

Particularly alarming is the low level of health found in migrant Hispanic children. A University of Texas at Galveston screening examination of migrant school children in Hidalgo, Texas, found that 50 percent of the 465 children screened had dental problems, 26.5 percent had ear problems, 18 percent had orthopedic problems, 13 percent had disability delay, 14 percent had lice. Eighteen of the children had previously undetected thyroid problems, 31 had eye problems, and 44 had urinary difficulties. All told, 1,086 health problems were discovered in 465 children.[29] It should be noted that these were children who were healthy enough to attend school.

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[23] As cited in *America's Children 1976,* op. cit., *p. 41.*

[24] *Health, U.S.,* 1979 *Ibid.,* p. 75.

[25] Children's Defense Fund, *Ibid.* p. 10.

[26] American Lung Association of Los Angeles County, *Tuberculosis Morbidity Report in the Hispanic Community Presented to the California Assembly Committee on Health, Nov. 7, 1979.*

[27] San Francisco General Hospital, Division of Outpatient and Community Services, Family Health Center, Statistical Report, Reporting Period 10-1-79 to 12-31-79 as cited in Padilla, *op. cit.*

[28] *Health, U.S.,* op. cit., *p. 16.*

[29] *Health of Mexican-Americans in South Texas,* p. 111.

Dental disease is a significant problem for all Americans, but the number of decayed, missing, and filled teeth among minority, especially black children, is increasing at a more rapid rate than those of white children.[30]

Finally, the prevalence of drug and alcohol abuse among minority youth is unacceptably high by any standards.

We have failed and are failing to produce the conditions under which minority children can grow healthy in mind and in body.

Minority Adults

The health status of American minorities does not improve with age: From infancy through childhood and into the adult years, minorities continue to suffer ill health well beyond what their numbers warrant. The difference in health status between whites and nonwhites is staggering. In 1977 a nonwhite adult was twice as likely to die from diabetes, more than three times as likely to die of hypertension, four times as likely to die of chronic kidney disease, 60 percent more likely to die of influenza or pneumonia, and five times as likely to die of tuberculosis as a white adult.[31]

Minority women continue to die at an unacceptably high rate during pregnancy and birth. In 1975 the maternal mortality rate among minority women was more than triple the rate for white women.[32]

This is not to say that no progress has been made in decreasing disease and disability among American minorities. For some diseases there has been a discernable decline in morbidity and mortality rates. But the gap between white and nonwhite remains and, in some instances, is widening. And that gap is filled with avoidable pain, disability, and death.

Blacks

Approximately 11 percent of the population is black. In 1976–77, 30 percent of black families earned less than $5,000, and 29 percent earned less than $10,000.[33] And, despite the promise of the "war on poverty," during the decade of the seventies, black family income fell relative to that of whites, from 60 percent of the white level in 1969 to 57 percent in 1979.[34]

When the rates of eight major causes of death are compared for black and white populations, a vivid picture is drawn of the health status of black Americans. In seven of the eight diseases compared—disease of the heart, cerebrovascular disease, accidents, malignant

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[30] DHEW, *Health, United States, 1978* Pub. No. (PHS) 78–1232, p. 30.

[31] Congressional Budget Office, *Health Differentials Between White and Non-white Americans,* 1977, p. 5.

[32] *Health Status of Minorities, op. cit.,* pp. 39–40.

[33] *Health, U.S., 1979,* p. 5.

[34] "Resentment is Building in the Nation's Black Urban Ghettos," *Time,* June 16, 1980, p. 20.

neoplasms of digestive organs and peritoneum, homicide, malignant neoplasms of the respiratory system, and diabetes mellitus—blacks have significantly higher mortality rates.[35]

Suicide was the only one of the eight causes studied for which the white population had higher death rates than the black population. Ironically, this race differential has been steadily decreasing since 1950 as more and more blacks take their own lives.[36]

The stress of being black and poor in America is clearly evidenced in the prevalence of hypertensive disease among blacks. Hypertension (high blood pressure) is a risk factor of coronary heart disease and a causal agent in other serious, life-threatening diseases, such as kidney failure, stroke, and congestive heart failure. Blacks are nearly twice as likely to suffer from hypertension as whites, at all ages.[37]

Similarly, blacks are more than twice as likely to die from diabetes as are whites.[38] Equally as disturbing as the high incidence of hypertension and diabetes in the black population is the lack of care received for these two conditions. Both diseases if neglected lead to circulatory failure. At D.C. General Hospital in the District of Columbia, the most common operation performed on the overwhelmingly black patient population is amputation—a result of untreated diabetes and hypertension.[39]

Not only do blacks suffer from a higher frequency of cancer, but their cancer is also diagnosed at a later stage. And, even when diagnosed at the same time, blacks have a lower survival rate.[40]

Self-rated health is a strong predictor of subsequent mortality. As important, it provides information on what people feel about their lives and the circumstances under which they live.

When asked, "compared to other persons your age, would you say your health is excellent, good, fair, or poor?" 60 percent more blacks than whites reported themselves in "fair" or "poor" health.[41]

Another survey asked interviewees to indicate their general psychological well-being. Here, too, dramatic differences were present. White men reported the highest level of well-being, with 70 percent having "positive" well-being. Black males and white females reported about the same level, with 54 percent and 58 percent respectively having "positive" scores. Black females reported not only the lowest level of "positive well-being," with 37 percent having positive scores, but

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[35] *Health, U.S., 1979, op. cit.* pp. 12–15.

[36] *Id.*

[37] *Health Status of Minorities, op. cit.* pp. 100–4.

[38] Ibid., pp. 105–6.

[39] Susan Okie, "D.C. General, Hospital Is Doctor, Druggist For Many Area Residents," *Washington Post,* June 15, 1980.

[40] *Health Status of Minorities, op. cit.* p. 123.

[41] Eleven percent of the white population reported fair to poor health compared to 19 percent of the black population, *Health, U.S., 1979, op. cit.*, p. 21.

more than half reported moderate to severe levels of distress. Almost one-third of the black females showed a level of distress comparable to those reported by three-fourths of an independent sample of mental health patients.[42]

The physical and psychological health of black Americans provides a backdrop for judging the steadfastness of this country's commitment to right the wrongs of the past. That commitment has been found wanting.

Hispanic

The Hispanic population is the second largest and fastest growing minority in America. Like blacks, this minority too is poor: 19 percent are estimated to live in families with an income below $5,000, and an additional 33 percent in families with incomes between $5,000 and $10,000.[43] Relatively little is known about the health status of the Hispanic population.[44] Further, from the studies available, it is difficult to judge the true nature or extent of the health problems facing this population. As with infant Hispanic mortality statistics, however, recent studies, while not conclusive, tend to show that the level of disease and death is much higher than previously thought.

Several studies indicate an Hispanic morbidity rate two to three times higher than the white rate. For example, the Hispanic area of east-northeast Los Angeles has over four times the rate of amoebic dysentery, more than twice the rate of measles, and 40 percent more hepatitis than found in the county as a whole.[45]

Unquestionably, the Hispanic population suffers from an inordinately high communicable disease rate. Approximately 20 percent of California's population is Hispanic. The State has the highest rate of tuberculosis and typhoid fever in the Nation, a rate which has been increasing since the early 1970s.[46]

Other prominent communicable diseases prevalent in the Hispanic population include V.D., parasitism, salmonellosis, hepatitis, measles, and mumps.[47]

Hispanic laborers suffer from poor health conditions specifically related to their employment. Working as agricultural laborers, garment assemblers in sweatshop conditions, domestics, menial service workers, or as hourly laborers, many Hispanics are exposed to

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[42] Debra Newquist, Mark Bergers, Karen Kohn, Charles Martinez, and Linda Burton, *Prescription for Neglect: Experiences of Older Blacks and Mexican Americans with the American Health Care System* (August 1979), Andrus Gerontology Center, University of Southern California.

[43] *Health, U.S., 1979, op. cit.* p. 5.

[44] Much of the health statistics collected by Federal and State agencies categorizes Hispanics as white.

[45] *California Raza Plan, op. cit.*, pp. 34–35.

[46] "States Failing Health," *Los Angeles Herald Examiner*, Apr. 15, 1979.

[47] *Raza Health Plan., op. cit.* p. 35.

disproportionately high risks of industrial accidents and diseases. These include pesticide poisoning or chronic backache from stooped labor in the fields, communicable diseases, and respiratory tract infections.[48]

Migrant farmworkers, according to one California study, suffer from conditions such as epilepsy and mental retardation caused by lack of prenatal care and nutrition. They experience above-average rates of diphtheria, tuberculosis, hepatitis, diarrhea, heat stress, and respiratory infections. Women develop urinary problems from unsanitary field toilets and unsanitary field conditions. These poor working conditions have led to a lowered life expectancy of 49 years among migrant farmworkers.[49]

Pesticide poisoning is an especially acute health problem for farmworkers. The Food and Drug Administration has estimated that as many as 90,000 farmworkers are injured each year from pesticide poisonings.[50]

Of particular concern to the Hispanic community is the previously unrecognized prevalence of hypertension in the population. One San Francisco study of adult Hispanic patients found that 26 percent of Hispanics between 40 and 49 years clearly demonstrated hypertension and 12 percent were borderline hypertension. For Hispanics 60 years and older, 47 percent demonstrated hypertension and 16 percent were borderline.[51]

Much work remains to be done before we will know how poverty and ethnicity affect the health status of the Hispanic population. However, the conditions under which Hispanics live—low-income, hazardous employment, poor education, inadequate housing, and the stress of being a minority in America—breed disease. It appears unlikely that this minority has escaped the health consequences of those conditions.

American Indians

There is no question that tremendous strides have been made in improving the health status of American Indians. Particularly encouraging is the decline in infant and maternal mortality and certain communicable diseases. Nevertheless, the health status of this minority is still well below that of the rest of the population, and several health problems—including hypertension, obesity, alcoholism, and diabetes—

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[48] Jerry Weaver, *National Health Policy and the Underserved*, St. Louis, C.V. Mosby Co., 1976, p. 73.

[49] See, Geraldine Dallek, *Health Care for California's Poor, Separate and Unequal* (July 1979) p. 23 available from Clearinghouse Review, no.28,202B, 500 North Michigan Avenue., Suite 2220, Chicago, Illinois 60611.

[50] James Pierre, "The Conditions of Farm Workers and Small Farmers in 1974" (Wash., D.C.: National Sharecroppers Fund, 1975) as cited in Lyndon B. Johnson School, *op. cit.* p. 110.

[51] Jo Ellen Brainin Rodriquez and Stanley Padilla, "An Analysis of an Urban Solo Family Practice." Unpublished manuscript in preparation for the *Journal of Family Practice* as cited in Padilla, *op. cit.*

continue to undermine the gains which have been made. American Indians still experience excessive death rates from cirrhosis of the liver (associated with alcoholism) as well as pneumonia and influenza. In California an estimated 30 percent of Indians have diabetes.[52] Alcoholism is estimated in some parts of the State to affect 80 percent of Indian families. Nationally, the death rate from alcoholism among American Indians has risen in the last decade from 4.3 to 5.6 times as high as the rates for the total population.[53]

One area where no progress seems to have been made concerns the prevalence of mental illness among American Indians. The social stress and dislocation under which American Indians live is reflected not only in the high rate of alcoholism, but in the way they die—violently. In 1977 the age-adjusted homicide rate was 2.6 times that for the total U.S. population; the suicide rate was 2.2 times as high. Accidents also claim a disproportionate number of American Indians; the age-adjusted death rate for accidents among American Indians and Alaskan natives was 155.5 per 100,000 compared to 44.7 for the total U.S. population in 1977.[54]

The fact that the disease rates among American Indian tribes has decreased in several instances must not mask the continued need of this minority. According to the National Center for Health Services Research, "The health status of American Indians and Alaskan Natives still lags 15–20 years behind that of the general population."[55] Fifteen to 20 years is a quarter of a lifetime.

Minority Women

Minority women suffer greater work-related disability and reproductive ill-health than white women.

Major health disabilities of black women include hypertension, obesity, high rates of cervical and breast cancers, and common drug and alcohol dependencies. Black women have a higher percentage of contraceptive operations (tubal ligations and hysterectomies) than other groups. Permanent contraceptive operations were performed on 11.8 percent of black women compared to 4.9 percent for white women and 6.8 percent for other women.[56]

Black women, who make up a majority of the domestic work force nationally, suffer from high rates of crippling arthritis and gout aggravated by domestic housework occupations in and out of the home.[57]

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[52] Dallek, *op. cit.*, p. 21.

[53] *Health, U.S., 1979, op. cit.*, p. 16.

[54] *Id.*

[55] *Id.*

[56] Women & Health Roundtable, *Roundtable Report*, vol. 2, no. 9, September 1978, p. 2.

[57] Ibid.

Black and Hispanic women suffer from nutritional deficiencies during pregnancy. Two-thirds of poor, urban black women were found in one study to be malnourished. In another study, the nutritional status of 131 Hispanic women during their first obstetrical visit to a county hospital was made. Fifty percent of these women were found to be anemic.[58] Rural Hispanic women are estimated 28 percent less likely than their urban counterparts to live until 60.[59]

Native American and Alaskan Native women are victims of an enormous rise in the rates of cervical cancer. According to one researcher, the 600–700 percent increase may be linked to increased use of birth control pills. Native American women, like Hispanics, have been victims of massive sterilization abuse. Despite recent HEW regulations requiring strict informed consent procedures, one New Mexico legal advocate notes that unnecessary sterilization on Native American women is still a problem in her area.[60]

Elderly Minorities

Minorities (with the exception of Asian Americans) are less likely than their white counterparts to live to a "ripe old age." And those that make it continue to suffer disability and illness-imposed limitations to a greater degree than do whites.

Even after adjusting for income differences, the burden of disability falls heaviest on elderly minorities. For example, 59 percent of elderly blacks with incomes less than 55 percent of poverty suffer limitations of activity, compared to 51.1 percent for whites with the same income level; 57.4 percent of elderly blacks with incomes between 55 percent of poverty and the poverty level are limited in usual activity compared to 48 percent of elderly whites with comparable income.[61]

This difference is true for Hispanic elderly as well as black elderly. In a recent study of minority elderly blacks and Hispanics (based on a survey of 1,969 black, Hispanic, and white Los Angeles County residents), researchers concluded that minority elderly experience more health problems than older whites. For example, 65 percent of the older blacks and 62 percent of the older Hispanics reported fair to poor health, compared to 38 percent of the older whites. Minority elderly more than white elderly reported health-related difficulties in performing tasks of daily living such as household chores, shopping, attending church or social functions (30 percent of elderly blacks, 18 percent of elderly Hispanics, and 8 percent of elderly whites).

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[58] Cardenas, Gibbs, and Young, "Nutritional Beliefs and Practices in Primigravid Mexican-American Women." *J. of the American Dietetic Association*, 1976, no. 69, pp. 262–65.

[59] *Raza Health Plan, op. cit.*, p. 40.

[60] Telephone conversation with Virginia Brynes, attorney, Crownpoint, New Mexico, August 1980.

[61] 1978 National Health Interview Survey; Division of Analysis, National Center for Health Statistics.

Low-income minority elderly reported poor health more often than low-income white elderly. Black and Hispanic elderly, especially those with low incomes, were more likely than white elderly to report that poor health was their major reason for retirement (46 percent of the black elderly, 40 percent of the Hispanic elderly, 25 percent of the elderly white).[62]

. . .And Death

Life expectancy at birth reached a record 73.2 years for Americans in 1977. In 1950 white people could expect to live about 8 years longer than people of all other races; by 1977 this differential had decreased to 5 years.[63] But the narrowing of this differential should not obscure the fact that age-adjusted overall mortality was 40 percent higher for minorities than whites. Nor can it hide the appalling health status of segments of the minority population, such as migrant workers or destitute blacks of Washington, D.C.

Explicit in a State-by-State (and D.C.) comparison of life expectancy and percentage of racial minority is the strong inverse relationship between minority status and early death. With the exception of Hawaii, the greater the percentage of minorities in a State, the lower the life expectancy. Thus, in 1969–71, the District of Columbia had a greater percentage of minorities and a lower life expectancy than any State in the Nation. Similarly, Mississippi had the third highest percentage of minorities and the third lowest life expectancy rate; South Carolina had the fourth highest percentage of minorities and the second lowest life expectancy rate; Louisiana, the fifth highest percentage of minority population and the fifth lowest life expectancy rate.[64]

Conclusion

Based on a number of indicators of health status, minorities are less healthy than whites at all ages and in all population groups. Their life expectancies are shorter, their morbidity rates are higher, and the differentials in health status between minorities and whites in important areas are increasing rather than decreasing over time. The next section explores some of the ascertainable causes of these basic problems.

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[62] Newquist, Bergers, Kohn, Martinez, and Burton, *op. cit.*

[63] *Health, U.S., 1979, op. cit.*, p. 90.

[64] *Health Status of Minorities, op. cit.*, p. 49.

The Causes of Lowered Health Status for Minorities

Mortality and morbidity rates among minorities are much higher for all age groups than among whites. Minorities also suffer more frequently from nearly all illnesses. These differences are not due to greater susceptibility on the part of minorities. Rather, they are the result of economic, educational, environmental, and cultural handicaps imposed directly or indirectly on minorities.

Socioeconomic status

Gunnar Myrdal described in *American Dilemma* the problem as it existed in 1944:

> Medical knowledge has advanced beyond medical practice and medical practice has advanced far beyond most people's opportunity to take advantage of it. . . .Of special significance to the Negroes is the lag of opportunity for some people to obtain the advantages of medical practices available to other people. Area for area, class for class, Negroes cannot get the same advantages in the way of prevention cure for disease that the whites can. There is discrimination against the Negro in the availability to him of medical facilities.[65]

He noted in describing the existence of discrimination against blacks, the interrelation of poverty, race, and geographic innaccessibility to health facilities:

> It is hard to separate the effects of discrimination from those of concentration of Negroes in those areas where medical facilities are not easily available and in those income brackets which do not permit the purchase of medical facilities in the competitive market. Discrimination increases Negro sickness and death both directly and indirectly and manifests itself both consciously and unconsciously. Discrimination is involved when hospitals will not take in Negro patients, or when—if they do permit Negro patients—they restrict their numbers, give them the poorest quarters, and refuse to hire Negro doctors and nurses to attend them.
>
> Ill health reduces the chance of economic advancement, which in turn operates to reduce the chance of getting adequate medical facilities or the knowledge necessary for personal care.[66]

The pattern of health care access and the causes of its inaccessibility today to minority groups are virtually unchanged from the pattern described 37 years ago. The socioeconomic status of minorities is

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[65] Gunnar Myrdal, *American Dilemma*, Harper and Row, 1944, pp. 171–72.

[66] Ibid., p. 174.

generally low in the United States except for the relatively high income and education levels of the Asian or Pacific Islander group.[67] The proportion of black families with incomes less than $5,000 is about three times the proportion of white families; for Hispanics the proportion is about two times that of the white population not of Hispanic origin.[68]

On a per capita basis, levels of family income and other resources are further decreased by the relatively large families of most minority groups. Three of every 10 black and Hispanic families consist of 5 or more persons, compared to 2 of every 10 white families.[69]

Environment

Poverty means not only that minorities have less money to purchase health care. It also means that minorities are more likely to live in an environment characterized by overcrowded, unsafe housing, poor sanitation, and inadequate nutrition. All of these factors predispose them to illness.

Both black and Hispanic populations are more urbanized than the white population not of Hispanic origin.[70] The National Center for Health Statistics reported in 1971 that in 14 of the 19 major cities it examined, well over half the people residing in poverty areas were of races other than white.[71]

The Environmental Protection Agency (EPA) has found that living in inner cities exposes residents to far greater health hazards. According to Barbara Blum, Deputy Administrator of the EPA:

> Suburbanites are exposed to less than one half of the environmental health hazards inner city residents face. . .diseases and chronic conditions from living with bad air, polluted water and cultural stress. Hypertension, heart disease, chronic bronchitis, emphysema, sight and hearing impairments, cancer and congenital anomalies are all roughly 50 percent higher than the level for suburbanites. Behavioral neurological and mental disorders are about double.[72]

Factors contributing to the inner-city environment include living near and working in areas where toxic byproducts are created in production. The effects of overcrowding, the prevalence of large numbers of automobiles polluting the air, and large pest populations causing pollution of the environment with urban pesticides add to this unhealthy situation.

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[67] *Health, U.S., 1979, op. cit.* p. 5.

[68] *Id.*

[69] *Id.*

[70] *Id.*

[71] National Center for Health Statistics, 1971.

[72] Ellen Hall, *Health in America*, Urban Environment Foundation, 1979, p. 7.

Pesticides and other toxins such as metal produced in industry often find their way into drinking water in the inner cities. In New Orleans, for example, total cancer mortality was 32 percent higher than the national average. Study of the drinking water revealed that there were 112 carcinogens. A coalition of environmentalists and low-income residents elected a black mayor, Ernest Morial, in part, because of his support for a strong carcinogen standard in water control.[73]

Nutrition

The United States Senate Select Committee on Nutrition and Human Needs released a set of dietary goals for the United States in 1979. Testimony used by the Committee in preparing the goals indicated that overconsumption of fats, sugar, salt, and alcohol have been related to 6 of the 10 leading causes of death in the United States. The six causes listed were heart disease, stroke, cancer, diabetes, arteriosclerosis, and cirrhosis of the liver. In addition, diet is thought to contribute to the development of conditions such as hypertension that affect health. Review of the testimonies by the Department of Health, Education, and Welfare resulted in a conclusion that further research would be necessary to conclusively link diet with many of the current public health concerns.[74]

Assuming that nutritional habits do contribute to poor health, it would still account for only a portion of the problem of poor health among minorities. Emphasis on this approach to explaining poor health invites policymakers to overlook important causes over which minority persons have virtually no control. This approach, known as blaming the victim, brings this reaction from one inner-city environmentalist:

> So long as we can blame Mrs. Doe for not making enough, not moving, not eating, sleeping, drinking, and working properly, we can and will fail to place the blame where it belongs, on industrial products and processes; on institutionalized race and sex bias; and on health-as-commodity practitioners.[75]

Failures of the Health Care System

Poor minority health is also often brought on or exacerbated by our present health care system. A minority physician and public health analyst observed that, in general, services provided to minority communities are deficient in the characteristics essential to a well-organized system. These factors include availability, accessibility, continuity, comprehensiveness, coordination, and appropriateness.

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[73] Ibid., p. 10.

[74] *Health, U.S., 1979, op. cit.*, p. 57.

[75] June Jackson Christmas, M.D., "How Our Health System Fails Minorities," *Health Pathways*, vol. II, no. 8, October 1979, p. 3.

By most standards, services that are provided to minorities are generally inferior to those provided to white communities.[76] In each of these areas, minorities also experience the effects of racial discrimination.

Lack of Access to Hospitals

Urban hospitals have long followed a pattern of segregated hospital services. Cook County Hospital in Chicago, for example, is 1 of 80 hospitals in the city, yet it serves half of all of Chicago's black patients. Seven of the 80 hospitals take care of 4/5 of all black patients in the city. These proportions have remained unchanged for the last 15 years.[77]

A recent study by Dr. Alan Sager of Brandeis University of hospital closures in 18 central cities in the Northeast over the last 40 years found that 29 percent of the hospitals had closed or relocated between 1937 and 1977. A disproportionate number of those closed hospitals were located in neighborhoods that were black or had become black.[78] Of the 132 hospitals that were in neighborhoods where the black population was 50 percent or more, 60 hospitals, or 45 percent, were closed or relocated. Of the other 194 hospitals in the study, those not in neighborhoods viewed as black, only 18 percent were closed or relocated.

Such closure patterns are often attributed to overbedding in the area. Dr. Sager, commenting on his research, stated that overbedding was not a predictor of the relocation or closure. Rather, the likelihood of closures was directly related to the percentage of blacks in the population in a city.[79]

Cook County Hospital remains open though its future was imperiled in recent months by a huge budget deficit. The same scenario of financial crisis of a major or only provider of minority or indigent health care is being repeated throughout the country in Chicago, New York, Los Angeles, St. Louis, Memphis, San Francisco, Tucson, Dallas, Detroit, Charleston, Little Rock, and rural areas of east Texas, Arizona, California, and Tennessee.[80]

Because so many minority people are crowded into inner cities they are often among those most profoundly affected by the closure, partial closure, or relocation of health care facilities.

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[76] *Id.*

[77] Pierre DeVise, *Slum Medicine: Chicago's Apartheid Health System Community and Family Study Center*, Univ. of Chicago, Jan. 1, 1969, pp. 17–26, 38–45.

[78] Roger Wilkins, "Loss of Hospitals in Central City Said to Cause Array of Problems," *New York Times*, Sept. 17, 1979.

[79] *Id.*

[80] See D. Lang, Testimony Before House Ways and Means Health Subcommittee, Crisis in the Public Hospitals, reported in *Congressional Quarterly*, Mar. 22, 1980, p. 805.

Relocations and closures increase barriers to access to care, lessen that care's social and cultural acceptability, and lower its quality. These access issues are pronounced in a relocation situation, but exist as general barriers in virtually all health systems.

The most common barrier to access is the increase in travel time which coincides with the deprivation of the health services in minority communities.[81] Increased travel time is especially burdensome to minority populations, since members of minority groups are more likely to be dependent on public transportation than are whites.[82] If private transportation is available, minorities are less able to bear the operating costs of a motor vehicle than are whites.

Increased travel time and expense disrupts access to health care services by minorities in many ways. Minorities are substantially more likely than are whites to depend on hospital-based ambulatory care departments or emergency rooms as their primary source of medical care.[83] When a hospital leaves a minority community, an important source of primary care is lost. This means that minority people will be less likely to seek primary care as needed and will often wait until the severity of the medical episode leaves them no choice.

Increasing the distance between patients and their source of acute care also needlessly jeopardizes those patients requiring attention for medical emergencies. The increased risk of accidental injury or death faced by inner-city residents heightens the dangers of a discriminatory effect in the closure or relocation of health care services on which such residents depend.[84]

Increased travel time and expense unfairly burden the patient and the patient's family. Health professionals are increasingly recognizing the important role of family support systems in the healing process.[85] In addition, the relocation or closure of health facilities will inequitably burden those minorities with chronic illnesses who depend upon local services.

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[81] *See,* Weiss, J.E., and Greenlock, M.R., "Determinations of Medical Care Utilization: The Effect of Social Class and Distance on Contacts with the Medical Care System," *Medical Care* 8:456 (Nov.–Dec. 1970); Walker, L.L., "Inpatient and Emergency Department Utilization: The Effect of Distance, Social Class, Age, Sex and Marital Status," *J. American Coll. Emergency Physicians* 5:105 (1976); Shannon, C., Bashur, R.L., and Metzner, C.A., "The Concept of Distance as a Factor in Accessibility and Utilization of Health Care," *Medical Care Review* 26:143 (1969), cited in Wolfe, W., and Ziegler, M., "A Health Planning Approach: The Impact on the Minority and Elderly Population of New Castle County of the Relocation of Wilmington Medical Center's Principal Facility to Stanton, Delaware," prepared for the Center for Law and Social Policy, Dec. 8, 1977.

[82] Lu Ann Aday, Ronald Anderson, *Health Care in the U.S., Equitable for Whom?* Sage Publications, 1980, p. 57.

[83] Ibid., p. 235.

[84] DHEW, *Criteria for Assessing HSA Performance and Impact with Respect to the Minority/Disadvantaged* Publication No. HRA 38-612, May 1977; National Center for Health Statistics.

[85] Gould, Edward, and Ira D. Glick "The Effects of Family Presence on Global Outcome for Hospitalized Patients." *Family Process,* 16:503 (December 1977).

Relocation or closure can also create or exacerbate financial barriers to care for minority members. There are an estimated 30 million Americans who have no health insurance or are underinsured. A disproportionately high number of this group are minorities.[86]

Approximately 43 percent of the beneficiaries of the current Medicaid program in this country are members of minority groups.[87] If the closure or relocation of a hospital has made them dependent on a suburban facility for primary or acute inpatient services, their access to this facility may well be hampered by their difficulty in finding a physician who is accepting new Medicaid patients and also has attending privileges at this hospital. Without such a physician they well may find access to the facility virtually impossible.

Even more severe pitfalls await uninsured patients seeking care. In the event that a publicly owned facility has been closed or partially closed, uninsured minority members may find themselves deprived of the one relatively certain source of care they once had.

Relocation or closure of health facilities may also reduce the accessibility of care to members of minority groups by requiring that they obtain services from institutions which provide an inhospitable or culturally unresponsive environment. The most basic manifestation of this problem may be the absence of health professionals and ancillary personnel who speak the same language as minority patients.

Many inner-city communities have increasingly high numbers of persons for whom English is a second language, if it is spoken at all. The large influx of Hispanics in the Southwestern United States and the high concentration of recent Asian immigrants in several major cities have created unique health care problems. Not the least of these is a severe shortage of health professionals fluent in Spanish, Vietnamese, Chinese, and Thai.

This problem seriously affects all sectors of the health care system—public and private, acute and longterm. California, for example, has an Hispanic population of over 4.7 million. Although many of these people are monolingual, most medical facilities employ no bilingual medical translators or staff.[88]

The closure or partial closures of hospitals serving minority communities can severely impact on this problem. When the facility in question is a public hospital, this impact is often even worse. At least one State has enacted legislation requiring that all public agencies

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[86] National Center for Health Statistics, *Health, United States, 1978,* Publication No. (PHS) 78-1232, p. 401; Lu Ann Aday and Ronald Anderson, "Who are the Uninsured?" October 1977, available from the Center for Health Administration Studies, the University of Chicago; California Department of Health Services, *Fact Book on Health Care for the Poor and Medi Cal Program,* Apr. 16, 1979, pp. 34–36.

[87] Lu Ann Aday, *op. cit.*

[88] Edward Medoza, Antonio Spampincto, Consultants, Santa Clara County Health Systems Agency, *The Need for Bilingual Health Care Services in Santa Clara County: A Preliminary Study,* Feb. 8, 1979.

providing services to a population in which more than 3–5 percent of the persons are Spanish surname or part of another identifiable linquistic group have persons who speak the appropriate languages available in public contact positions.[89] If the public facility is lost, this mandate is meaningless.

Similar problems arise with the closure or relocation of private facilities where sensitive health systems agencies have conditioned capital expenditures by requiring that hospitals hire a reasonable number of translators or bilingual personnel. Relocation of the facility may sufficiently diffuse the non-English speaking population that the HSA would be unlikely to impose such requirements in the future.

All of the factors discussed above impact the quality of care patients will receive following closure or relocation. These include disruptions in continuity of care, greater travel time to emergency services, decreased family support, increased travel time, and expense for repeated treatment of chronic conditions, and inadequate or insensitive care stemming from language barriers.

Lack of Access to Physicians

Another major problem facing the minorities in need of medical care is the severe and increasing scarcity of physicians treating minority and Medicaid patients. In large part because of the restrictions imposed by discrimination, minority physicians have historically and continue today to primarily serve minority patients.[90] Systemic discrimination in educational and employment opportunities have meant that disproportionately few minority members have completed medical training.

Only 2 percent, for example, of American physicians are black although blacks represent 11 percent of the Nation's population. Similarly, it is estimated that there are only 250 practicing Mexican American physicians although the Mexican American community represents 2 percent of the population. Of over 1 million Native Americans and Alaskans only 72 are professionally trained physicians.[91]

The absolute number and percentage of minority medical students enrolled as freshmen is decreasing despite the fact that medical school enrollment has expanded as a whole to the benefit of white students. In 1974–75, blacks made up 7.5 percent of the first year enrollment. Other minorities made up 2.5 percent of the first year class. Since that date, and the beginning of the *Bakke* litigation, that enrollment has dropped to 6.4 percent for blacks and 2.3 percent for other minorities.[92]

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[89] California Government Code, Article 9.5, Section 11135 (Assembly Bill No. 803).

[90] June Jackson Christmas, *op. cit.*, p. 4.

[91] *Id.*

[92] *Id.*

Another pattern contributing to physician scarcity is the limited and decreasing willingness of the physician community to treat Medicaid recipients. As one Medicaid authority has noted:

> Manpower problems plagued medicaid from its inception, especially in urban areas. Physicians, dentists and other health practitioners refuse to participate citing low fees, delays in payment and excessive paperwork. The greatest manpower shortage has occurred in medical and dental specialties. In some areas of the nation, an orthopedist or periodontist willing to accept medicaid patients was as rare as a tropical bird in Alaska.[93]

In California, the bulk of the Medicaid primary care services are rendered by very few providers. In 1977, 41 percent of all outpatient primary care was rendered by 3.7 percent of all providers; nearly 60 percent of all Medicaid recipients received their primary care from only 7 percent of the primary care providers.[94] Since a significant percentage of the Medicaid recipients in this country are minority, refusal to participate in Medicaid must be interpreted in large measure as a reluctance on the part of majority physicians to treat the minority poor.

A third element of physician scarcity is the refusal of many hospitals to give staff privileges to minority physicians or physicians treating Medicaid recipients. Physicians hold the key to hospital admission. Neither patients nor hospitals themselves are permitted to "practice medicine" by making admissions. Thus, unless a hospital has physicians on staff who will accept minorities and Medicaid recipients, minorities and the poor will be excluded from that facility.

Finally, private physicians shun the practice of medicine in poor minority communities and, like hospitals, relocate as the proportion of minorities in an area increases. In the last few decades, ghettos and barrios have shown a steep decline in the number of physicians available to treat inner-city residents.[95] For example, in 1938 a ghetto area in the Bronx, New York, had 50 physicians serving the 25,000 middle-class white persons; by 1969 the racial composition of the area had changed, and only five physicians in the area were left to serve nearly 50,000 blacks. In the Bronx as a whole the 1969 ratio was 700 patients per physician, while in this primarily black ghetto there was only one physician available for every 10,000 people.[96]

Maldistribution of physicians within the city of Chicago alone is similarly dramatic. A study of the inner-suburban area of Chicago in

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[93] Spiegel and Podair, *Medicaid Lessons for National Health Insurance*, 1975, p. 49.

[94] California Department of Health Services, *Report to the Governor and Legislature, Effects of the Uniform Physician Reimbursement Method in the Medi Cal Program*, January 1979, p. 11.

[95] H.R. Rep. No. 94–266, 94th Cong., 2nd Sess. 4966-67 (1976).

[96] Harris, *The Economics of Health Care/Finance and Delivery* 225 (1975).

1970 showed a ratio of 123 physicians per 100,000 population while the inner-city area (not including the Loop) had 75 physicians per 100,000 population.[97] In 1970 one single North Shore medical building had more private physicians than were located in the entire west side poverty ghetto of 300,000 blacks.[98]

Physician scarcity exists in Hispanic urban and rural communities as well. In California, for example, there are few private providers located in heavily populated Hispanic areas of the State. In Los Angeles County, the white, upper and middle-class areas of Van Nuys, Beverly Hills, Bel Air, and Santa Monica have a primary care physician to population ratio of 1:458, while in the barrio of east Los Angeles the ratio is 1:3,700. In rural California, it has been estimated that only 10 percent of the farm worker population has access to rural community clinics and that 33 concentrations of farmworkers and their families in 13 counties have *no* accessible primary care services.[99]

Lack of Access to Appropriate Types of Health Services

Rural areas and inner cities lack critical services needed by minorities and particularly by the minority poor. Treatment centers for alcoholism, home health services, community mental health, and mental retardation programs are all insufficient in number to meet the needs of minority communities. Indian Health Service programs established to take care of the health needs of Indian people focus largely on reservation Indians, when in fact the majority of Indian people today live in urban areas.[100]

While the minority elderly are sicker than the white elderly population and therefore more in need of long term care services, they account for only 4 percent of all nursing home residents in the United States.[101] In 1969, 500 percent more was expended for nursing home services for white Medicaid recipients than for minority recipients.[102]

Where long term institutional care is desired, minorities have historically encountered, and continue to encounter, a dual track system of care. In Memphis, Tennessee, for example, black residents of unlicensed inferior quality board and care facilities have recently filed suit against 13 licensed skilled nursing facilities which have denied them access and have historically served small numbers of minority

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[97] H.R. Rep. No. 94–266, 94th Cong., 2nd Sess. 4966–67 (1976).

[98] DeVise, "Persistence of Chicago's Dual Hospital System," *Slum Medicine: Chicago's Apartheid Health System* (1969).

[99] *Raza Health Plan, op. cit.*, pp. 43, 54.

[100] The 1970 Census shows only 38.7 percent of 828,000 counted Indians living on reservations. 1970 Census Final Report, PC(1)–B6 at 6–310. See generally, Indian Health, National Health Law Program, *Health Law Newsletter*, August, 1979.

[101] Prescription for Neglect, *op. cit.*, p. 15.

[102] DHEW, PHS, *Health of the Disadvantaged Chartbook*, pp. 56–57.

patients in the Tennessee area. The board and care facilities in which the plaintiffs reside are virtually 100 percent black.[103]

Elderly persons need community-based health supports to help them maintain independent community living. Yet health benefit programs as they are currently designed inadequately provide for those needs. Health benefit programs are oriented toward acute, episodic illnesses and not the chronic health problems common among the elderly. As a result of these inadequacies, health benefit programs inadvertently encourage institutionalization of older persons.

Minority communities, more than white communities, have informal support systems available to older residents. Contact with family and friends is high among these subpopulations. According to the California survey cited above, the minority elderly were more able to accept family support when they needed it than were the whites.[104] Thus, lack of alternative, community-based, long term care programs (e.g. home health, in-home supportive services, day care) denies needed assistance to the minority community caring for the elderly in their midst.

Community health centers have been provided by Federal funds. Poor planning resulted, in some instances, in location of centers where services are already adequate.[105] Similarly, health maintenance organizations, which may have the potential of providing appropriate care through preventive, comprehensive, coordinated, and continuous services are so intent on economic survival that the usual HMO patient membership has been middle class.[106]

By virtue of their design and/or policies, many health care providers and facilities are not accessible to minorities. For example, many health care services are available on weekdays between 9 a.m. and 5 p.m., hours inaccessible to most of the working and low-income minority groups.

Lack of Access to Pregnancy and Delivery Care

Infant mortality and morbidity are linked directly to low birth weight. Comprehensive prenatal care can result in higher birth weight infants. Given no prenatal care, an expectant mother is three times as likely to have a low birth weight child. Yet minority women are half as likely as white women to receive prenatal care at minimum recommended levels.[107] Over 10 percent of all black mothers receive no prenatal care until their final trimester of pregnancy.

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[103] *Hickman v. Fowinkle*, CA No. C-80-1014 (W.D. Tenn. Jan. 11, 1980).

[104] Prescription for Neglect, *op. cit.*, p. 15.

[105] "Are Neighborhood Health Centers Providing Services Efficiently and to the Most Needy?" Comptroller General Report to Congress, Washington 1978.

[106] Health in America, *op. cit.*, p. 38.

[107] 14.7 percent of white women compared to 27.4 percent of minority women receive their first prenatal care visit after the 4th month of pregnancy. *Health Status of Minorities, op. cit.*, p. 214.

TABLE 1
Births Not In Hospital Or Physician Attended Clinics

	Total	White	Nonwhite
United States	1.3%	1.1%	1.9%
Selected States:			
Florida	1.3	0.8	2.7
Virginia	1.0	0.6	2.4
South Carolina	2.0	0.5	4.2
Georgia	1.1	0.2	2.8
Alabama	2.8	0.6	6.7
Mississippi	2.9	0.5	5.5
Alaska	3.3	1.7	7.3

Large numbers of minority children continue to be born outside of hospitals or physician-attended clinics. In 1975 the rate was 1.1 percent for white infants and 1.9 percent for nonwhite infants. A closer examination of these figures, however, reveals alarming statistics in States which have large minority populations and a history of hospital access problems (see table 1).

Instances of minority women in labor being turned away from hospitals have been reported in several States, including Tennessee, Texas, California, and Mississippi.[108] In one Hispanic area of south Texas, half the women give birth outside of a hospital.[109]

Lack of Quality of Care

Minorities generally receive inferior medical care compared to whites. A heavy dependence on emergency and outpatient departments, reliance on underfunded public hospitals, a questionable level of services provided, and linguistic barriers result in inadequate medical treatment for tens of thousands of minority poor.

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[108] Legal services from these States have reported to the National Health Law Program instances of pregnant women during labor turned away from hospitals for lack of an admitting physician.
[109] The Lyndon B. Johnson School, *op. cit.*, p. 131.

Outpatient and Emergency Room Care

Data from health surveys conducted by the Center for Health Administration Studies (CHAS) at the University of Chicago show that minorities are over 50 percent less likely than whites to have a regular source of care.[110]

Because physicians do not practice in minority communities and often refuse to care for Medicaid recipients, minorities are forced to rely on emergency rooms and outpatient departments as their source of primary care. Minorities, for example, are two and a half times more likely than whites to seek care at hospital outpatient departments and emergency rooms.[111]

These conditions surrounding the receipt of primary care for minorities produce long distances to and waits for care. Minorities average between twice and three times the travel time to obtain care and have to wait almost twice as long for that care as whites.[112] Researchers have conjectured that where primary care is received is largely responsible for the greater dissatisfaction expressed by minorities with the health care system.[113]

Emergency rooms provide poor quality primary care. For nonemergent conditions, at best, care will be costly and episodic. At worst, no care will be rendered without insurance or a preadmission deposit.[114] For true emergencies, poor minorities face the dismal prospect of transfer to public hospitals.

The transferring or "dumping" of poor minorities from private to public hospitals is a way of life in American medicine. In Los Angeles County alone, 2,000 largely minority patients a month are transferred from private hospital ER rooms to public county hospitals. A recent series of articles appearing in a Los Angeles newspaper documented that the large majority of these transfers were medically dangerous—persons with a stab wound to the stomach, a gunshot wound to the heart, comatose children and adults, and major trauma victims are transferred to county hospitals with little or nothing done to stabilize these patients before the long ambulance ride.[115]

Public Hospitals and Clinics

Public hospitals are the primary providers of care for inner-city poor minorities. These facilities are grossly underfunded. A shrinking

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[110] The number of minorities reporting no regular source of care had increased from 15 percent in 1963 to 16 percent in 1970 compared to a decrease of from 12 percent in 1963 to 10 percent in 1970 for whites. *Health Status of Minorities, op. cit.*, p. 234.

[111] *Health, U.S. 1979, op. cit.* p. 132.

[112] *Health Status for Minorities, op. cit.*, p. 236.

[113] The Robert Wood Johnson Foundation, Special Report, *No. 1, 1978, pp. 8–9.*

[114] See generally, Dallek, *op. cit.*, pp. 48–53.

[115] John Fried and Gerald Merrell, "Emergency Care Risking Lives," *Long Beach Independent Press-Telegram*, July 6–15, 1980.

municipal tax base and the astronomical inflation in health care cost have left large urban public hospitals in financial crisis. Local governments have responded by cutbacks in dollars and full or partial closure of many public hospitals.[116]

The relative poverty of these institutions, where they remain open, is reflected in a number of ways. There is a critical nursing shortage, for example, in public hospitals of New York, Memphis, and Los Angeles. This shortage is due to an inability of the hospital to afford enough nurses to assure quality patient care. In addition, shortages of support personnel such as janitors, nurses aides, and clericals, have forced overworked nurses to assume duties that those staff should perform. Service in public facilities by physicians in turn becomes unattractive since doctors must perform nursing duties in addition to their physician duties. Those duties that remain unperformed further reduce the quality of patient care. Poor financial backing also results in an inability of public hospitals to keep equipment in good repair and to maintain adequate supplies, including pharmaceuticals. Again, the quality of patient care is reduced.

Another vicious cycle in the public hospital sector concerns an inability to efficiently bill patients who are covered by a third party payment program such as Medicaid. Establishment of efficient systems, including computerization of records, requires large expenditures. Given a choice between spending scarce resources on patient care or on billing systems, many public hospitals have chosen the former.

Poverty of public hospitals is exacerbated by the failure of third-party payers such as Medicaid to cover large numbers of poor people. In most Southern States, for example, less than one-third of families living below the poverty line are eligible for Medicaid. Medicaid also does not require coverage of many mandatory services. A considerable number of States have chosen not to cover all optional eligibles or all optional services.

The Medicaid reimbursement system impoverishes public hospitals further by its inadequate method of reimbursing outpatient services. While inpatient services are reimbursed on a reasonable cost basis, outpatient services have been reimbursed on a set fee schedule that does not take into account the full cost to the hospital of providing those services. Since public hospitals provide a greatly disproportionate amount of outpatient care, inadequate Medicaid reimbursement places an unconscionable strain on public hospital capabilities.[117]

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[116] See, *Report of the Task Force on Public General Hospitals of the American Public Health Association,* Oct. 16, 1978.

[117] Lang, *op. cit.*

Questionable Medical Care

Minorities receive different quality care in both the public and private sector because of race and poverty. In one study of welfare families, 70 percent of the blacks but only 35 percent of the Anglos agreed that doctors were sometimes rude. Seventy-two percent of blacks and 46 percent of whites agreed that doctors were prejudiced against people on welfare. Two out of three blacks thought the doctors were prejudiced against them.[118]

A study of a large urban hospital in the mid-Atlantic region, conducted by researchers at the Johns Hopkins School of Public Health, found that over the past two decades black patients with private insurance were 2.2 to 4.3 times more likely than self-pay or private insured white patients to be under the care of resident surgeons in training. Similarly, black emergency patients were more likely than white emergency patients to be cared for by resident surgeons in training. Finally, Medicaid patients, who were disproportionately black in the area surveyed, were more likely than private patients to receive treatment from surgeons in training. One assumes that the quality of care a patient receives from a student is inferior, at least in terms of experience, to that of the teachers, the staff surgeons.[119]

HEW found in a recent study of office visits by black patients that physicians focused on a limited examination, that is, an examination confined to the body site or system connected with the patient's chief complaint. Reliance on this diagnostic approach, though general throughout ambulatory care, was significantly stronger in the treatment of black patients.[120] The study also found that the duration of contact and overall average length of time spent in face-to-face contact with physicians was less for blacks than it was for white patients.[121] While drug therapy played an extensive part in the overall pattern of office care, it was even more extensively applied in the case of black patients. Finally, in the physicians' judgments, most of the conditions presented by black office patients were not considered very severe.[122]

In a study of health care delivery to Southeastern residents of the United States, Karen Davis and Ray Marshall found that blacks received less thorough examinations than whites and that black

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[118] Podell, Studies in the use of Health Services by Families on Welfare, p. 41, as cited in Jerry L. Weaver, *National Health Policy and Underserved/Ethnic Minorities, Women and the Elderly,* C.V. Mosby Co. (1976) p. 82.

[119] See "Relation Between Race and Economic Status of Patients and Who Performs Surgery," *New England Journal of Medicine,* July 14, 1977.

[120] Advance Data from Vital and Health Statistics of the National Center for Health Statistics, DHEW, No. 50 July 23, 1979.

[121] Ibid., p. 36.

[122] *Id.*

women were more likely to undergo surgical procedures resulting in sterilization than were whites.[123] These findings regarding sterilization are supported by other studies as well.

Similarly, the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce of the House of Representatives, in their report on the *Cost and Quality of Health Care: Unnecessary Surgery,* found that the Medicaid population rate of surgery was almost two and one half times the rate of surgery for the rest of the population.[124]

In the Southern States, inferior and discriminatory care in the physician office context is also the result of continuing discrimination on the basis of race.[125]

Linguistic Barriers

Inferior quality of care is also received because of failures of medical personnel to recognize the need for bilingual services. An 8-year-old Spanish-speaking child, for example, was mauled in Phoenix, Arizona, by a German shepherd dog. After considerable delay over the acceptability of the insurance carried by the parents, an emergency room doctor saw the child. He stitched up the bites on her arm and leg. He did not remove her dress or slip and did not see the bleeding wounds on her back.

After returning home, her father noticed that the child was still bleeding on her back and returned her to the hospital. The doctor said he had not seen the other wounds during his initial examination.

The doctor refused on both occasions to let the father accompany his daughter, despite the fact that the child spoke no English. If present, the father could have interpreted and directed the doctor to the places where the child had been bitten. A week following this incident, the child's father took her to another doctor to have the stitches removed. The wounds were found to be infected because they

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[123] Karen Davis and Ray Marshall, "Primary Health Care Services for the Medically Underserved Populations," Papers of the National Health Guidelines: The Priorities of Section 1502, DHEW Publication No. HRA 77-641.

[124] Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, House of Representatives, *Cost and Quality of Health Care: Unnecessary Surgery,* Government Printing Office, January 1976, p. 44.

[125] In *Lee v. Reddick,* —F. Supp.—, (N.D. Fal. 1979) appeal pending No. 79-2908 (5th Cir.), a white Tallahassee physician maintained a segregated practice. The defendant testified at trial that when he established his separate rooms with white and colored signs, all other physicians with whom he was acquainted in the town of Tallahassee had similar practices. No black physicians practiced in the city or county of his practice. Said the doctor, "And I hired this lady to work for me. She told me, "This is where the white people sit." And I said, "My goodness, is that right?" And she said, "Yes, you won't have any practice if you don't go along with that custom." (Trial Transcript, Vol. II, pp. 138–139). See also, Los Angeles, Tuesday, July 24, 1979, reporting television special entitled "Blacks in America, With All Deliberate Speed," a film showing segregated physician's waiting rooms in the town of Lexington, Mississippi.

had not been cleaned thoroughly when she was in the emergency room.[126]

Monolingual citizens of Mexican American descent are often presumed to be illegal or undocumented persons when they arrive for services in hospitals in southern California. A November 1979 newsletter reports an incident involving a Hispanic man who arrived in an emergency room for treatment of stab wounds suffered in an attack at 7 p.m. The man was conscious and speaking Spanish.

No doctor arrived until 8:30. Upon arrival the doctor inquired about insurance for the patient and whether the patient was in the country legally. The wife, also Spanish-speaking and monolingual, could not satisfactorily answer these questions. By 10 p.m. that evening, 3 hours after his arrival, the patient died. He had been inadequately treated. He was a U.S. citizen.[127]

One California ER physician has noted that he can get a private physician to care for a white, unconscious ER patient in 1/2 hour, but it takes 3 to 4 hours for an unconscious brownskin patient.[128]

Undocumented persons of Hispanic origin are routinely denied care or given inferior care despite legal mandates in the cases of Hill-Burton hospitals that *all* residents be served. Undocumented persons, in the words of one administrator, are deemed not to "merit our services."[129]

Minority women are especially singled out for inferior quality care. Sometimes this takes the form of sterilizations being performed without knowing consent.[130] Frequently this poor treatment extends to minority pregnant women.

A young black woman in Memphis, Tennessee, suffering from a ruptured ectopic pregnancy was refused at one private hospital which did not take Medicaid patients and was refused by a second private facility on grounds that the hospital did not take Medicaid patients for "female problems." She finally was forced to seek treatment at a public hospital facility.[131]

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[126] This incident was the subject of a Title VI complaint filed with the Department of Health, Education, and Welfare on July 24, 1978 by Robyn E. Brown, Urban Indian Law Project, 3200 N. 7th Street, Phoenix, Arizona 85012.

[127] "Women Hold Up Half the Sky," Nov. 1979, Vol. 1, No. 1, Los Angeles, California.

[128] Health System Agency of San Diego and Imperial Counties, Testimony before the Select Commission on Immigration and Refugee Policy Concerning Federal Funding of Health Care for Undocumented Aliens, Feb. 5, 1980, Los Angeles.

[129] See complaint filed by the Welfare, Education, and Legal Assistance Center with the State of California on Dec. 21, 1978 by Jonathan McCurdy, Esq.

[130] See *Madrigal v. Quilligan,* —F. Supp. (S.D. Cal. 1978) appeal pending, 9th Cir. No. 3187. See also *Walker v. Pierce,* 560 F.2d (4th Cir. 1977) upholding the right of physicians to require Medicaid patients with a certain number of children to voluntarily submit to sterilization following delivery or to otherwise refuse them medical services.

[131] Complaint filed with HEW under Title VI of the 1964 Act and Hill-Burton Community Services with the Department of Health, Education, and Welfare on Oct. 7, 1977, by Don Donati, Memphis Legal Services, 46 No. 3rd Street, Memphis, Tenn. 38103.

Sometimes death occurs from a total inability of minorities to gain access to hospitals. In March 1979, for example, a 29-year-old Hispanic woman and her baby died of a ruptured uterus in a rural part of Texas. Two hospitals turned away this acutely ill, 8-month pregnant woman for inability to pay.[132] Similarly, Ysidro Aguinagas, an 11-month-old Hispanic baby, died in December 1978 after being denied admission to a public hospital in Dimmitt, Texas, despite the fact that the hospital was a Hill-Burton facility and publicly financed. The hospital would not admit the baby without a $450 deposit. Since the parents were without a $450 deposit they left the facility to seek other sources of care but the baby died en route.[133]

Poor Minority Health Status Resulting from Discrimination Is Legally Redressable

Nonwhites of this country are less healthy than whites, they get less health care, and the care they get is less effective, according to a recent Congressional Budget Office Study.[134] Despite the advent of Medicare and Medicaid as financial support systems, and the establishment of neighborhood health clinics and increases in personnel under the National Health Service Corps, the health of the minorities has remained relatively static compared to the health of whites.[135]

The current national focus on cost containment in all areas and particularly in the health care field makes the passage of any national insurance plan unlikely in the immediate future. However, even within the present patchwork health system, significant changes in the health status of minority persons and the efficacy of the current health delivery system are possible. These changes will occur if current law and regulations are treated seriously by the Federal Government, Federal policymakers, and the Federal judiciary.

Hill-Burton Assurances: A History of Sorry Performance

The Hospital Survey and Construction Act of 1946, Title VI of the Public Health Service Act, commonly known as the Hill-Burton Act, had as its declared purpose to "assist the several States. . .to furnish adequate hospital, clinic, or similar services to *all their people.* " (Emphasis added)[136] From 1947 to 1974, Hill-Burton grants and loans totaled $5 billion. More than 70 percent of these monies went to general hospitals for inpatient beds.[137]

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[132] See *Dallas Times Herald,* Saturday, Mar. 10, 1979, p. 1.

[133] *Aguinaga v. Castro County Hosp.,* N.D. Texas CA 279, 205 (Dec. 10, 1979).

[134] Congressional Budget Office, *Health Differentials Between White and Nonwhite Americans,* September 1977, at 37.

[135] Ibid., pp. 1–5.

[136] 42 CFR §124.601 (44 Fed. Reg. 29397).

[137] 44 Fed. Reg. 29399.

In return for these Federal funds, assisted facilities were required to provide two assurances: first, that a reasonable volume of services would be made available to persons unable to pay; and second, that the services of the facility would be made available to all persons residing in the area of the facility. These two statutory obligations are known as the "uncompensated service" and "community service" assurances, respectively.

In 1974 the National Planning and Resources Development Act, P.L. 93-641, was enacted. This law authorized a new Hill-Burton program: Title XVI of the Public Health Services Act, 42 U.S.C. §3000 *et seq.* Congress was extremely critical of the "sorry performance" by HEW and the State agencies in administering the uncompensated and community service obligations.[138] The Secretary was therefore mandated to issue new regulations under the new and old statute (Title VI and Title XVI) that would prescribe compliance and monitor standards. New regulations were issued in October 1978 and became final in May 1979.[139]

The new community service regulations offer especially great promise for access previously denied to minorities. The new regulations prohibit denial of services on the basis of race, color, national origin, creed, or any other ground unrelated to an individual's need for or the availability of needed services in the facility. Facilities must participate, if eligible to do so, in Medicare and Medicaid as well as other Government programs that provide reimbursement for services at an amount not less than actual cost.

Certain admissions policies are also prohibited. The new regulations prohibit a Hill-Burton facility from denying emergency services to any person who resides in the facility's service area on the ground that the person is unable to pay. Emergency patients may be transferred or discharged only when appropriate medical personnel determine that transfer or discharge will not subject the person to a substantial risk of deterioration in the person's medical condition.[140] The new regulations also prohibit Hill-Burton facilities from using admissions policies which have the effect of excluding persons on grounds other than those permitted in the regulations. This rule reaches the practices of excluding persons without private physicians, excluding Medicaid recipients because of staff physicians' refusal to provide treatment, or excluding persons because of advance deposit requirements.

In enforcing compliance with the regulations, HHS has provided for establishment of an affirmative action plan to ensure that services are available in accordance with the regulation should noncompliance be

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[138] *Id.*

[139] 44 Fed. Reg. 29399.

[140] *Id.*

found. This will allow HHS to require hospitals to obtain an agreement from staff physicians that they will accept Medicaid referrals or establish new clinics through which Medicaid patients and other persons requiring hospitalization may be admitted, or requiring hiring or contracting with qualified physicians to treat Medicaid patients and minorities who do not have private physicians.

HHS has been slow to fully implement these powerful new regulations. More than 6 years passed before an assurance reporting form was issued, although it was mandated by the National Health Planning and Resources Development Act. HHS also has not yet issued a civil rights survey for use in monitoring community service and Title VI of the 1964 Civil Rights Act compliance. A stipulation was entered into on March 12, 1980, in *Lugo v. Harris,* 426 F. Supp. 28 (N.D. Ohio 1976), by which HEW agreed to forward to OMB a hospital survey of this nature. It is imperative that this form be released without further delay.

Finally, HHS must commit itself to enforcing these assurances. For too long the department has paid only lip service to its enforcement obligations, proceeding only when forced to by litigation. Continuing reliance on private enforcement actions cannot, by themselves, realize the potential of these assurances.

Title VI of the 1964 Civil Rights Act

On December 1, 1976, a Federal regulation was issued under Title VI of the 1964 Civil Rights Act. This regulation required all Federal agencies to publish Title VI guidelines for each type of program to which they extended financial assistance. Such guidelines were to be published within 3 months of the effective date of the regulation.

The guidelines were to describe the nature of the Title VI coverage, methods of enforcement, examples of prohibited practices in the context of the particular programs, required or suggested remedial actions, and the nature of the requirements related to employment, data collection, complaints, and public information. These guidelines were to be made available to recipients and beneficiaries of Federal financial assistance and were to be made available in languages other than English where appropriate.

HHS has not yet issued such guidelines for State-administered continuing programs.[141] Guidelines should also be issued immediately by the Office for Civil Rights in HHS for hospitals, nursing homes, categorical grant recipients such as community health clinics, rural health clinics, community mental health clinics, health systems agencies, and State health planning and development agencies. Once

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[141] 28 CFR §42.404, 405, 41 Fed. Reg. 52669 (Dec. 11, 1976).

issued, those guidelines must be aggressively enforced by the Department.

Medicaid

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Medicaid EPSDT program requires that States provide comprehensive primary and preventive health care services to approximately 10 million children, the majority of whom are nonwhites. States must not only pay for care but assure that it is received in a timely fashion. Yet nationwide, the program reaches only one-fourth of the eligible population. The participation rates for minorities are even lower than for the general population, yet States have failed to evaluate the causes for lower participation rates and correct them. Furthermore, of children screened, nearly half of disclosed conditions are never treated.

Poor State administration accounts for much of the EPSDT program's failures. Few providers participate in the program due to such factors as poor payment rates. Many caseworkers fail to tell eligible families about the services to which they are entitled and how they may be obtained. Outreach efforts are particularly poor in minority neighborhoods. Many States refuse to offer such mandatory support services as scheduling and transportation.

Eligibility

In general, the Medicaid program itself gives the States optional choices of eligibility which have the effect of curtailing minority participation and denying vitally necessary services. States have not been loath to select those eligibility options which have a discriminatory impact; for example, prenatal care is urgently needed by pregnant minority women due to higher neonatal mortality rates, yet many States with substantial minority populations opt not to provide coverage for first time pregnant women. Many Southern and Southwestern States have selected eligibility options which have the effect of limiting the participation by rural southern blacks, Hispanics, and Native Americans, and divert funds away from vitally needed health care for minorities. No Title VI guidelines have been issued for compliance in this area, and the Federal Government fails to systematically collect data or monitor compliance.

Cutbacks

When States cut back on Medicaid services, the first to go are often the very basic primary and prenatal care services which minority children and mothers so desperately need. To cite an example, the State of Texas recently responded to its latest Medicaid budget reduction by drastically reducing EPSDT services below medically acceptable levels. A year ago children were able to obtain medical checkups and dental care on an annual basis. Now care is available only once every 3 years. The majority of Medicaid eligible children in Texas are members of racial minorities.

Cutbacks in North Carolina had a vastly disproportionate impact on minorities. Despite the failure of HHS to investigate and review the cutbacks, a private lawsuit was filed against the State. This litigation was successfully settled without trial and the cutbacks were withdrawn. *Graves v. Morrow*, E.D.N.C., No. 77–324-CV5 January 1, 1978. HHS should be performing its responsibilities in this area, rather than abdicating its responsibilities to the public interest bar.

Data Collection

Medicaid Management Information Systems (MMIS)

MMIS is a 90 percent funded Medicaid computer system to increase the efficiency of State Medicaid agencies. Almost all States either have or are developing this system to issue Medicaid cards and pay Medicaid providers. HCFA [Health Care Financing Administration] has established extensive criteria for what information MMIS should collect. One criteria which HCFA has failed to establish is the inclusion of racial identifier(s) to allow MMIS information and data to be broken down by race. This relatively simple requirement would allow States to fulfill their own obligations under both 45 CFR 80.6(b) to have data on Medicaid usage by racial minorities and under 45 CFR 80.4(b)(2) to establish methods of administration to monitor the Title VI compliance of Medicaid providers. Yet HHS has failed to take even this first step to guarantee information so essential to Title VI compliance.

Professional Standards Review Organizations (PSROs)

The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95–142) contained a provision which creates a potential data base for monitoring of patient service patterns of hospitals participating in Medicare and/or Medicaid. Section five of the act, the PSRO amendments, states that PSROs shall provide data and information in such format and manner as may be prescribed by the Secretary. Subject to PSRO review are aggregate health statistics on a geographic, institutional, or other basis to reflect the volume and frequency of services furnished, as well as demographic characteristics of the population. PSRO patient profiles should thus be recorded in terms of age, sex, diagnosis, and zip code, as well as race or ethnicity.

HHS could use such data to supplement other reporting forms and identify problem areas for compliance proceedings. HSAs could also effectively use such data to plan better access in the health planning process. Moreover, the availability of such data could expedite private enforcement actions. Despite this potential, HHS has aggressively sought to maintain the confidentiality of this data.

Maternal and Child Health, Title V

Extremely poor health planning to develop primary or prenatal services where they are needed results in effective discrimination against minorities. State maternal and child health agencies, which are expressly charged with developing these services for medically underserved mothers and children, tend to spend their funds in unaccountable fashions. For example, 20 out of 100 North Carolina county health departments offer no prenatal services whatsoever, while between 80 and 90 percent of all mothers and children served through special Title V maternity and child projects are nonwhite. States have spent a progressively smaller share of their Title V funds on expanding and enriching these projects. Again, civil rights enforcement by HHS in this area has been negligible.

Public Hospitals

The current fiscal crisis, causing closure of the only hospitals available to a majority of the inner-city minority poor, should be addressed in a forceful way by the Federal Government. Expansion on Medicaid and Medicare waivers to permit public hospitals to compute the cost of unreimbursed care in the reimbursed rates for Medicare and Medicaid should be undertaken. Grants should also be given directly to financially troubled hospitals based on such criteria as location in a medically underserved area where no alternatives for indigent medical care are available. Financially troubled hospitals in medically underserved areas should also be able to bill Medicaid for the reasonable cost of outpatient as well as inpatient services.

If greater enforcement of Hill-Burton and Title VI prohibitions were carried out by HHS, minorities would have greater access to private facilities, relieving to some degree the burden on public hospitals. The Federal Government should also take the lead in establishing specific indigent care criteria to qualify hospitals for Federal nonprofit tax status.

Health Planning

With the passage of Public Law 93-641, the National Planning and Health Resources Development Act of 1974, much health planning activity has been focused around local health systems agencies which were designed to identify and plan for the health needs of local health service areas.

Some of the major activities of the health systems agencies have been development of health systems plans, reviews of certificate of need applications for capital expenditures and new services provided by hospitals, and reviews of proposed federally funded projects. Participation today in these activities has been minimal and certainly not reflective of the large percentage of minorities in the country.

Minority representation and participation on governing bodies, committees, and staffs of HSAs has been poor. Often, those minorities that are chosen are neither selected by nor responsive to the needs of the minority communities, especially the low-income segments.

As a result, health systems plans often inadequately address the needs of minorities. HSAs have also consistently failed in reviewing projects to consider whether the project meets the needs of the minority and low-income members of the community.

HHS has finally recognized that requirements of Title VI of the 1964 Civil Rights Act are applicable to health planning. (P.L. 93–641, Title XV, and §1122 of the Social Security Act (42 U.S.C. §1320(a)(1)). Current proposed regulations would require Title VI review of reductions of services and hospital closures.[142] However, review should not be required where capital expenditures are not involved.

Specific guidelines for health planning agencies still have not been established. These guidelines must be promptly promulgated and activities of these agencies must be closely monitored. In this way the Department can assure that such products as State health plans will be responsive to the needs of minority communities.

Conclusion

Gunnar Myrdal articulated the importance of Federal leadership in overcoming discrimination in health care in 1944:

> We can conclude from known facts. . .that what is needed in the way of special attention to Negroes is *constant vigilance against popular and official prejudice* in the application of a general medical and health program. In view of the racial attitudes prevalent. . .it is. . .necessary that national organizations, and specifically the federal government, take a firm lead in this work.[143]

The need is as great for such leadership in 1980 as it was in 1944. It has been said that without the possibility of action, all knowledge is received and labeled "file and forget".[144]

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[142] 45 Fed. Reg. 20026 (Mar. 26, 1980).

[143] Gunnar Myrdal, *American Dilemma, op. cit.*, p. 175.

[144] Ralph Ellison, *Invisible Man*, Random House, 1947.

I urge this body to act on the information it has received. Schedule hearings, rather than consultations, assign staff to this issue, develop reports, and urge congressional oversight investigations. The continuing inequities in the American health care system is apparent from the most cursory review. All that is required is a collective will to correct them.

HEALTH CARE AND CIVIL RIGHTS

Roma J. Stewart*

In earlier years and still today, education-related civil rights issues have commanded the lion's share of attention from management and from investigative staff of HEW's Office for Civil Rights. For the past 2 years, however, OCR has devoted an increasing amount of its time to health-related civil rights issues.

One consequence of that early emphasis on education is that the public is generally less aware of the major disparities faced by minorities, the handicapped, and the aged in terms of accessibility to health care. Another consequence is that much remains to be done in identifying and correcting discriminatory practices in the health care system.

The Scope of the Health Care System

The term "health care system" covers a multitude of entities differing markedly from the more familiar and less complex education system in management, in financing, in the ways that people gain access to services, and in the ways they are served. Schools have a relatively simple administrative structure, with boards to make policy, superintendents to carry out policy, and funds which come largely from public sources—local, State, and Federal.

By way of contrast, hospitals—the core of the country's health delivery system—are supported in part by public funds, in part by payments from private citizens, and in part by insurance programs, both private and public. About half of the Nation's health care bills are paid by private insurance policies. Communities do not control the practices of the health care system. While schools are managed at the staff level by educators, and at the top by elected board members, hospitals are controlled by many professions, each with an independent relationship to the patient. For all these reasons, health care presents an extraordinarily complicated set of problems. Responsibility for discrimination and for corrective action is far more difficult to pinpoint in health than in education.

The scope of the job is enormous. For example, there are more than 6,000 short-stay hospitals with a million beds, and more than 600 long-stay hospitals with 300,000 beds. There are some 18,000 nursing home facilities that provide intermediate or domiciliary care for 1.3 million

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people. The rate of nursing home care is going to rise with the increase in the number of people past the age of 65.

The Federal investment in this massive health care system is large. Between 1946 and 1979, the Federal Government provided approximately $4 billion in grants and loans to finance the construction and modernization of 7,000 hospitals, nursing homes, and other health care facilities. In addition, the Federal Government through Medicare and Medicaid paid close to $40 million in FY 1977 for health care, or almost 28 percent of the total expenditures for health services nationwide. The Federal share goes up each year.

By midyear health and education will have separate Cabinet-level identities for the first time. Congress has mandated the establishment of a new Department of Education. As a result, two-thirds of OCR's resources will move into the new Department by May 7 and one-third will remain in the Department of Health and Human Services. Enforcement of civil rights throughout the health care system can only benefit from this change. For the first time, the Office for Civil Rights will mount an enforcement program with a separate management and investigative team devoted exclusively to Health and Human Services issues.

Of the 1,700 positions currently authorized for the Office for Civil Rights, 567 will be assigned to Health and Human Services. The other positions will go to the Department of Education.

HEW has asked Congress for 100 additional positions for OCR by FY 1981, and for an authorization of $21,931,000. The additional positions are sought to permit the effective enforcement program which experience clearly shows to be essential.

The reorganization is a new factor among the priorities facing the Office for Civil Rights this year. At the same time, the new structure affords an unprecedented opportunity to establish a vigorous and productive civil rights program directed toward health and human services.

In making plans for FY 1980 that will help to achieve this goal, OCR divides health care into three general categories for purposes of analysis:

1) Barriers to access to health care on the basis of race, national origin, or handicap.

2) Disparities in the quality of care afforded minorities and handicapped as compared to care for others.

3) The extent to which health planning agencies take civil rights into account in project review and planning.

To make the best use of the experience gained so far, and to acquire the basic information needed to identify patterns of discrimination in the health care system, OCR initially is focusing more of its energy on eliminating barriers to access for minorities and the handicapped. Ultimately, we intend to probe the even more difficult area of comparability of care—that is, whether minorities, the aged, and the handicapped receive the same quality of care once they have gained access into a health care facility.

In examining the problems that beneficiaries have in gaining access to health care institutions, OCR has identified some specific areas in which past investigations have revealed frequent problems. They include the following:

1) Admissions practices of hospitals and long term care facilities.

2) Hospital services to minority group persons and the handicapped.

3) The activities of health planning agencies.

4) The failure of State Medicaid agencies to monitor hospitals and other providers to ensure that they do not discriminate.

5) Availability of services, including such issues as hospital relocations or closings, and their impact on minorities and others.

6) Practices of mental health centers and mental hospitals.

OCR Plans for Program Support

OCR will direct its attention to effectively formulating policy, gathering data, and training personnel.

New policy guidance is planned specifically in the following areas:

- Hospital closings. Where hospitals are located in areas with high minority group populations, hospital closings, relocations, or reductions in service may have adverse effects on minority patients.
- Provision of bilingual services. Those with limited English-speaking skills are often denied access to essential health and social services because of the lack of bilingual services.
- Access to hospital services. Minorities have difficulty in being admitted to services, particularly inpatient services, because of policies racially neutral on their face but discriminatory in practice. They are then forced to travel excessive distances to reach hospitals willing to accept them.
- State agency planning. The need for efficiency and cost containment in health service delivery makes health policy planning at the State level increasingly important. OCR policy is needed to provide guidance to planning organizations to ensure that State policies do not discriminate against minorities, the handicapped, and the aged.
- Long term care. A policy will be developed to provide nursing home operators and compliance and enforcement staff with guidance in ensuring that referrals and admissions do not violate civil rights laws.

New data must be collected to determine which issues and institutions should receive priority attention. Just as data has always been an extremely important tool for civil rights compliance in the education area, data is critical for reviewing the health care system as well. A review of available information confirms that major disparities exist between minorities and nonminorities in access to health care, and strongly implies pervasive racial discrimination. HEW's recently released annual health report to Congress, *(Health, U.S.A., 1979)*, indicates the extent to which the health status of minorities lags behind other Americans. It shows:

- That black women are much less likely than white women to receive prenatal care during the first trimester of pregnancy—only 59 percent of black women do so, compared with 77 percent of white women.
- That the black infant mortality rate is twice the rate for white infants—23.6 compared to 12.3, per 1,000 live births.
- That blacks suffer from cardiovascular disease, such as heart disease, stroke, and hypertension, at a higher rate than whites.
- That blacks and American Indians have a much higher death rate than other groups.

To obtain more specific data on institutions, OCR is preparing a hospital survey form to assist the Department in targeting hospitals which may not be in compliance with the civil rights laws, or with their obligation under the Hill-Burton Act. In addition, the types of data needed for use by health planning agencies have been identified. Specifically, OCR believes that these agencies cannot adequately plan for the needs of minorities and other medically underserved persons unless they collect and analyze demographic data and medical indicators of need.

In education, both public funding and public policy have long supported the collection and use of data to count the number of children by race, ethnicity, handicap, and sex. In medical care there are no uniform data systems to count and describe all the people who need medical care services, or to measure the effect of medical care on the health of the population. If we can begin to develop such uniform data systems, our job will be considerably easier in the future.

OCR will do more compliance reviews of systems of health care in the future. OCR is developing a comprehensive training program to be held in late spring and summer of this year to improve the quality of systemwide compliance reviews and complaint investigations.

OCR Plans for Compliance and Enforcement

The impending reorganization opens the first major opportunity for OCR to concentrate more of its resources on systemwide compliance reviews, where patterns of discrimination can be found and corrected in ways that benefit larger numbers of people than are helped by individual case resolutions. Because of the *Adams v. Califano* lawsuit, OCR has applied much of its investigative staff to the resolution of individual complaints. There is no question that through systemic compliance reviews OCR can achieve more far-reaching results than can be obtained by investigation of an individual complaint.

In FY 1980, OCR plans to undertake 275 health and human development compliance reviews. Plans call for the following schedule:

- 17 reviews for discrimination in accessibility and admissions in hospitals, nursing homes, and extended care facilities.
- 17 reviews of delivery of services in the provision of Medicaid and Medicare services.
- 59 reviews of hospitals for discrimination on the basis of national origin or handicap, including bilingual services and capability for meeting the needs of visually or hearing impaired patients.
- 59 reviews of welfare agencies for discrimination in the provision of services to minorities and the handicapped.
- 17 reviews of child welfare referral practices, including foster care, bilingual services and location of services in terms of accessibility for minorities and the handicapped.
- 17 reviews of planning activities by health service agencies.
- 59 reviews of supportive services to the elderly and disabled.
- 30 reviews of mental health centers and mental health hospitals in terms of equal care and bilingual services.

This schedule is based on the early completion of reviews started in FY 1979. In addition to the compliance reviews, regional offices will continue to conduct individual complaint investigations and to commence them promptly after receipt of complaints.

Problems of Discrimination

From all indications, minorities do not have equal access to health care. Health care traditionally has been provided through a "dual track" system. Public hospitals serve the indigent, including most minority patients. Private hospitals serve the paying patients, and have a predominantly white clientele.

Some disparities are the vestiges of historical patterns of racial segregation. In Louisiana, for example, separate hospitals were built for blacks. Race, not ability to pay, determined which hospital was accessible to which patient. Until 1964 the Federal Government made grants and loans to segregated hospitals under the Hill-Burton Act. Further, until the mid-1960s, black physicians were not given staff privileges at some nonpublic hospitals. The vestiges of this system when combined with subtle discriminatory practices of today, perpetuate health care access problems for the black American.

Any efforts to ensure equal access and equal quality of health care for minorities must confront the economic framework that obscures discriminatory practices. To do this, OCR must look at the procedures and policies step-by-step. Following are some examples of what OCR has learned about these policies and procedures.

Many hospitals admit only patients who are referred by doctors. Minorities often have no private physician who can open the door. Some doctors automatically reject patients who rely on Medicare or Medicaid to pay their bills, ostensibly because the doctors consider the rate of reimbursement under these programs to be less than they can get from patients covered by private insurance policies. The refusal of doctors to handle Medicare and Medicaid patients automatically excludes low-income minorities from the service of a physician who could serve as a conduit for hospital admission. Faced with such barriers, minorities often use emergency rooms for primary care when others might consult a private physician. Even at the emergency room door, minorities are often given only the immediate life-sustaining treatment and a quick referral to a hospital that cares for indigents.

Hospitals sometimes require a deposit before admission, setting rates so high that minorities cannot meet the initial expense. For all practical purposes, the deposits bar minorities from access. This practice appears to be used often in areas populated by Hispanics. OCR finds also that physicians in some areas serve on the staffs of more than one hospital but routinely refer nonminority patients to one hospital, while referring minority patients to another.

Native American Indians are often denied inpatient and emergency care by hospitals. OCR finds that some hospitals routinely refer Native American Indians to the Indian Health Service facilities, even though these regional care facilities are located many miles away. This is a violation of Title VI of the Civil Rights Act of 1964, and where we find the practice we attempt to obtain corrective action. Federal policy is clear on this issue. Indian Health facilities are a supplemental resource, and other federally assisted hospitals are not relieved of their obligation to accept patients without discrimination.

Hospital Closures

OCR is particularly concerned about still another economy-related practice that is heavily weighted against minorities—the relocation or closure of hospitals. Inner-city hospitals are often the only source available to minority citizens for emergency care, outpatient care, or long term care; at least they are the only source of care within reasonable distance. Nevertheless, economic reasons appear to dictate closing of some community facilities, and it is inevitable that the first ones targeted for closing are the older inner-city hospitals, which are chronically understaffed and overcrowded with aging buildings and equipment.

The inner-city poor, most of them minority citizens, are least able to cope with the additional costs of transportation. Whether they can afford to travel to the suburbs or not, they are forced by hospital closures and relocations to assume greater risk in case of emergency—including childbirth as well as life-threatening accidental injury, strokes, heart attacks, or other health problems.

Aside from outright closure or relocation, some communities seek to relocate certain kinds of hospital-based services, such as obstetrics. Actions of this kind can be taken so quietly that they are accomplished before the community is aware of impending loss of vital services.

The Federal Government itself, with its emphasis on cost containment, may inadvertently contribute to the relocation or closure problem, since reductions in hospital beds are encouraged by HEW. OCR must attempt to ensure that no civil rights are violated in the process.

Other Examples of Discrimination

Out of its experience to date in health care investigations, OCR has identified several other problems involving a strong probability of discrimination. They include:

- Refusal by some hospitals to provide inpatient care to persons addicted to drugs or alcohol.
- Denial of admission for care for persons who have not been referred by a doctor.
- Segregation of patients based on whether they are clinic patients or private patients, thereby racially segregating portions of the hospital.
- Denial of staff privileges to doctors on the basis of race.
- Denial of services to Hispanics and Asians in hospitals and health maintenance organizations (HMOs) which are unprepared and unwilling to hire bilingual staff.
- Denial of equal care to hearing-impared patients by hospital emergency wards because no interpreters are provided.

These examples of discrimination have already been identified in OCR's dealings with civil rights issues in hospital care. Similar patterns pervade long-term care. We find:

- Nursing homes that limit Medicaid admissions to a set percentage of total numbers of patients.

- Nursing homes that consistently rule out admission of patients with certain handicapping conditions, including deafness and blindness.
- Nursing homes and other health care facilities that refuse to hire qualified handicapped persons.
- Nursing homes that segregate minorities and persons with certain types of handicap once they have been admitted.
- Fraternally owned nursing homes that explicitly refuse to admit people of a particular race or national origin.

In general, blacks are barred from nursing homes by so many obstacles that they are often reduced to living in unlicensed and substandard boarding homes where they cannot receive Medicaid benefits, and where the quality of care is inferior.

Although most of these problems relate to accessibility, they also raise questions about the quality of care in hospitals and nursing homes.

Minorities often allege that even when health care is available, the quality of that care is suspect, compared to the quality of care for nonminorities.

While the issue targeted in this report is physical health care, OCR has noted the overlapping relationship of physical and mental health care. An example is in the failure of some health care programs to refer handicapped persons for counseling or psychological help.

Health Planning Systems

Also noted earlier is the importance attached to the role of health planning systems in the equal planning for health care on the basis of race, national origin, sex, handicap, and age.

Health planning, as discussed here, is the process by which resources are developed to meet present and future needs of the community, under the Health Planning and Resources Development Act of 1974.

Part A of the National Health Planning and Resources Development Act established a National Council on Health Planning and Development, and directed the Secretary of HEW to issue national guidelines for health planning. These guidelines, in effect since March 28, 1978, set standards for the supply, distribution, and organization of health resources.

Part B creates a network of health systems agencies (HSAs) that are responsible for area health planning and development.

Part C provides Federal funds for State governments to develop State Health Planning and Development Agencies (SHPDAs). Most of the power in the planning process is vested in the SHPDAs, which will administer certificate of need programs and review institutional health services offered in their States every 5 years.

These federally supported agencies have a responsibility to assure delivery of services free of discrimination. OCR has an obligation to hold them to their legally mandated commitment. In at least one instance, a planning agency disregarded findings of past civil rights violations by institutions under review. OCR has likewise observed that civil rights issues are not afforded an appreciable amount of consideration in the planning or review process. Minorities and handicapped persons are underrepresented in HSAs and SHPDAs, where their presence in greater numbers could be expected to focus more attention on civil rights priorities.

During the past 2 years, OCR has conducted several compliance reviews which provide new information on the role of the planning agencies in connection with discrimination in health care. Additional reviews will add to the knowledge on hand and enhance OCR's ability to devise policy and remedies for civil rights violations.

HEW is improving coordination of health-related civil rights efforts within its component agencies. For example, a memorandum of understanding between the Office for Civil Rights and the Public Health Service allows each agency to use its fields of knowledge and resources in a concerted effort to root out discriminatory practices. Under this agreement, OCR will assume part of the compliance responsibility for the community service obligation of facilities that received Hill-Burton funds. The Hill-Burton funds were provided to hospitals and other health care facilities under Title VI and Title XVI of the Public Health Service Act. These funds require facilities to make their services available without discrimination on any ground unrelated to the individual's need or the availability of the service. The community service obligation also bars denial of emergency care to patients who cannot pay. If a facility is covered by the agreement, it must admit Medicare and Medicaid beneficiaries to the facility. These civil rights and community service obligations are closely related and can be monitored by both OCR and PHS for best results. Community service reviews will be incorporated in civil rights reviews already scheduled by OCR. OCR will investigate complaints and initiate compliance reviews, and the PHS staff will help secure remedial action where no civil rights issues are involved.

OCR has recently been assigned enforcement responsibility for the Age Discrimination Act. Major tasks with reference to age discrimination include:

- Development of compliance and enforcement policies and procedures. Procedures for the processing and investigation of complaints will be developed and implemented. Age discrimination compliance reviews will be initiated in Fiscal Year 1981.

- Provision of technical assistance to Federal recipients and beneficiaries, including public information initiatives to inform people of their rights and how to obtain help when discrimination is suspected.
- Development and issuance of policy interpretations and periodic revisions of the Age Discrimination regulations. Once OCR has had some experience in addressing and resolving ADA complaints, we will issue policy guidelines and interpretations as needed. This approach will also help OCR determine whether revisions to the ADA regulations are required.

OCR has gained considerable experience in the health field in its long investigation of and subsequent legal proceedings against a number of New Orleans hospitals. A summary of Title VI proceedings in those cases helps to indicate the problems OCR finds and the legal process OCR uses for obtaining remedies. The summary follows:

New Orleans Hospital Review

Background

In 1971 HEW was sued in *Cook v. Ochsner,* U.S. District Court for the Eastern District of Louisiana, for not enforcing Title VI with respect to seven hospitals in New Orleans. In 1974 OCR agreed in a consent decree to conduct a Title VI review of all hospitals in New Orleans. Central to the review was the collection (from all hospitals in New Orleans receiving Federal assistance) of data on the number of patients admitted, by race, methods of payment, and admission, and by name of admitting physician. Mercy and Southern Baptist Hospitals refused to provide the data until OCR obtained a court order requiring them to do so.

Hotel Dieu, Mercy, and Southern Baptist Hospitals

On July 17, 1977, OCR notified Hotel Dieu, Mercy, and Southern Baptist Hospitals that it found them in violation of Title VI. Investigation revealed that prior to their participation in the Medicare program in the mid-1960s, each of the hospitals had an official practice of excluding black patients. Although each of the hospitals adopted open-admission policies upon entering the Medicare program, they took no action to make their facilities open to black patients, and the hospitals remained all-white institutions. OCR also concluded that the present underutilization of the hospitals by black patients was a vestige of past discrimination which these institutions must eradicate.[1]

In May 1978 OCR initiated administrative enforcement proceedings. In November 1979 the administrative law judge (ALJ) agreed with OCR's allegations of past [pre-1964] discrimination. The judge ordered all Federal assistance in the form of Medicare and Medicaid to Mercy and Hotel Dieu Hospitals terminated. The ALJ, however, refused to terminate Federal Assistance to Southern Baptist Hospital because of a settlement proposal submitted by Southern Baptist during the course of the hearing.

OCR filed exceptions with the Reviewing Authority to the ALJ's acceptance of the Southern Baptist plan, on the basis that OCR was not permitted to evaluate the plan and that evidence introduced by the hospital showed that the plan would not work.

Ochsner Foundation Hospital

On July 17, 1977, OCR found Ochsner Foundation Hospital in violation of Title VI. In October 1978 Ochsner's attorneys orally presented a plan for compliance.[2] The plan included a commitment to open up the Ochsner Clinic (a private medical partnership whose physicians constitute the staff of the Ochsner Foundation Hospital) to Medicaid and Medicare patients on a walk-in basis, to open up a sickle-cell clinic, to formally recruit black physicians on a national basis, and to appoint a black to the Ochsner Foundation Board of Trustees. This proposal was tentatively accepted. OCR is monitoring progress.

Methodist Hospital

In December 1977 OCR found Methodist Hospital in noncompliance with Title VI. Investigation showed that Methodist had several methods of administration which excluded black patients. In fall 1979

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[1] The three hospitals—Hotel Dieu, Mercy, and Southern Baptist—deny OCR's findings that they had an "official practice of excluding black patients" prior to the mid-1960s and that they "took no action to make their facilities open to black patients, and. . .remained all-white institutions." The hospitals point to instances of blacks being treated at the hospitals prior to 1964 and to the Administrative Law Judge's finding that "there is no evidence that [the hospitals] promoted or espoused the doctrine of segregation." The ALJ pointed out, however, that there is also no evidence that the hospitals "disobeyed, resisted, or opposed the pervasive pattern and law of segregation. Thus, it was a situation of compliant obedience" (*Hotel Dieu Hospital,* 79 HUD No. 30, (Oct. 6, 1979), p. 23). He also stated that "neither the prior Federal approval nor the State requirements, lessens the discriminatory impact of segregation, or excuses [the hospitals'] participation" (ALJ decision, p. 82). The Administrative Law Judge did reject the reference to "white only," but found that two of the hospitals remained "racially identifiable," by his definition. He also found that although there were isolated instances of blacks being treated prior to 1964, these did not constitute an "overall open admissions policy" (79 HUD No. 30, p. 24).

The hospitals objected to OCR's finding that present underutilization of the hospitals by black patients was a vestige of past discrimination. The Administrative Law Judge found that, whereas little direct evidence pointed to discrimination since 1964, statistical evidence could be used to determine whether vestiges of past discrimination remain (79 HUD No. 30, pp. 83–84).

[2] The Alton Ochsner Medical Foundation denies that it has ever been in violation of Title VI. The fact that it submitted a plan of compliance does not, in its view, imply acquiescence in OCR's findings, but is an attempt to avoid litigation.

OCR accepted a plan by the hospital to bring it into compliance. As part of its plan, Methodist agreed to stop providing the race of the patient and his or her method of payment when referring a patient from its emergency room to its medical staff physicians. In addition, the hospital agreed to accept patients from nearby primary care clinics treating large numbers of black patients.

Louisiana State Department of Health and Human Resources

When OCR initiated enforcement proceedings against Mercy, Hotel Dieu, and Southern Baptist Hospitals, it also ordered all agencies responsible for disbursement of HEW assistance to defer all applications for additional and new assistance pending a decision by the ALJ. Mercy and Southern Baptist Hospitals applied to the State Department of Health and Human Resources for funding under Section 1122 of the Social Security Act. Their applications were approved notwithstanding contrary instruction from HEW.

After months of unsuccessful attempts by OCR to settle its differences with the State Department of Health and Human Resources, in September 1979 OCR initiated enforcement proceedings. The ALJ has ruled that OCR lacked authority to impose deferral. This decision will be appealed.

Health Services Administration: Providing Health Care in Rural America

The Federally Responsible Government

George I. Lythcott, M.D.*

Health Services Administration

Overview

As Administrator of the Health Services Administration (HSA) for the past 2 years, I have become increasingly aware that this agency must respond to a broad spectrum of human needs. We must also meet the special challenge of delivering needed health care to a diversity of people in a variety of cultural and geographic settings.

The HSA responds to these demands by insuring access to care where there are no doctors, nurses, or other resources; by helping define what services are needed by what groups of people; by establishing effective ways of delivering those services; and by insuring the quality of care.

In discharging our responsibility to deliver health care to the underserved, we help develop and support primary health care programs, recruit and deploy health manpower, meet the special health services needs of particular groups in our population, and devise creative and efficient plans to make quality health services as comprehensive as possible.

The overall HSA mission is similar to that of other health related organizations involved in the delivery of care; that is to offer high quality, effective, and efficient health care. The HSA, however, is unique in that it serves several populations which have special needs which have to do with their employment, location, age, sex, and economic status. For example, the programs of HSA's Bureau of Community Health Services include migrant workers, mothers and children, residents of Appalachia and of other medically underserved areas of rural and urban America. From program to program the groups served are:

- *young* —20 percent in Maternal and Infant (M&I) projects to 67 percent in Children and Youth (C&Y) projects are under 17 years of age;
- *female* —51 percent in Maternal and Child Health (MCH) projects to 91 percent in M&I projects are female;

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- *disadvantaged minorities* —17 percent in MCH projects to 84 percent in Community Health Centers are black and 3 to 67 percent are Spanish;
- *unemployed* —23 percent using CHC have no employed family member; and
- *without health financing coverage* —51 percent of the users of M&H projects had neither public (Medicaid or Medicare) or private insurance.[1]

In addition, much of the Indian population of the country is covered by the HSA's Indian Health Service.

The HSA service population tends to have a lower health status than that of the general population. Its programs for the most part focus on services to the poor, disadvantaged minorities, individuals living on fixed or limited incomes, and those who otherwise do not have the ability to receive or seek care through our traditional health care delivery system.[2]

The HSA seeks to locate its programs in only those urban and rural areas where they are most needed. In fact, the Agency is required by legislation to use much of its program resources within Medically Underserved Areas and Health Manpower Shortage Areas.

This year HSA was the major source of primary health care for nearly 6 million Americans. In addition, HSA programs, particularly those serving mothers and children, reached millions of others. Is this enough? Over 50 million people live in some 7,500 urban and rural areas that are medically underserved; that is, where health manpower resources are scarce, where infant mortality levels are high, where the population falls below the poverty level, and where the percentage of people 65 and over and other demographic factors affect the population's demand for health services. We estimate about half of the residents of such areas are themselves unserved or underserved. The HSA programs place special emphasis on developing the capacity to deliver health care to as many of these populations as resources allow.

Over the past several years, especially, beginning with a Rural Health Initiative in 1975, this Agency has developed the primary care capacity at a significant rate. This initiative has been successful in bringing together providers, staff, and health care managers at the local level via federally funded health care organizations. Partnership agreements were established between our Community Health Centers, the National Health Service Corps, and other programs that influence

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[1] U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services Administration, Office of Planning, Evaluation, and Legislation (OPEL). "Characteristics of Bureau of Community Health Services/Target Populations and Use of Selected Preventive Services: An Evaluation of Program Effectiveness." (Christoffel and Eggers), Mar. 27, 1978.

[2] Many of these people—39 to 75 percent—view HSA's BCHS facilities as their principal or "usual" source of health care.

the efforts of rural communities, inner-city health facilities, local and State health departments and hospitals to better serve underserved populations. From 262 primary health centers serving 1.4 million persons in 1974, we progressed to a level in 1979 of 4.6 million served through 814 projects.

In FY 1980 these efforts will continue. About 250 new primary care projects are being funded, (145 rural and 105 urban). By the end of FY 1980 we expect that well over 5 million persons will receive the bulk of their care from these projects. (This total does include the 750,000 Indians and Alaska Natives).

Finding ways to link statewide and community wide systems of care to improve services to mothers and children was another major Agency goal during 1979. The Child Health Initiative strengthened State-based child health systems through our Maternal and Child Health and Family Planning programs, through the Department of Agriculture's program to provide food and nutrition education to pregnant women and to infants and preschoolers, and through continued support of special projects which help establish or improve State systems of Child Health Care.

Our Maternal and Child Health program supported the development of regionalized perinatal care projects in States with high risk infant mortality rates. These projects built care capacity at different levels to improve services to high-risk mothers, including pregnant teenagers. This support will continue in FY 1980. Services will be coordinated with other Agency programs, and referral systems developed with our Migrant Health projects and other primary care providers.

The HSA also has the responsibility for helping to build a shared health services program for the Indian people. The Indian Health Care Improvement Act (P.L. 94–437), in conjunction with the Indian Self-Determination and Education Assistance Act (P.L. 93–638), defines the goals of improved health care and health status and the role of the Indian people:

1. To insure that the health status of Indian people is raised to the highest level; and
2. To encourage the maximum participation of Indian people in the planning and management of health programs.

These two goals provide HSA with the direction it will take in the years ahead. The direction is structured to address the significant backlog of unmet health care needs of Indian people in both reservation and urban settings, and to maintain a health system for providing high quality and quantity health services to these two groups.

Serving the medically underserved areas, urban or rural, is a complex, expensive, and time-consuming task. This Agency has made substantial progress in meeting the needs of the medically underserved, yet there is much to be accomplished.

The remaining sections of this paper, will:

- describe the programs within this Agency, serving rural areas;
- discuss the issues specifically identified by the Commission for review; and
- describe some of the problems facing this Agency in meeting the health needs of rural areas.

Health Services Administration

Programs Serving Rural America

Two of the three HSA Bureaus are heavily involved in the provision of rural health care—the Bureau of Community Health Services (BCHS) and the Indian Health Service.

Bureau of Community Health Services

The BCHS addresses the health service delivery problems of rural communities in medically underserved communities across the United States. Programs which exemplify BCHS effort to develop the Nation's capacity for delivering high quality, accessible health services to rural areas are Community Health Centers (CHC), Migrant Health Programs (MHP), Appalachian Health, and National Health Service Corps (NHSC).

Rural Health Initiative

The Rural Health Program within the BCHS has as its objective the improvement of access to health care. Its targeted service population includes all of the 13 percent of the total United States population which live in rural areas and are unserved or underserved.

In view of the conditions which characterize many rural areas, such as high proportion of poor and elderly residents, and remoteness from hospitals, it is not surprising that there is a critical shortage of physicians in those areas. It is the purpose of the Rural Health Program to reduce barriers of access to care by bringing health personnel into these areas and establishing health care delivery systems. To induce personnel to remain in the area and to improve the access to secondary and tertiary care, the program focuses also on developing linkages between existing health services and hospitals in the surrounding areas. Such linkages assist in increasing the level of comprehensive care available to the target population and provide the health service personnel with professional contacts and educational opportunities, increasing their levels of retention in the areas they are serving.

In FY 1975 the Rural Health Initiative (RHI) was introduced to develop and integrate health care resources in communities having the greatest need. Through the integration of BCHS programs, such as CHC, MHP, NHSC, and the Appalachian Health Program, a system was developed to better utilize resources in addressing obstacles encountered in serving various population groups in underserved areas. Fourty-seven projects were developed the first year. A more effective distribution of financial, medical, and personnel resources has been developed through linkages with secondary and tertiary levels of care and a system of referral and consultation activities with other Public Health Service (PHS) programs (such as: Community Mental Health Centers, alcoholism programs, etc.).

In January 1976 the Health Underserved Rural Areas (HURA) program was transferred to BCHS from the Social and Rehabilitation Services as part of the Department's effort to consolidate major rural health activities under one administration. The program provided health services as well as supported research and demonstration on methods for the provision of heath services.

In FY 1978 the PHS Act was amended by P.L. 95–626. The new section 340 "Primary Care Research and Demonstration Projects" replaced the HURA program and required that projects which were providing health services only be transferred to other authorities. Forty-one of the HURA projects that were providing health care to rural medically underserved areas were transferred to section 330 Rural Health Initiative projects in FY 1979.

In FY 1980, 133 new rural primary health care centers were added so that the RHI rural projects funded through the Primary Health Care Services and rural Hospital Affiliated Primary Care Centers totaled 575 projects providing access to care to 2.8 million rural persons. The 10 Hospital affiliated Primary Care Centers that are in their planning and developmental phase will become fully operational in FY 1981 to provide access to care in community hospitals to 40,000 persons who otherwise would be utilizing hospital emergency rooms for primary care services.

Migrant Health Program

An integral part of the BCHS effort to build health care capacity in rural areas, the Migrant Health program, continued to support the planning, development, and delivery of high quality health care services in rural areas for migrant and seasonal farmworkers and their families. Poverty and the migrants' necessarily transient relationship to the community have created tremendous obstacles to meeting their health needs. The health care services provided by the BCHS program are comprehensive and organized to be accessible to migrant farmworkers and their families.

In FY 1979, with Federal appropriations of $34,500,000, the Migrant Health program provided services to 557,000 migrants and seasonal farmworkers through 112 projects, many of these projects are operated with combined resources from the Migrant CHC and NHSC programs. The projects provide diagnostic treatment and preventive services and may also offer dental care, rehabilitation, and nutrition counseling, home care, and environmental services. In addition, projects provide referrals to existing health resources within the community.

An FY 1979 agreement between the Department of Health and Human Services and the Department of Agriculture made Farmers Home Administration (FmHA) loans available for construction and renovation of BCHS-funded or migrant community health centers in medically underserved rural communities. Before this agreement, many rural areas did not qualify for FmHA loans. Under the agreement, BCHS provides operating funds which in turn provide the working capital and cash flow to repay the FmHA loan. In FY 1979, 64 projects accepted $25 million in loans for construction, renovation, and equipping of Rural Health Centers.

Appalachian Health Program

Grants to assist States and communities in the 13-State region comprising the Appalachian Health program are awarded to develop and improve their capacities to deliver health services to their citizens. The program is jointly administered by BCHS and the Appalachian Regional Commission. Appalachian health projects are coordinated with the National Health Service Corps, Community Health Centers, and Migrant Health program, and are often supplemented by funds from the Family Planning, Maternal and Child Health, and Home Health Services programs. Other programs within the Department, such as Emergency Medical Services and Community Mental Health Centers may also provide supplemental support.

The 205 active grants awarded through FY 1979 under the broad authority of section 202 of the Appalachian Regional Development Act supported activities as diverse as hospital construction and halfway houses for alcoholics. A very large proportion is used to establish, improve, or systematize the delivery of primary health care services. Sixty-one primary care projects, many with several rural sites, serve over 125,000 persons who make nearly 250,000 visits per year. These projects employ innovative approaches to the provision of health care. Appalachian Health Demonstration projects have pioneered in the use of nurse practitioners and physician assistants on physician supervised health care teams, and the linking of individual primary care centers into systems.

National Health Service Corps

The NHSC was established in 1970 to provide health care services to people living in health manpower shortage areas. Since the first 20 NHSC health professionals were placed in Health Manpower Shortage Areas in FY 1972, the majority of the placements have been in rural areas. In FY 1977 there were 635 NHSC assignees in rural areas. In FY 1979 that number more than doubled. The HSA strategy for more adequately providing qualified health care for all disadvantaged or underserved rural populations calls for the development of organized, integrated systems of care which includes the utilization of NHSC personnel to expand the capability of grant-funded centers to provide services to persons located in rural areas.

Indian Health Service

The Indian Health Service (IHS) is the primary Federal health resource for approximately 777,000 Indians and Alaska Native people living on or near Federal Indian reservations or in traditional Indian country such as Oklahoma and Alaska.

The decade just ending has seen significant change in the structure of programs providing health services to Indian people. Twenty-five years ago, when the IHS was transferred from the Bureau of Indian Affairs, it was a relatively small program, able only to provide acute care to an Indian population desperately in need of such care. At that time, the basic program was to provide acute medical care to the degree available resources permitted. Over the years, Congress has not only provided resources to meet these acute care needs, but more importantly, has given legal sanction to complete Indian involvement in their health programs. The Indian Self-Determination Act, (P.L. 93–638) reinforced by the Indian Health Care Improvement Act, (P.L. 94–437), have altered the traditional methods and systems for providing health care. Under the aegis of these pieces of legislation, Indian people are no longer the passive recipients of programs designed and operated for them by the Federal Government.

These two laws have resulted in a significant alteration in the basic health programs carried on by the IHS in its early history. The management structure, the health delivery systems which provide the services, and the concepts of health planning, have all been altered by increased Congressional support. The current IHS program and structure is a result of these factors. This budget reflects the changing nature of the relationship between the Federal Government, represented in health matters by the IHS, and Indian people represented by their tribal governments.

As of October 1, 1979, the IHS delivery system provided direct health services through 48 hospitals, 101 health centers (including 19 school health centers) and more than 300 health stations and locations. By the close of FY 1981, it is anticipated that two additional hospitals and three clinics will be added to these counts. These facilities are carefully located to conveniently provide as complete a range of health services to the Indian communities as possible.

The need for an effective emergency medical response and transport service is especially acute within the Indian health program due to high incidence of trauma and other emergency medical situations, and the isolated wilderness and rural settings within which the program is carried out. Until recent years such services were practically nonexistent in American Indian and Alaska Native communities.

Specific Issues Raised by the U.S. Commission on Civil Rights

Quality of Health Care in Rural America

Quality of care in a primary care setting may be thought of as encompassing at least two major considerations: (1) whether the scope of services offered by the primary care provider is sufficient to assure both a full range of preventive and treatment services, and (2) whether the system follows a protocol of their efficacy and safety.

With respect to the scope of services, the Health Service Administration (HSA) has established specific standards for assessing the quality of care provided with followup reporting on these standards. Standards include full immunization of children and adolescents, followup and treatment of all hypertensive patients, anemia screening, family planning counseling of adolescents, prenatal care, continuing care for children, and cervical cancer screening and followup.

With respect to internal review of efficacy and safety, each primary care center and independent provider must establish and operate a program to monitor and maintain quality of care. These programs have been effective in assuring quality. Once centers are fully organized and operational, the quality of care they provide is equal, and often superior, to other public or private providers of primary care, particularly because of the emphasis on preventive and comprehensive care.

Independent studies over the past decade have shown that HSA projects currently under review have a positive effect on the health of the population served. A study released in FY 1979 shows significantly lower hospitalization rates for Community Health Centers (CHC) users than for comparable populations (1); A study by the Southern Regional Council in 1973 associates lowered infant mortality rates with health center activities (2); and another released in FY 1978 shows significantly higher use of preventive health measures by CHC clients (3). While each of these studies is limited in scope, the consistency of their findings provide strong evidence that the care provided in CHCs is effective.

In view of the characteristics of the people served and the nature of the rural and urban areas in which they reside, the program's success in developing, staffing, and operating efficient and effective primary health care systems in such areas is impressive.

Usefulness of the Index of Underservice for Making Funding Determination

A substantial degree of success has been achieved through the HSA approach to delivery of primary health care services. In FY 1974 our Community Health Centers (CHC) and Migrant Health (MH) centers provided services to 1.2 million persons. In FY 1979, 3.8 million were served. During that period, the volume of services increased by more than 200 percent, while grant funding increased only 20 percent. This year, CHCs expect to serve 4.2 million persons, and by the end of FY 1980, the capacity will be established to serve 6 million residents of underserved areas.

The centers are reaching underserved areas and the populations intended to be served. Eighty percent of CHC users are members of minority groups—67 percent black, 10 percent Hispanic, and 3 percent other minorities. Seventy-one percent had incomes under $7,000 in FY 1979. Almost one-third of center users are members of large families—31 percent have 5 or more family members. A majority of those served lack any third-party coverage for health services—49 percent have no employed family members. Only 43 percent of the users are entitled to Medicaid coverage. Women and children are heavily represented—59 percent of those served are female and 41 percent are under 18 years of age.

Our approach to the delivery of primary care to underserved areas includes both the establishment center with grant dollars and the placement of National Health Service Corps (NHSC) personnel as staff in centers. In addition to placements in centers, the NHSC places professionals in free-standing sites where no grant dollars are involved.

This record reflects the Department's efforts to target resources on high priority populations. Four criteria are used to identify highest priority areas—status as a Medically Underserved Area (MUA), status as a Health Manpower Shortage Area, status as a High Infant Mortality Area, and status as an area highly impacted by migrant farmworkers. Seventy-seven percent of the counties served by our center meet two or more of these criteria of need.

There are multiple factors integral to the designation process including the acquisition of national data from the American Medical Association and the American Osteopathic Association (physician to population ratio), the Bureau of Census (population below poverty and over age 65), and the National Center for Health Statistics (infant mortality in 5-year rates). In recent years, the most current information on all data elements has been used to update the MSA file.

In addition, the designation process includes a review phase which takes place after the data are accumulated and matched and proposed national listing has been produced. The State Health Planning and Development Agencies (SHPDAs) and Health Systems Agencies review and amend the national listing to include the most current data.

The Department plans to continue monitoring the criteria and improving the process used to identify priority areas. We feel that CHCs and MH have been placed in areas of greatest need. In January 1980 a comprehensive review of the location of all primary care centers in relation to the four major needs criteria was completed. The results, found in table 2, show that primary care centers serve 86 percent of the counties in the United States which meet all 4 of the need criteria, 50 percent of the counties meeting 3 criteria, and 31 percent of the counties meeting 2 criteria. In total, approximately one-third of all MUA designated counties are served by HEW funded health centers despite the program's limited resources.

Adequacy of the Health Care Program in Meeting the Needs of Groups in Rural Areas

The rural health programs, administered by the Health Services Administration have, as their objective, the improvement of health care access and service delivery for those persons residing in rural areas of the United States. Currently, there are approximately 51 million people who live in nearly 8,000 areas which are medically underserved. Of this 51 million, approximately 27 million live in over 2,040 rural medically underserved areas. The general characteristics of such rural areas are—

- a low population,
- a high proportion being poor and elderly,
- remoteness from hospitals, and
- lack of medical manpower

In addition to these characteristics, the programs administered by the Indian Health Service (IHS) must also address a population which has maintained much of its traditional culture. Some Indians and Alaska Natives speak little or no English and live on reservations that

TABLE 2

Primary Care Centers in Relation To Need (County Basis)

Need Criteria Met	U.S. Counties	Counties Served by					Unserved	%
		CHCs	Mig. Ctrs	HURA	Total	%		
4	35	24	6	0	30	86	5	14
3	532	223	27	16	266	50	266	50
2	1,577	375	47	65	487	32	1,090	69
1	730	113	45	18	176	24	554	76

are isolated and in rugged areas. In Alaska, for example, Alaska Natives live in areas where roads are nonexistent.

Despite these barriers, the programs administered by this Agency have accomplished a great deal in meeting the needs of rural Americans. Let me cite a few examples of the progress we have made in serving the medically underserved:

- Infant mortality rates for Indian and Alaska Natives has decreased over 77 percent since 1955 to a rate of approximately 14.5 percent per 1,000 live births in FY 1978.
- Provision of preventive services such as pap smears and breast exams in our projects at a greater rate than for the Nation as a whole.
- Most people using BCHS supported projects consider that facility their usual source of care. In fact, for Community Health Centers, 69 percent of the users consider the facility their usual source of care with 51 percent of the migrant users considering the migrant health facility their usual source of care.
- Reducing hospitalization by 25 percent below the level experienced by similar populations not using such centers. These reduced rates have been documented in a FY 1968–1971 baseline and FY 1975 followup study for Atlanta, Charleston, Boston, Kansas City, and East Palo Alto.
- Cutting infant mortality in half, as shown in studies in Alabama, Mississippi, and Denver.
- Reducing preventable diseases such as rheumatic fever by 60 percent, according to a study in Baltimore which attributed the drop to the center's detection of streptococcal infections in five 14-year-old users.

Reasonable Cost

Primary care centers also provide care at costs comparable to those in the fee for service sector. This is true despite the fact that they serve persons with more difficult health conditions, language barriers, and other problems that make them more time-consuming as patients than the general population. For example, annual costs per year for physician services are $72 for CHC users and $99 for Medicaid recipients.

The BCHS and the IHS have made tremendous progress in improving the delivery and health status for people living in medically underserved areas.

In FY 1980 we estimate that HSA's rural health programs will be serving approximately 3,200,000 (including 700,000 Indian and Alaska Natives).

Despite the efforts of this Agency, there is still the problem of access to preventive and primary care service in rural areas.

This lack of access is clearly a major contributor to poor health status, along with nonmedical factors—housing, sanitation, nutrition. Examples of problems associated with underserved areas and population groups include:

- Twenty-five percent of Americans live in rural areas, but only 12.8 percent of all physicians practice there.
- Madison and Combs state that 16.8 percent of the population and 6.9 percent of physicians are in rural counties, "Location Patterns of Recent Physician Settlers in Rural America."
- The black infant mortality rate has decreased over the last decade, but it is still 23.6 per 1,000 live births, nearly double that for whites.
- Mexican American migrant agricultural workers have a life expectancy of only 49 years, 20 years less than the total population.
- Persons in rural areas which the Federal Government has designated as medically underserved have 24 percent higher hospital utilization, 33 percent more disability days, and 22 percent more chronic limitations than those in rural areas not so designated.

I have briefly described some of the accomplishments and some of the hurdles yet to be addressed by HSA's Rural Health programs.

Outline of the Issues to be Discussed on April 15, 1980

The U.S. Commission on Civil Rights has an important role in this society in the eradication of racism and poverty. We in the Health Services Administration try to deal not so much with the discrimination itself but with the ill effects of this phenomenon. We also have to deal with the vast rural spaces of this country and the enormous difficulties of trying to move resources into them, even under the best of circumstances. Thus, as we pose issues, we look not at the fundamental problems but how to work with poor, rural, and often minority populations in need of services, in getting through often difficult lives with as much of the American entitlement of life, liberty, and the pursuit of happiness that we can extend.

Providing Adequate Care to the Children of Rural America

Life in rural America, in terms of health, has greatly improved over the past two decades. Today we have public health networks whose areas of concern encompass basic public health practices, better housing, improved nutrition, more sophisticated baby care, and expanded knowledge bases in sophisticated health technologies. Obstetrics and pediatrics have become a specialized field. The infant mortality rate is now 14 per 1,000 live births—1/8 of what it was at the beginning of the century. If our progress is clear so too are our dilemmas.

- The differential death rate of white and black infants today is unchanged from 20 years ago.
- A reliable criterion on survival risk for newborn baby infants is its birth weight. Black newborns have a 50 percent higher mortality rate than white newborns.

The problem is complicated when one begins to examine the relationship between the environment and the lack of sanitation systems upon the health of the residents of specific areas. For example, the recent environmental sanitation survey of Hines County, Mississippi, shows that:

- One-third of the rural families there have no indoor privacy. One out of 25 has no toilet facilities, outdoors or indoors; and
- One-third have no water supply on their property.

This county is not unique. While the health care system—or more narrowly the medical care system—can provide a partial response to the results of racism, poverty, and poor and isolated environments it can never fully compensate for them. Modern medicine briefly touches only a few of the many who live outside the mainsteam of American life. These are real dilemmas we face if we are to have any hope of driving down the infant mortality rate in the United States, or restoring health to millions of other victims of neglect.

The frustration in our modern medicine system is that through use of highly skilled teams, we can save the life of, for example, a Navajo baby with a complicated lung disease only to lose this child once he or she returns to the reservation and home, due to diarrhea contracted through a polluted village water supply system.

Provision of Adequate Health Care to American Indians and Alaskan Natives

The majority of the 777,000 Indian and Alaska Natives who receive care through the IHS are located in rural America. A current health assessment with the Indian population shows that:

- The death rate for Indians is still 1.3 times as high as the infant death rate for the general population.
- The death rate for Indians as the result of alcoholism is about five and one-half times as high.
- Many Indian homes do not have modern systems for solid waste disposal and adequate supply of pure drinking water.

The problem of providing adequate health care to Indian and Alaska Natives looms even longer when one considers the recognition of cultural differences and the shortages of trained Indian health workers.

The problem is not simply a lack of adequate numbers of trained Indian physicians, but also the lack of allied health professionals. Finally, the IHS has experienced difficulties with receiving adequate reimbursement from Federal entitlement programs. The IHS, by law, is entitled to receive monies from State Medicaid agencies for the provision of health care services through IHS facilities and Medicaid eligible recipients.

In the past, several States have been unwilling to recognize IHS facilities for reimbursement of IHS doctors. This Department has undertaken a vigorous program working with the Health Care Financing Administration to alleviate or to correct the barriers that have been placed on adequately reimbursing IHS for services provided.

Illegal Aliens

Because of their immigration status, illegal aliens cannot obtain lawful employment; they are ineligible for Medicaid, cash assistance, food stamps, and other emoluments. The question of whether this Agency ought to provide care to legal or illegal aliens has been raised repeatedly over the years. This is particularly a problem facing the migrant health program. The determination of whether a migrant is a legal or illegal alien is irrelevant in providing adequate health care to prevent disease and infestation spread among the population. It is this Agency's (and Congress') policy not to have HEW supported projects determine citizenship of migrant workers or use health projects to enforce immigration codes. Since both legal and illegal aliens work side-by-side, the provision of health services to all migrants and their families is the better interpretation of the Migrant's Health statute.

Aging

In 1977 the U.S. Commission on Civil Rights concluded that:

- barriers had been erected by both public and private administrators between persons falling within particular age groups—especially children and older persons and;
- erection of these barriers has had, and is having, a serious, adverse impact on the lives of children and older persons who need these services.

The most significant finding with respect to HSA programs was that the community health center program places a strong emphasis on serving mothers and children. The Commission suggested that this emphasis stems from policy directions by the Health Services Administration and from the Public Health Service itself. It also suggests that such emphasis has worked to the detriment of potential patients who are aged.

As we indicated in 1977, it is fair to say that both the Health Services Administration and the Public Health Service have given such policy direction. It is also fair to say that the President and the Secretary have strongly recognized maternal and child health programs, childhood immunization programs, teenage pregnancy programs (and the presentation of alternatives to abortions in such programs) to be very important priorities. Recent appropriations acts have endorsed such emphasis. While this strong emphasis has been placed on the health of mothers and children, we do not have any evidence to indicate that it has caused or has contributed reduced care or reduced access to older age groups, or, in particular, the aged.

Recognizing that many of this Agency's issues have been directed at specific high risk groups such as children, adolescents, and pregnant women, in 1978 the Agency undertook a program to improve the accessibility and quality of primary care services for elderly and high risk American adult patients. The care of adult patients requires not only preventive care but also an assessment and management of common physical impairments and chronic illnesses. Without proper management, these conditions can lead to premature disability, physical and mental deterioration, and death. Since the Commission's report on discrimination against the aging, this Agency has undertaken the following activities:

1. Developed a memorandum of agreement with the Administration on Aging. This agreement calls for the development of linkages between HSA primary care projects and AOA Senior Citizen and Nutritional programs.
2. Undertaken a regional conference to orient administrators and medical personnel in projects to effective approaches to care for elderly patients.
3. Distributed to HSA projects guidance on the development of high blood pressure control programs.
4. Established the Needs of an Aging Population as one of four major program evaluation and policy development priorities during the next 2 years.

The joint Health Services Administration and the Administration on Aging initiative will expand the amount and scope of services, increase the number of elderly persons served, and improve the quality of services currently provided. It also will serve as a demonstration model, and will provide information to HSA on how its primary care centers may better serve the elderly and the chronically impaired older person.

CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY

Henry A. Foley*

The Health Resources Administration is charged with assisting in the development of both the personnel and physical resources needed for the delivery of health care services and with supporting a nationwide health planning system. The agency does not provide or support the provision of health services. None of the programs is directly targeted at urban areas, but many have aspects which relate to the concern of the U.S. Commission on Civil Rights for ensuring adequate health care in urban areas. This paper will discuss issues relating to availability of appropriately trained health personnel, the financial viability of health facilities, and planning for a health system which contains cost and provides an appropriate mix of services and institutions, as they pertain to urban areas.

Those responsible for policy development and program management within HRA have, themselves, focused to a greater extent on access questions over the past 2 years. This led to the development and publication in 1979 of a booklet titled, *Promoting Equal Access to Health Careers and Health Care.* It states HRA's commitment to a goal which includes: assuring equal opportunity for access to health careers; alleviating specialty and geographic maldistribution of health professionals; assuring equal opportunity for access to health facilities; assuring equal access to available health resources at a reasonable cost for all groups, including minorities and the handicapped, and providing leadership and staff support to accomplish this goal.

We are in the process of refining and further developing this access strategy and, at the same time, tying it to specific program objectives. Carried out over a period of time, this will assist us in targeting access issues in the operation of all of our programs. Though the access question is broader than urban health, many of the racial and ethnic minorities, the elderly, and the poor, reside in urban areas and would be affected.

Health Planning

The Health Planning and Resources Development Act of 1974 (P.L. 93–641, amended by P.L. 96–79 in 1979) lists among its 17 priorities for health planning the provision of primary care services for medically underserved populations and the promotion of activities to achieve

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needed improvements in the quality of health services. Under the act, health service areas are established across the country. These are served by 204 Health Systems Agencies (HSAs) and 57 State Health Planning and Development Agencies (SHPDAs).

A health service area is defined as a geographic region appropriate for effective planning and is generally required to include between 500,000 and 3 million people. Each standard metropolitan statistical area (SMSA) is to be entirely within the boundaries of one health service area except for interstate SMSAs in which each Governor of the affected States, together with the Secretary, has determined otherwise.

Thus, most major cities comprise one health service area, perhaps with the inclusion of surrounding suburban areas. Some cities, such as New York and Los Angeles, far exceed the 3 million mark and utilize subarea councils to facilitate the involvement of larger numbers of residents in the planning process. As health service areas are to include at least one center for the provision of highly specialized services to the extent practicable many of them contain at least a medium-sized city. Large urban HSAs have been defined as those serving (1) all or a major portion of one or more SMSAs with a population of 500,000 or more, and (2) an area with a total population of at least 1 million. Of the 204 HSAs in the country, 57 fit this definition.

Consumers Involved

Each Health Systems Agency is required to have a governing body which includes 51 to 60 percent consumers who are not providers of health care and who are broadly representative of the health service area, including individuals representing the principal social, economic, linguistic, handicapped, and racial populations and geographic areas of the health service area. All committees, special task forces, and subarea councils of HSAs must also meet these requirements.

The Health Systems Agencies are responsible for the production of a long-range health systems plan and an annual implementation plan for providing technical assistance to entities attempting to develop needed services, and for reviewing proposed capital expenditures and changes in health services. They also review and approve or disapprove proposed uses of Federal funds under the Public Health Service Act; the Community Mental Health Centers Act; the Drug Abuse Prevention, Treatment, and Rehabilitation Act; and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, which fund the development, expansion, or support of health resources.

They must also perform appropriateness reviews; that is, they review all institutional and home health services in the area at least every 5 years and make recommendations to the State agency regarding their appropriateness. This appropriateness review may, but is not required to, result in institution specific findings; otherwise, it results in findings as to the appropriateness of specific services in the health service area.

The Health Systems Agencies do not have regulatory powers but submit their recommendations to the State Health Planning and Development Agencies, which are part of the State government and do have regulatory authority. The State agencies are responsible for developing State Health Plans and for approving or disapproving the obligations of capital expenditures within the State, the offering of new institutional health services, and the acquisition of major medical equipment. This process results in the issuance or denial of certificates of need.

The State agency (SHPDA) must consider the recommendations of the HSA but is not bound by them. Projects not awarded a certificate of need by the State may not be developed. The State also considers HSA recommendations on appropriateness and makes its own review. In some States, there is a movement to link this activity to delicensure or decertification of beds or facilities found not to be needed. This is not a Federal requirement. In performing the various reviews, HSAs and SHPDAs must employ criteria based on factors spelled out in the act or in regulations. A number of these factors specifically relate to access and are discussed below.

The SHPDA is advised by a Statewide Health Coordinating Council (SHCC), appointed by the Governor of the State and including representatives of each HSA in the State. Not less than half the SHCC members are to be consumers of health care, and it must include individuals who represent rural and urban medically underserved populations if such populations exist in the State. The SHCC does not have to meet the broadly representative requirements of the HSA governing bodies.

HSA Activities and Goals

The purpose of the HSA activities is to:

1. Improve the health of residents of a health service area.
2. Increase accessibility, acceptability, continuity, and quality of health care services.
3. Restrain increases in the cost of providing health care services.
4. Prevent unnecessary duplication of health resources.
5. Preserve and improve competition in the health service area.

The Health Systems Plans, which set the framework for all of the other activities, are to be detailed statements of goals describing a healthful environment (primarily with regard to health care equipment and to health services provided by health care institutions, other providers of health care, and other health resources) and health systems in the area. Plans are to be responsive to the unique needs and resources to the area, and are to take into account the national guidelines for health planning which the Secretary must issue as well as to the priorities cited in the act.

The presence on the governing bodies of the planning agencies of representatives of all major population groups in the community and the effective functioning of these consumer members is essential to assuring that the health systems plan, the annual implementation plans, and actions taken in accordance with them reflect community sentiment and address community needs.

It is obvious to all that in a time of fiscal constraint and rising health care costs, not all desired facilities and services will be available. It is critical that all population groups have a voice in the resource allocation decisions and priority setting which must occur, and that local control over the health system be enhanced.

The planning agencies have been the target of criticism about the composition of the governing bodies in terms of representation of the consumer members. The Congress has stated clearly that the broadly representative requirement is not meant to be a quota system. Determining and enforcing compliance in those agencies which do not appear to meet the intent of the law has not been a simple matter. Even more complex a problem is the effectiveness of consumer representation when actual board composition appears to be well-balanced and inclusive. Those population groups who have the most difficulty in obtaining adequate health care services are also at a disadvantage in participating in the functioning of an HSA and in influencing its actions. The average board member donates an estimated 10 or more hours of volunteer time per month. Board members must read complicated technical documents, understand the implications of the issues, and articulate a position. They must be able to attend meetings which may conflict with personal work schedules. Those at the lower end of the economic scale are least likely to have employers who will give release time for such activities. In addition, consumer members are often more intimidated by professional provider members of the governing body and feel unable to challenge their views or opinions.

Attempts to Increase Effectiveness

HRA and the Bureau of Health Planning have undertaken the development of a comprehensive strategy to enhance the effectiveness of citizen participation. This will include the designation of staff in the HSAs to provide assistance to the board members as required by the new statute, training for staff and board members, and development and distribution of more and better informational, and training materials. We also have begun an effort to strengthen our relationships with a number of national organizations which represent the interests of ethnic and racial minorities, the handicapped, the elderly, and women, and to seek their advice on increasing the effectiveness of citizen participation. We recognize as clearly as any of these groups that a seat on the governing body is only the beginning in ensuring access to the decisionmaking process.

The Bureau of Health Planning also has taken a leadership role with the Health Systems Agencies in directing attention to certain health system issues through the distribution of policy guidance and information, and through the issuance of regulations. For example, the April 1979 regulations regarding certificate of need advised State agencies that they must give special consideration to (a) the health related needs of medically underserved groups and, in particular, members of groups which have traditionally experienced difficulties in obtaining equal access to health services, such as minorities, women, and the handicapped; and (b) the contribution of the proposal being reviewed in meeting those needs. Within the past year, guidance has been sent on Section 504 of the Rehabilitation Act of 1973, having to do with handicapped individuals, achieving equal access to health care, and problems of the chronically ill in attaining needed services.

The 1979 amendments allow up to 5 percent of the funds appropriated for Health Systems Agencies to be used to assist those facing extraordinary costs. The Bureau of Health Planning will make $1.7 million available this year for fully designated HSAs which serve (1) interstate areas, (2) large geographic areas, (3) large medically underserved populations (where 25 percent of the residents or 250,000 people reside in designated medically underserved areas). Twenty-three urban HSAs will receive additional funds under category 3.

Accomplishments of HSAs

A number of HSAs can point with pride to real accomplishments in ensuring access to health care in urban areas. An HSA can stimulate positive developments even though it does not provide direct service. Individual HSAs have taken the initiative by getting hospitals to agree voluntarily to provide uncompensated care; stimulating the development of clinics to meet the needs of the poor, the elderly, and migrant workers; promoting the availability of home health services; and assuring access in the face of closure.

In a random survey of 100 agencies' plans, 57 percent contained goals and objectives dealing with urban health problems. These goals include: improving emergency medical services, increasing services in OB/GYN and pediatrics for non-English-speaking populations, expanding social and medical outreach services, increasing access for ambulatory care, increasing primary care services, upgrading crisis intervention services, reducing rodent infestation and substandard housing, prevention of preschool child lead poisoning, expansion of urban hospital staff complements, increasing accessibility to general hospital services, provision of transportation to health and social services, increasing availability of home health services, day care centers for the elderly, greater coordination among urban providers, expanding urban area dental care availability, increasing community sewer systems, establishment of drug abuse prevention programs, detection and treatment programs, and assuring adequate recreational facilities in urban areas.

In addition, approximately 75 percent of our sample (141 plans) have access, discrimination, and services to minorities goals. These include: initiating screening and nutrition programs for disadvantaged populations; reducing infant mortality rates for black populations; transportation for the disabled; increasing the number of bilingual health professionals; increasing access to health care for migrant workers; assuring access to rehabilitation services; expansion of consumer education to poor, black, and elderly populations; and improvement of housing conditions.

Several urban areas have undertaken major projects in determining the need for accessibility to health care. For example, the New York City HSA has completed a study on short stay hospital care. That study recommends denial of new hospital construction in areas already oversupplied, along with steps to prevent facilities from closing or relocating and thus reducing access to the underserved population of that city.

The Chicago health planning agency is coordinating major efforts in prevention of lead poisoning as well as the development of a new facility to serve the residents of the southern portion of the city, who are for the most part presently underserved and economically disadvantaged. The District of Columbia health planning agency is coordinating a major effort designed to reduce infant mortality in the District.

Civil Rights Implications

In the performance of their many functions, both HSAs and SHPDAs take actions which may have civil rights implications for various populations. They may also review applications for certificate of need from certain facilities which some members of the community feel have not complied with civil rights requirements. The HSAs, most of which are private, nonprofit corporations, cannot perform a civil rights monitoring or compliance function. While the Office for Civil

Rights has the responsibility of enforcing Title VI of the Civil Rights Act, HSAs can, of course, alert OCR to possible violations. HSAs do not have the authority or capability to conduct Title VI investigations, and an attempt to do so would threaten the availability of the data they need from the health facilities for health planning purposes as well as their ability to develop a broad based acceptance of health planning activities.

HRA has responsibility for providing guidance to the health planning agencies on the access requirements of Title XV of the PHS Act, which is the health planning program's authorizing legislation. As discussed above, it has done this through provisions in the regulations governing certificate of need reviews, as well as those for reviews of existing institutional health services for appropriateness also discussed above, and those for review and approval by HSAs of proposed uses of Federal funds. The Bureau of Health Planning is working toward a policy issuance which will bring together the various policies and guidelines on access contained in various regulations and guidelines.

As stated earlier, the health planning program is directed at containing costs while improving access to quality care. Some see those objectives as contradictory and therefore unobtainable. It is true that certain tensions are inherent in the program, given this multiple mission. However, just as inflation is generally most harmful to those in lower economic classes in which the target groups are proportionately overrepresented, the extraordinary inflation in the health care sector has hit hardest at those who are dependent on public or subsidized services. Inpatient care in acute care hospitals is the most costly method of delivering health care, and often not the most appropriate. A number of studies have shown that an excess capacity of acute care hospital beds greatly raises the costs of care. The National Guidelines for Health Planning propose a standard of four beds per 1,000 population as adequate for the provision of needed services. Many major cities far exceed this number.

Reducing Excess Capacity

In thinking about access, quality, and cost containment, one has to think about reducing the number of excess acute beds while promoting the development of an appropriate mix of ambulatory services, nursing home beds, and other resources suited to the health care needs of the population. Although many see the reduction of beds as reducing access for target groups, the runaway inflation in the current system is bound to exceed the capacity of State and local government and the Federal Government to pay the costs. This will result in financial failure for some hospitals, and an unplanned and uncoordinated curtailment of services. We take the position that changes are going to occur in urban areas, and that it is preferable to plan for appropriate reductions and development of alternatives rather than just let those institutions which are financially weakest go under, since many of them are truly serving the disadvantaged.

In recognition of the problems of many hospitals in the country, Nathan Stark, Under Secretary of HEW, has convened a Task Force on Financially Troubled Hospitals, and testified before the Congress on this subject in February of this year. The Department is concerned about hospitals, particularly those which serve the poor, that are reported to be experiencing financial difficulties. Characteristically, these hospitals are in medically underserved areas and serve as the principal source of ambulatory care for individuals who have no or inadequate health insurance coverage. Among those most seriously affected are publicly owned and operated hospitals.

Inadequate Insurance Protection

Perhaps the most serious problem some hospitals face is uncollected revenues due to inadequate health insurance protection for many of the patients they serve. It is currently estimated that 22 million people, most of whom are poor, have no health insurance at all. Another 20 million individuals have inadequate coverage. Compounding this problem is the growing and uncertain number of undocumented aliens, perhaps as many as five million. Most are indigent, have no health insurance and, in emergencies, seek care from local community hospitals. Furthermore, much health insurance provides poor coverage for ambulatory services. Such coverage deficiences reduce incentives for physicians to treat patients in their offices, thereby shifting the burden of care to hospital outpatient departments.

The National Council on Health Planning and Development, at its March 1980 meeting, passed a resolution stating, in part, that the core problem of much institutional financial instability is financially troubled people. It then called for comprehensive health insurance for Americans not covered and for Medicare and Medicaid modifications to share reasonable payment for free care and bad debts.

Hospital operating costs also are increasing at high rates due to inflation, rapidly advancing medical technologies, excess hospital beds, and ineffectual institutional planning. Many inner-city hospitals are burdened by aging or obsolete physical plants which are costly to operate. Furthermore, some hospitals have a history of bad management manifested by poor accounting practices, inadequate collections operations, lack of leadership, and an inability to operate under conditions that promote effective personnel management and efficient staffing patterns.

Limited public financing and reimbursement limitations by other third-party payers are placing a further strain on some hospital budgets. Local funding for some urban public-general hospitals is becoming increasingly constrained as a result of diminishing local tax bases. In addition, States and municipalities are pursuing general policies of fiscal austerity and are limiting expenditures and curtailing services.

The perverse incentives built into the reimbursement practices of third-party payers further exacerbate the financial problems of hospitals. Low Medicaid physician reimbursement rates in some States, and a shortage of office-based physicians in many inner-city areas, limit local patients' ability to obtain care in nonhospital ambulatory care settings. Consequently, hospital outpatient departments and emergency rooms frequently must provide primary care to patients who more appropriately and cost-effectively should receive that care in physicians' offices. Moreover, some State Medicaid programs severely limit reimbursements for hospital outpatient services, thereby further exacerbating the financial pressures on certain hospitals.

Developing Appropriate Strategy

The Department is attempting to develop an appropriate strategy for addressing the problems of financially troubled hospitals. However, as the Under Secretary stated in his testimony before Congress on the subject, we must be concerned about both access and delivery system reform. Institutions which serve as the primary sources of care in underserved areas must be kept viable, or acceptable alternatives must be developed. The assumption should not be made that all hospitals in financial trouble should necessarily be saved, or even supported with their present missions, modes of operation, and governance. Federal policies should encourage significant restructuring of local health delivery systems in order to produce institutions with a promise of future viability. Such restructuring must take account of the total health resources of the area, and should emphasize the appropriate use of ambulatory care, as opposed to institutional treatment modalities.

The Department is examining a number of ways to assist financially troubled hospitals, such as revising reimbursement formulas under Medicare and Medicaid, and various other categorical programs. This paper will focus on programs administered through the Health Resources Administration.

The one authority under which direct financial assistance is provided to hospitals is Section 1610 of the Public Health Service Act, which allows the Secretary to make grants to institutions for construction and modernization to correct safety hazards and noncompliance with State or Federal codes that could lead to loss of licensure or accreditation. An institution must be unable to obtain other financing in order to qualify.

Of projects obligated since the start of this program in 1974, 54 percent of the funds, or $21,085,590, have gone to urban facilities, including 10 hospitals, one public health center, and a number of nursing homes. Of the remaining funds appropriated under this authority, we anticipate awarding 76 percent, or $7,669,959, in urban areas to assist seven hospitals, one public health center, and some nursing homes. There have been no new monies appropriated for this program since 1977, however, and there is no request in the President's current budget.

In the main, hospitals must borrow funds for capital improvements; however, HRA administers, through an interagency agreement, the Department of Housing and Urban Development's guaranteed loan program under the Federal Housing Administration, Section 242. We attempt to determine financial feasibility and conformance with health planning guidelines. Projects to develop excess services or bed capacity, or those found to be unneeded by the health planning agencies are not approved. The financial feasibility requirement means that these guaranteed loans are not available to financially troubled hospitals. Current high interest rates are resulting in large increases of as much as $50 per patient day attributable to debt service. Those increases will both increase costs to public and private third-party payers and price some people out of being able to afford coverage. This will increase the demand for indigent care, often in institutions which provide at or near the maximum level they can carry. This burden can serve as an inducement for the hospital to turn patients away, referring them to public institutions. In many urban areas, these institutions themselves are being less adequately supported by municipal governments and State Medicaid programs than they have been in the past, and are less able to provide uncompensated care.

Assurances Programs

The Hill-Burton Act of 1946 authorized the Secretary to require assisted institutions to (1) make their services available to all persons residing in the facility's area (the community services assurance); and (2) provide a reasonable volume of uncompensated services to persons unable to pay (the uncompensated care assurances). The community service obligation specified that Hill-Burton assisted facilities were not to discriminate on the basis of race, creed, or color. Provisions for regulating the act and enforcement of the assurances have been extremely varied since its inception.

In 1975 P.L. 93-641 replaced the Title VI program of assistance with Title XVI and made several changes in the assurances program. These included (1) facilities receiving aid under Title XVI would now be obligated for an unlimited period of time; (2) the facilities aided under Title VI or XVI would file periodic compliance reports; (3) the joint State-Federal monitoring and enforcement process was ended, and the Secretary of HEW was given the sole responsibility, although States may participate on a voluntary basis; and (4) individuals could file complaints with the Secretary charging noncompliance by a facility. Proposed regulations were issued in October 1978 to which over 1,000 comments were received. Two days of public hearings were held in December 1978, and the final rule was published in May 1979.

Title VI assisted facilities have an obligation limited to 20 years from the date when they received Federal assistance, while those assisted under Title XVI are obligated for an unlimited period of time. Facilities must provide uncompensated care equal to 3 percent of operating costs, less Medicare/Medicaid reimbursements, or 10 percent of the amount of the assistance, whichever is less. In FY 1980 we estimate that 5,392 obligated facilities are to provide $435 million worth of uncompensated care. This figure will be adjusted annually for inflation in future years.

Since the publication of the final regulations we have held three meetings with the States and four public meetings in various parts of the country to explain its implementation. We have developed a providers' guide, an assessment manual, a complaint investigation manual, and a reporting form for institutions. We have mailed 14,000 provider manuals to 7,000 institutions, and have notified each facility of its assistance amount. We also have distributed 87,000 signs, in both English and Spanish, to be posted by obligated facilities to inform the public about the assurances program. All activity related to Federal implementation and monitoring of this program must be carried out by 27 staff members in the central office and 10 employees in the HEW regional offices. The law provides authority to develop memoranda of understanding with the States to carry out this responsibility, but we are not able to provide any financial assistance to States for this purpose. Although the Justice Department may investigate an alleged violation, there are no penalties for noncompliance above having to provide the obligated amount of care.

The Hill-Burton program, affecting over 5,000 institutions, is a tool for assuring access to care for all members of the community and for removing barriers based on discrimination or inability to pay. The program also holds the potential, in some cities, for providing relief to public hospitals. By enforcing the obligation of some private institutions to provide uncompensated care, we may cut into the practice of referring medically indigent patients to public facilities. However, it is also true that in some institutions with large numbers of Medicare and Medicaid patients from whom reimbursement (except for Medicaid in a few States) does not include reasonable costs of delivering uncompensated care, the Hill-Burton requirements may heighten financial difficulties. The same may be true in some States with rate setting commissions which will not allow hospitals to set rates high enough to cover the costs to the institution of uncompensated care.

As stated above, it is our view that not all financially troubled institutions should be preserved, but that there should be a restructuring of the health care and long term care services. A number of major cities exceed the guideline figures of four beds per 1,000 population, and are currently considered to have excess acute care beds. For example, Chicago has about five beds per 1,000; Philadelphia, 4.6 per 1,000; and Cleveland, 5.1 per 1,000.

It is generally agreed that the presence of excess beds contributes to overutilization, and that even those beds which are not utilized or staffed generate significant costs for an institution. The costs of excess beds have stimulated an interest in bed reduction programs. The cost savings will vary, often related to whether a few beds, a unit, a wing, or a whole facility is to be closed. Unnecessary duplication of tertiary care and high technology services also is costly in terms of capital investment and staffing. In addition, evidence exists that health outcomes are better in specialized units and services which are operated relatively near capacity than in those which are inadequately utilized.

Several States have already begun or are considering programs to reduce excess capacity, partly because of concern about rising Medicaid costs. The State of Michigan is planning to reduce hospital beds by 10 percent, or 3,800 beds. A unique "Coalition of Health Care Costs," comprised of the big four automakers, United Auto Workers, Blue Cross/Blue Shield, and the legislative and executive branches of State government, made this legislative mandate possible.

New Certificate of Need Requirements

Until the Public Health Service Act was amended by the Health Planning and Resources Development Amendments of 1979 (P.L. 96–79), there was no Federal requirement that State certificate of need programs cover reductions or decreases in the bed capacity of a health care facility. The amended act, however, requires that a State certificate of need program provide for the review and determination of need for any capital expenditure which "substantially changes the bed capacity of the facility with respect to which the expenditure is made." The Department has interpreted "substantial changes" as those which increase or decrease the total number of beds (or distributes beds among various categories, or relocated beds from one physical facility or site to another) by 10 beds or 10 percent.

Although all of the standard criteria required for certificate of need reviews must be applied in reviewing bed reductions, certain criteria which relate to the health needs of underserved groups are particularly pertinent. State Health Planning and Development Agencies (SHPDAs) and Health System Agencies (HSAs) are required, both in developing their health plans and in conducting certificate of need reviews, to consider the extent to which the health needs of low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups are being met and will be met by proposals under review.

I wrote a letter to all HSAs and SHPDAs in November 1979 expressing concern about possible effects of closure and conversion on access. I stated that HRA policy was that HSAs should require that alternative services be in place prior to a closure and that they should have made a commitment to providing services to those who had previously utilized the facility or service to be closed. I also stated that retraining and relocation programs for displaced workers, when needed, were essential for HSA approval. This letter was prompted by a concern that alternative services were often still in the planning stage at the time of a proposed conversion or discontinuance, and that hospitals in the vicinity which, on the basis of occupancy rate, had the capacity to provide replacement services, were not always willing to do so. This was especially true when those affected were minorities or disadvantaged. Furthermore, it seemed apparent that unskilled and semiskilled hospital workers, often women and minorities, were those least likely to find other employment. With restraining, they would be useful resources providing needed services in long term care facilities, ambulatory settings, and home health services.

Apart from requiring review under State certificate of need programs for capacity reduction, the Department is proposing to provide financial assistance for conversion and discontinuance with the objective of better balancing the levels and types of services available, and containing costs.

The Health Care Financing Administration is considering reimbursement for costs attributable to reduction of patient care capacity in hospitals. The proposal would permit reimbursement for certain costs incurred by hospitals participating under Medicare and Medicaid that reduce patient care capacity. The proposed regulation also specifies the conditions that must be met by a hospital to receive reimbursement. The purpose of the regulation is to achieve savings by encouraging hospitals to reduce unneeded and costly patient care capacity.

Proper health planning, coordinated by the local Health Systems Agency and the the SHPDA, should prevent closure of needed service, as well as encouraging elimination of excess capacity. Any reviews conducted by the SHPDA for reimbursement will also address a number of civil rights concerns relating to access to health care. The Office of Civil Rights (OCR) is preparing policy guidance regarding enforcement of the nondiscrimination requirements of Title VI of the Civil Rights Act for use by the HEW regional offices and by hospitals planning closures.

Conversion and Discontinuance

In addition, the 1979 amendments to Title XVI included a new authority for actual grants to hospitals for conversion and discontinuance of services. This would be a voluntary program to reduce excess hospital capacity and convert the unneeded beds to needed health uses. It would be a program of last resort for funding, and could assist financially troubled hospitals to retire outstanding debt as a prelude to closure. This program would also stress protection of access for the poor and minorities. The statute requires that the Secretary of the Department of Labor issue regulations regarding the fair and equitable treatment of employees, and to certify that employees are fairly and equitably treated prior to HRA funding of an applicant. Funds could be made available for retraining and relocation, and could also be awarded to SHPDAs for excess hospital capacity reduction projects. The HEW Office for Civil Rights is closely involved in the development of regulations for this new authority, which is, as yet, unfunded. Authorizations are for $30 million in 1980, increasing to $50 million in 1981, and $75 million in 1982.

Not much is known about the effects of capacity reduction, so we consider such a program as a demonstration to be closely monitored and evaluated. HRA has recently published a monograph in the Health Planning Series titled, *Conversion and Other Policy Options to Reduce Excess Hospital Capacity,* which presents 17 case studies and examines some of the issues.

We recognize that hospitals in urban areas are often the sole source of health care for surrounding communities. However, a well-planned reduction of acute beds, together with reasonable access to an appropriate mix of alternative services, should help us realize the objective of providing adequate services while containing costs and improving the financial health of the remaining institutions. An example of the type of change we would like to see occurring would be reduction of a 600-bed hospital in an area exceeding the 4 beds per

1,000 guideline, which has few ambulatory and emergency services, to a 300-bed hospital with more ambulatory and emergency services, and with long term care, mental health, alcoholism, or drug abuse units. It has been estimated that this type of program could "save" $3 in health care expenditures for every $1 spent on discontinuance of excess capacity.

Health Personnel

Along with the heavy focus on the total health system and the availability of facilities, we must also recognize the importance of health personnel to urban health care delivery. For some time, the administration has recognized that the critical issue is not the total numbers of graduates in the various health professions, but serious geographic and specialty maldistribution. We have tended to train too many physicians who end up practicing specialized medicine rather than providing primary care services. In addition, physicians and other health professionals tend to practice in more affluent urban areas, suburbs, and medium-sized towns rather than in the inner cities or remote areas. In many States, low Medicaid reimbursement rates for office visits serve as a disincentive to opening a practice in a poor neighborhood.

Prior to passage of the Health Professions Educational Assistance Act of 1976, most shortage area designations were in rural areas. This was because the criteria for shortage were based primarily on practitioner-to-population ratios applied to county data, and most urban counties did not qualify. However, the HPEA Act of 1976 specifically mandated designation of urban as well as rural areas, and designation of population groups as well as geographic areas. In addition, that legislation required that indicators of health status and of access to health services be considered along with practitioner-to-population ratios.

To implement those legislative provisions, HRA developed revised criteria for determining shortages of health manpower. These criteria allowed for designation of urban neighborhoods and population groups (such as medically indigent and Spanish-speaking populations) with health manpower shortages within metropolitan counties which, on the whole, had adequate supplies of health manpower. As a result of our application of these criteria, approximately 25 percent of the currently designated primary care health manpower shortage areas (including designated population groups) are in metropolitan areas. Moreover, the population residing in these areas represents 50 percent of the total population of all primary care health manpower shortage areas.

The designation of a health manpower shortage area can allow the community to receive certain assistance, such as the discretionary funding to urban HSAs serving areas with a significant problem discussed above. The designation of a medically underserved area also makes the area eligible for the placement of a physician or other health care provider through the National Health Service Corps. The Community Health Centers and Urban Clinics programs administered by the Health Services Administration also provide direct services to these areas.

It is currently the intent of the administration to eliminate general institutional support for health professions schools and to concentrate on funding targeted programs aimed at meeting identified needs. These needs will generally fall into the two categories of correcting geographic maldistribution and increasing the proportion of primary care practitioners.

National Health Service Corps and Scholarships

One of the most important programs for placing physicians in shortage areas is the National Health Service Corps Scholarship Program and the National Health Service Corps. Medical students who are committed to entering a primary care field such as family practice, general pediatrics, or general internal medicine, as well as psychiatry, are supported through the scholarship program. In return, following a deferment for residency training, they must agree to serve where placed in a shortage area on the basis of a year of service for each year of support. Currently there are 1,070 scholarship recipients fulfilling their service obligation, and 8,988 individuals in awardee or deferment status. A major objective of the program is to have a number of the practitioners remain in the area following the time of obligated service. There are some who think that the stresses of practice in certain inner-city areas are such that it is more realistic to think in terms of part-time inner-city practice for physicians, and greater utilization of physician extenders. A limited number of other health professionals are also supported through the scholarship program. Many of the other health professionals have been recruited directly into the Corps to work at the Corps site.

Foreign Medical Graduates

For the past 20 years, large numbers of foreign medical graduates (FMGs) have entered this country for graduate medical education, filling significant numbers of residency positions. A disproportionate number of these slots have been in those hospitals less attractive to U.S. medical graduates. From both a quality of health care perspective and a foreign policy "brain drain" point of view, this influx of FMGs was viewed as an undesirable situation.

Title VI of the Health Professions Educational Assistance Act of 1976, Public Law 94–484, as further amended by Public Law 95–83, contained several amendments to the Immigration and Nationality Act that significantly affect the process by which FMGs are allowed to enter the United States as immigrants or exchange visitors, and limits the time for remaining in the country.

In order to enter the United States to participate as an exchange visitor or in a graduate training program, a foreign medical graduate must have passed the Visa Qualifying Examination or obtained a waiver of the requirement under the Substantial Disruption Waiver Provision discussed below. The number of FMGs entering the country through either avenue has been dropping sharply as indicated by the total number of exchange visas under Educational Commission on Foreign Medical Graduates sponsorship: in 1975, 7,507; 1977, 5,310; 1979, 2,578.

In the graduate medical education programs conducted in hospitals, the high reliance on FMGs had become a serious issue. The FMGs filled 29 percent of graduate medical education positions in the United States and 28 percent of the first-year positions in 1974–75. By 1978 these figures had begun to reflect a downward trend, and FMGs represented 15.4 percent of all residents in graduate medical education programs.

If entering FMGs were evenly distributing themselves by location, by specialty, and by type of hospital, the impact of the recent Immigration and Nationality Act amendments would be minimal. However, it was clear from data collected by the American Medical Association (AMA) in 1977, that the reliance on FMGs to fill house staff positions was concentrated in certain types of hospitals, geographic areas, and specialties. For example, 73 percent of the FMG-filled residency positions were located in nine states: New York, New Jersey, Illinois, Delaware, District of Columbia, Maryland, Michigan, Ohio, and Pennsylvania, even though only 35 percent of the U.S. population resided in the same States.

Several of the large metropolitan areas, especially in the Northeast and North Central regions, showed high proportions of FMGs in residency positions. FMGs filled substantial proportions of the total number of residency positions in the following metropolitan areas: Baltimore, 40 percent; Chicago, 46.6 percent; Cleveland, 36.6 percent; Detroit, 37.4 percent; New York City, 42.1 percent; and Philadelphia, 30.6 percent.

In addition, a large proportion of hospitals in several major metropolitan areas had more than one-half of their residency positions filled by FMGs: Baltimore, 56 percent; Chicago, 70 percent; Cleveland, 75 percent; Detroit, 44 percent; New York City, 52 percent; and St. Louis, 54 percent.

Because of the expected severe reduction in the number of alien physicians entering the United States annually as a result of the amendments to the law, Congress provided for waivers of two of these requirements on a case-by-case basis. The waiver clause, which extends through December 31, 1980, can be granted if a graduate medical education program can demonstrate that application of these requirements would result in a "substantial disruption" of health services. The substantial disruption waiver was developed to provide programs and institutions traditionally placing significant reliance on alien physicians, a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, programs and institutions are expected to develop alternative provider resources and to attract primarily graduates of U.S. medical schools. If substantial disruption waivers fail to meet the manpower needs of particular programs or institutions, the waiver mechanism provides for an appeal process in which additional waivers can be requested.

A Federal Substantial Disruption Waiver Appeal Board has been established to consider appeals from those programs and institutions. The Waiver Appeal Board functions in an advisory capacity to the International Communications Agency, the Agency responsible for administering the Exchange-Visitor program for alien physicians. The waiver mechanism has been in operation since May 1978.

Information collected since the program became operational supports the early predictions on the geographic location of hospitals which would be most severely affected by the reduction in FMGs. Hospitals in some cities have been much more aggressive and successful in reducing their dependence on FMGs than those in other urban areas. For example, of 64 applications for 185 positions considered during calendar years 1978 and 1979, 52 were from public and private nonprofit hospitals in the Northeast and Central Northeast regions for 171 of these 185 positions. Large cities also were heavily represented in the applicant pool. For example, 38 of the applications were from urban centers, while 18 were from medium-sized cities, and 8 were from small cities and/or rural areas.

The statistics on the specialty programs, however, are not as consistent as was expected. While neurosurgery, psychiatry, anesthesiology, pathology, and other specialties which rely heavily on FMGs are reflected in the applicant pool, the primary care specialties of pediatrics, internal medicine, and surgery also represent large numbers of training programs. This may reflect the heavy utilization of the waiver mechanism by hospitals in large urban centers which provide extensive primary care services, as well as acute inpatient services. It is estimated that as much as 75 percent of outpatient services in the New York metropolitan area is provided by FMGs. It is likely that a limited extension of the waiver authority past the December expiration date will have to be considered by the Congress, especially for the greater New York City metropolitan area.

Physician Extenders

Physician extenders, a term which encompasses both nurse practitioners and physician assistants, are another source of health personnel, particularly in organized care settings such as urban clinics. A number of studies have shown that physician assistants and nurse practitioners perform those functions for which they are trained equally as well as physicians. The degree of supervision under which they must practice varies from State to State, depending on the medical practice acts as well as the various Medicaid reimbursement rules. Medicare Part B only reimburses for the services of a nurse practitioner incident to a physician's professional service. The fact that a nurse practitioner may cost more out-of-pocket for the patient reduces utilization, even if the overall cost is less. A study in 1979 indicated that 23 percent of nurse practitioners were practicing in inner-city areas, and that 60 percent of nurse practitioners were employed in ambulatory clinical practices such as community-based clinics, with an additional 10 percent employed by health departments or home health agencies. Since 1972, 7,600 physician assistants (PAs) have been graduated from federally assisted programs. The number of females in the profession, which was once dominated by former military personnel, has increased markedly, but minority representation has not. The Federal grant program has required deployment of students to health manpower shortage areas, and studies have shown that graduates do tend to locate in both urban and rural shortage areas. Although data are not available on the impact of PAs on the populations of interest to the Commission, studies indicate that PAs have definitely had an impact on accessibility to care where access was previously minimal.

Area Health Education Centers

The Area Health Education Centers (AHECs) program is aimed at training physicians and other health care providers with a primary care orientation, and requires that a significant portion of the training take place in a rural or urban site remote from the Health Science Center. This program hopes to interest developing health professionals in practicing in such locations, while also providing important professional linkages for existing practioners in that area.

Although the predominant number of AHEC projects, originally 11 and now 21, were oriented toward rural areas, 3 have been rural-urban and 4 have been totally urban in nature. The AHEC program, begun in 1972, was developed along lines recommended by the Carnegie Commission. Its goals are to improve access to health care services in underserved areas by providing decentralized training, education, and experience; increasing primary care training; and encouraging more efficient utilization of health care personnel. The program is continually being evaluated, most recently by the Carnegie Council, as well as the Department in a report to Congress, and has shown some positive results, both in stimulating new practitioners to locate in underserved areas and in making it more professionally rewarding for those who are already there to remain.

Primary Care Practitioners Needed

In talking about health professions, we have used the term "primary care." We are concerned that increasing numbers of physicians have gone into the specialties and subspecialties, while the greatest need is for the primary care practitioner, who is the physician one sees first, and who is capable of treating 90 percent of our ailments (according to the Institute of Medicine), and who refers patients to specialists as appropriate. A primary care practice is not hospital based, and often is not as well-reimbursed by third-party payers. In addition, it is less prestigious in academic health science centers than surgical specialties and those which are more closely tied to the research community. However, meeting the health needs of the disadvantaged will require primary care physicians. In targeting support for medical education, HRA is providing funding for primary care residencies in general internal medicine, general pediatrics and family practice, and family medicine curriculum development. For these projects, a preference for funding is given to applications which propose a substantial portion of the training program in health manpower shortage areas (Section 332) or in a federally funded AHEC. Many of these are in urban settings. Support also has been provided for the development of geriatrics and nutrition curricula in medical education. It is our position that geriatrics ought to be incorporated into all medical education, rather than becoming another subspecialty. We also have provided support for projects such as interdisciplinary team training for hospice care.

Concern on Nursing Problems

There is concern in all parts of the country about the high vacancy rates for nurses in hospitals. In 1977 there were 1,401,633 nurses in the Nation; some 423,400 of them were not employed in the nursing field. The various nursing education programs graduated 77,874 new students in 1978. We are currently attempting to better understand the factors affecting the high drop-out rate, such as salary, scheduling, burn-out, and career mobility opportunities. It is more logical for us to study such factors than to produce more and more graduates to compensate for the numbers of nurses leaving the profession. We intend to have the Institute of Medicine of the National Academy of Sciences carry out a study over the next 2 years on issues relating to nursing education and retention.

Apart from generalized support of nursing education, we have been supporting programs aimed at furthering identified priorities. These projects include nurse practitioner programs focusing on women's health and on geriatrics. Other projects address the needs of women in child bearing and child rearing. Although such programs are organized along disciplinary lines or focus on subject areas as in nursing research, it is easy to see their relevance to the health care of target populations in urban areas.

Decreasing Federal Support for Schools

It is unclear in the present fiscal situation what funds that have been available for undifferentiated support of health professions schools will be redirected into targeted priority activities. With the decreasing level of Federal support for health professions students, the role of the States is increasingly significant, both in terms of financial resources and potential service obligations. A number of States also are imposing service requirements on health profession students who have attended State-supported schools or on those who have received State financial assistance. We are increasing our monitoring of State activities in this area, and are attempting to coordinate service obligations for students.

The Commission has asked us to discuss the quality of health care received by target population groups. We do not, however, participate in the actual monitoring of the quality of health services delivered.

The principal health professions programs administered by this agency which relate to quality are those in curriculum development and continuing education development. We also have played a strong role, in conjunction with various health professional associations, in supporting the development of credentialing standards for these personnel.

Health Careers Opportunity

Within the Health Resources Administration, the Office of Health Resources Opportunity (OHRO) directs the Health Careers Opportunity Program (HCOP), which funds projects aimed at the identification, recruitment, and retention of minorities and the disadvantaged into the health professions. We cannot provide direct data on the relevance of this program to urban health care for population groups of concern to the Commission, except to note a study published by OHRO titled, *The Treatment Practices of Black Physicians,* which states that in 1975, 87 percent of patient visits to black physicians were by black patients, and 90 percent of patient visits to nonblack physicians were by nonblacks. One can infer that the training of more minority health professionals increases access for minorities. Currently, blacks constitute 5.7 percent of medical students; mainland Hispanics, 2.8 percent; and women, 25.3 percent. We have found that over the last 9 years, the average percent of minority students in the first year was 9.3 for those nonminority schools which received grants under this program, compared with 6.8 percent for schools which did not receive grants.

Although place of residence is not a determining factor for participation in HCOP programs, except for those directed at American Indians, a listing of HCOP grantees shows that 131 are urban-centered out of a total of 151. It can be assumed that a significant number of the more than 10,000 youths served by these projects are from urban settings. The projects themselves range from general information and motivation at the secondary school level through identification and compensatory education. This program does not provide student assistance; however, approximately 640 students in FY 79 were recipients of Exceptional Financial Need Scholarships for the first year of health professions education. These scholarships enable the student to determine how well-suited he or she may be to such an education before incurring a debt for tuition loans. The program is based on need and not racial or ethnic background.

Other Factors

It is, of course, obvious that urban health is influenced by much more than the availability of health care facilities, services, and personnel. Adequate food, housing, education, a healthful environment, and a health promoting life style are critical elements. Even within the realm of actual health services, we need better coordination between financing and reimbursement practices and programs which deliver health services or which promote the development of health resources. Building a structure for the planning and implementation of a rationally organized health care system and training professionals to provide needed services is an important part of a broader approach to problems relating to urban health.

ACCESS TO MEDICAL TRAINING FOR MINORITIES AND WOMEN

Alonzo C. Atencio*

Introduction

As public attention was drawn to the problems with the health care delivery system in the United States in the 1960s, severe shortages arising from limited access, maldistribution of resources, and uneven quality of care in the private office and in the public clinics were found. The problems were mainly those arising from poverty.

These early studies also revealed that the state of health of the American people in general was not faring well either. Judging from some key indicators of health status, the U.S. had a lower life expectancy and a higher infant mortality than other affluent nations.

It was alarming that such problems of health care and poverty could exist in the U.S. with all its advanced technology and scientific achievement. Something seemed to have gone out of the health care delivery system. At first it was thought to be caused by physician and other health care personnel shortages. Closer examination, however, showed that the physicians were not practicing in rural, ghetto, barrio, Indian reservations, or in the poorer urban sections. There was also indeed a shortage of general practioners and an oversupply of specialists. The shortage of physicians and other health care personnel were greater in the areas predominantly minority (Chicano, black, mainland Puerto Ricans, and Native Americans).

The vital health statistics were bad for poor whites but were significantly worse for the minority population. But this data alone failed to indicate the extent to which health problems were affecting minorities as they were in other social and economic situations. The evidence, however, clearly showed that the health care failed minorities not only through omission of health services but actively discriminated against them in a way that continued to place them at a disadvantage. Increasing expenditures through Medicare and Medicaid have failed to address the underlying problems.

The problem of minorities is not solely poverty but is overlayed with racial discrimination. It is not surprising to find that over 30 percent of the minorities earn incomes less than $10,000 annually compared to only 10 percent of the white population. To be poor means you can purchase less education, especially college level and

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above; purchase less health care, and purchase less adequate housing. In short, be subjected to a substandard environment predisposed to illness, trauma, and violence. To be poor means more disability, affecting the early education of children. Studies have shown that children of both whites and nonwhites with annual incomes less than $5,000 lose more school days due to chronic ailments.

Although poverty and disease transcend racial lines, to racial minorities it is a double burden. In 1974–75 the average life expectancy at birth was 73 percent for whites compared to 67 percent for nonwhites. During their life time, nonwhites are three times as likely to die from hypertension, kidney disease, and diabetes. A nonwhite is twice as likely to be a victim of homicide. The uncontrolled illicit drug traffic in minority communities is prevalent.

Discrimination limits access to housing, employment, and recreational facilities supportive of good health. It contributes to internal conflict, repressed anger, inner stress, all elements capable of not only precipitating disease episodes but also are liable to create destructive behavior. Alcoholism takes its toll of lives in the minority community.

All of the elements of conditions cited above are symptomatic and, in general, services provided the minority communities are deficient in the characteristics essential to a well-organized system: availability, accessibility, continuity, comprehensive, coordinated, and appropriate. By most standards, services provided to minorities are frequently inferior in quality—unfortunately, mostly caused by overt or subtle discrimination, lack of cultural empathy, lack of a second language in monolingual communities. The resources in general are inadequate in number, type of care, long or acute mental health care.(1)

Torrey cites statistics, relative to involvement of psychiatrists in the delivery of mental health care, indicating that over 65 percent of their time is involved in private practice or private general hospitals as opposed to State or county mental health centers or in alcohol rehabilitation centers. The area of mental health treatment is culturally loaded.(2)

One of the most crucial natural resources to adequate health care delivery is health care personnel, and there is a severe lack of minority health professionals. For instance, while there were less than 26 black physicians per 100,000 black Americans in 1975, there were 177 white physicians per 100,000 population.(3) Among Chicanos there were fewer than 250 practicing physicians. Of over a million Native Americans and Alaskans there were only 72 practicing physicians.

In this monograph I will address what has occurred in the medical education of minorities during the last decade; what role the Federal Government has played in increasing minority participation in medical education; what changes have occurred in medical school admissions;

what effect the *Bakke* decision has had on the admissions process; what steps could be taken to increase the enrollment of minorities.

Preparation

In order to understand the nature of the barriers to minorities' access to medical education, we have to know something about the process leading to admission to medical school.

The preparation for a career in medicine begins early, around the seventh or eighth grade. As a child moves on through the educational "pipeline" he begins to make choices on what he would like to become professionally, as an adult. It requires an uninterrupted flow through the "pipeline" from high school on to college before reaching out for professional school. For minorities the flow is often interrupted early. Starting with say 1,000 elementary school children, as they move on through, there are losses occurring at the junior and high school level. Many of them drop out either because they find school noneducational or they need to work to contribute to the family income.

In New Mexico in 1970, we found that 80 percent of the Chicano and Native American high school students did not plan to enroll in college. Of the original 1,000, that left only 200 viable candidates for college. Coming from substandard secondary schools, they found college difficult, accelerated, foreign, causing a 65 percent dropout rate by the second year of college, that left only 70 continuing. Of the remaining 70, the large percentage would stop their education to pursue work after their bachelors degree; perhaps one of the original 1,000 would eventually end up in a professional school. We found, for instance, that while the population of New Mexico was 40 percent Chicano only 19 percent of the college and 3 percent of the medical school enrollment were Chicano. For their Anglo counterpart, the representation rose from 48 percent of the State population to 91 percent at the medical school level. There is a clear divergence in the pathway for the two groups as each progresses on up through the educational pipeline.(4)

Many have investigated the causes of this divergence. The reasons range from the absence of role models in the professions to overt exclusion due to racial discrimination. Role modeling has certainly played a major role in the exclusion of females from the medical profession. But this is self-exclusionary more than discriminatory. Others have attributed the exclusion of women to sexist views held by admissions committees.

Relative to Chicanos in the Southwest, the Commission on Civil Rights in 1972 found that there were certain practices affecting the education of Mexican Americans.(5)(6) While not being overtly racist, they noted that teachers praised and encouraged Anglo student participation in class exclusively.

A quote from their report illustrates this point: "There were several Chicanos who kept raising their hands eagerly at every question. Ms. G. would repeatedly look right over their hands, and call on the same Anglo students over and over again. In some cases, she would call on the Chicanos only because the Anglos stopped raising their hands."

They also found that teachers built upon contributions of Anglo students 40 percent more frequently than on those of the Chicanos. Overall, the Chicano student received less attention from teachers than their Anglo counterparts. I can relate similar personal experiences but suffice it to say the Commission has independently recorded these incidents of educational neglect that are still being implemented. Similar episodes happen to blacks, American Indians, and mainland Puerto Ricans.

These dynamics obviously do not foster creativity or cultivate the faculties of the mind, rather they make students feel inferior; create anger and rebellion and eventually a disdain for the educational system. Of course this negative stroking does little to promote self-worth and self-esteem. Rather it creates insecurity by nonparticipation eventually leading to self-elimination from the educational system.

Economic Barrier

Another hurdle in the path of minorities achieving a higher education is their economic status. We live in a socioeconomic reality that requires people to purchase education. At lower income levels, people tend to prioritize the expenditures of their meager incomes. Usually education and "necessary" health services are delegated lower priorities over say food, shelter, etc.

In 1974 a study of 55,053 families showed that 49 percent of nonmetropolitan areas earned less than $10,000 per year. The correlation to educational attainments of persons older than 25 years was significantly lower for nonwhites.(7)

Financial need has had a long range effect on minority education, particularly those desiring to pursue a professional career in medicine. Even though the awareness created by the civil rights movement led to increased efforts by colleges and universities to enroll more minorities, there is still a fear of accumulating debt by minorities. In the mind of minorities a $6,000 debt accumulated in college is significantly high to preclude the student anticipating adding $30,000 more by the time he/she finishes medical school. This is compounded by the obvious fear of failing in school and being saddled with a "high" debt. The fear is real since most minority students are considered "academic risks" by most professional schools.

Medical Education: The Process of Selection, Training, and Retention

As mentioned previously, the process of preparing for a medical degree begins early. The process of selection and admission to medical school is based on this long range preparation. A preparation that leads to conditioning to test taking and a belief that following a given series of courses will produce a well-qualified applicant.

The admissions process is strongly dependent on measurable cognitive variables in the initial stage and noncognitive subjective variables at the later stage. It is in the initial stage that minority applicants, that is those who have survived college to apply, are eliminated from the process. The noncognitive evaluation, which is unquantifiable therefore becomes the most meaningful parameter in the admission of minority medical students.

In the initial stage, the screening stage, the grade point average and the MCAT scores play a significant role. Medical schools tend to have a GPA cutoff of 3.5 (scale of 4.0) and MCAT scores about the 85th percentile. It is from the survivors of the initial screening that the matriculants are selected.

Minorities seldom achieve high cognitive scores, consequently they seldom survive the initial screening. One medical school developed a formula for screening medical applicants that included points with adequate multiplying factors for GPA, MCAT scores, letters of recommendations, college attended, interview impressions, etc. The formula had a high predictability for students scoring above a certain score and it worked so well that not a single minority fell in the admissable range.

It has been well-established that minority applicants score at or below the 30–40 percentile in the MCAT and bring GPA averages around a 2.7. A cognitive profile for the majority and minority applicants clearly shows a biphasic distribution or two distinct populations.(8) Schools therefore feel justified in screening out those with the lower scores and grade point averages without taking into consideration the events causing them.

This myth of measurability is based on the assumption that the qualities desirable in a physician are measureable.(9) Using such selection criteria not only serves to feed the ego of those selected but will also select a homogeneous population of overachievers trained in test taking and perhaps rather insensitive to human facilities. Their emphasis has been to score well rather than learn more about human interaction.

In the period from 1947 to 1956, for instance, there was an increase of only 173 black medical students compared to 5,900 whites in medical school. However, the enrollment of blacks at Meharry and Howard accounted for 2/3 of those enrolled.(10) Thus two-thirds of 761 black medical students in 1956 were enrolled at the two black medical schools and the remaining one-third in the remaining U.S. medical schools. There is no evidence that those students enrolled and graduated from Howard and Meharry were inferior physicians. By the same reasoning, those graduated from predominately white institutions were evidently not superior physicians. If anything, the selection of a homogeneous population of overachieving medical students has led to the maldistribution problem as witnessed by the decline in general practitioners.

The second stage in the selection of students surviving the preliminary screening is largely noncognitive if implemented fairly.

There are many qualities, difficult to quantify, that are desirable in a physician. Admissions committees attempt to glean these qualities through a personal interview and analyzing the students involvement in community organization, etc. Given a preselected group in which the committee is reasonably assured they do not present an academic risk, the noncognitive evaluation is reasonably safe unless they detect some obvious qualities of insensitivity or sociopathic behavior. This is difficult to achieve in a 30-minute interview and from self-identified student involvement indicating a sensitivity to people. Since the medical profession has high rates of suicide, drug abuse, alcoholism, and divorce, something must not be working properly in the selection of medical school matriculants.

Medical School Enrollment of Minorities and Women

Reacting to social pressure, U.S. medical schools in 1968–69 began to seriously address the absence of minority medical students. In 1970, at the annual AAMC meeting in Los Angeles, there was an aura of frustration. For some naive reason, many schools felt that if they opened their doors and go out and "beat the bushes" there would be a flood of minority applicants. Much to their dismay, qualified minority applicants were not that easily located. Years of educational neglect had taken its toll. Very few minorities had survived the educational trauma and even fewer were enrolled as premedical students. The medical schools had to turn to seeking minorities majoring in the sciences totally unrelated to medicine. These students became the potential pool of applicants. Furthermore, they had to reexamine their admissions procedures in order to give minorities a more equitable evaluation.

The Federal Government meanwhile reacted to a perceived shortage of physicians and initiated Physician Augmentation Programs and Capitation Grants to medical schools, rewarding them for increasing their enrollment. What was neglected in this analysis was the maldistribution of physicians arising from overspecialization and the near elimination of the general practitioner.

Enrollment in medical schools increased as schools expanded the class size. But the problem of increasing minority enrollment in particular continued to lag. Admissions committees encountered much difficulty in accepting students with what they considered substandard academic credentials. Medical school faculties reacted similarly and felt that minority students could not cope with the rigors of medical education. Resistance to the admission of minorities also came from the white applicants who felt discriminated against. This was not without some justification, after all, they had been preparing for a medical education most of their life. They also represented a small percentage of survivors of premedical students (a large number of college freshmen enroll as premedical students but only about 10 percent actually become eligible to apply using the standard GPA and MCAT criteria).

This change placed some medical schools in a dilemma. On the one hand, those which wanted to enroll more minorities now felt that their standards had to be lowered to accomodate the minority and women applicants. Naturally under these circumstances, the graduate from medical school would also be considered substandard. Many discussions on the criteria for admitting minorities ended in stalemates.

Much to their surprise however, women applicants were bringing with them excellent credentials from college so their admission did not require drastic changes in admission policies. The only major adjustment was altering or accepting women as equals in a predominantly male profession.

The problems remain with minorities and statistics comparing the rise in enrollment of minorities and women verifies the above statement.

U.S. medical schools, some more rigorously than others, began to alter their admissions policies and initiated special programs for identifying, recruiting, admitting, and retaining minority medical students.

Emphasis was placed on identifying minority students with a high potential for successfully completing medical school. Rather than relying solely on the grade point average, they now would examine the students grade trend. Recognizing that most minority students had attended poor secondary schools, it was anticipated that they would do poorly in the first and second years of college. But by the time they were juniors they were expected to be doing somewhat better. A strong finish was considered evidence of academic reserve and potential. Similarly, the MCAT score was scrutinized and two parts of the old MCAT were considered to be culturally biased. Emphasis was therefore placed on the students performance in science and mathematics portion of the MCAT.

Another change, instead of prescreening minority applicants, now most minority applicants were given the opportunity to file a complete application and bring it in for personal interviews. The interviews were obviously designed to probe more into the minority students background, his educational achievements, economic situation during his/her childhood, and cultural richness, i.e., did they come from predominately monolingual parents, what type of counseling was received during the secondary school years, etc. From all of this a composite of the minority student emerged, yet there was still uncertainty as to how well they would do in medical school. To relieve this nagging doubt, the more committed schools designed enrichment programs designed to help the student prepare for medical school.

We initiated such a course in New Mexico in 1970. Its premise being that the school take a chance on minority students by offering them a position, often contingent, on satisfactory completion of the summer course. These minority programs at New Mexico have been described in detail.(11) This course is open to medical schools other than New Mexico and to date we have had 21 medical schools and 183 minority medical students participating in the programs. Retention of these programs is 95 percent.

Most medical schools with successful minority programs encourage early recruitment and educational counseling. Another one of the components in these programs is an ongoing retention effort by providing National Board Review courses, makeups for examinations during the academic years, counseling, test-taking advice, and training as well as remedial makeup course work.

As of 1980, there are 25 medical schools offering summer programs to high school level students; 32 offering summer programs at the undergraduate college level; 43 offering summer programs to minority students accepted to their medical school; 5 offering post-baccalaureate programs and 2 offering preentry programs to minority students accepted at any medical school. Of the 112 U.S. medical schools responding to the AAMC inquiry, 76 offer some form of summer and/or yearly motivational program.(8) This leaves some 36 schools that have not made any form of committment.

As a result of these efforts, enrollment at medical schools has increased from 37,690 in 1969 to 63,800 in 1979 for a net increase of

25,110 students. During this decade minority enrollment rose from 1,178 (8.1 percent) to 5,084 (7.9 percent). Though the enrollment increased in absolute numbers the percentage enrollment of minorities dropped by 0.2 of a percent. Perhaps a more significant figure in the changes is in first year enrollment.

From 1969 the total first year enrollment in U.S. medical schools has risen from 10,422 to 16,930 in 1979, for a net increase of 6,508 students. Minority first year enrollment rose from 501 to 1,540 during this decade. In percentage, the first year minority enrollment rose from 4.8 percent to 9.1 percent.

First year enrollment of women starting in 1971 meanwhile, rose from 1,359 to 4,707 in 1979. During this same period the total first year enrollment rose from 12,361 to 16,930 for a net increase of 4,569. Minority enrollment increased from 1,051 to 1,540 for a net increase of 489. Thus, women enrollment in first year classes represented a net increase of 3,348 accounting for 73.3 percent of the overall increase; minorities account for 10.7 percent and white males for 16 percent. The rise during this period has been largely in women enrollment.

Before white males become concerned, it should be pointed out that they still represent 63.1 percent of the total first year medical students (16,390) enrolled in 1979. Another point of clarification, there may become overlap in figures representing women enrollment if minority women are included. I do not believe this is true however; the AAMC has been careful not to include minority women in the "women" category as well as in the minority category.

Trends

The initiative to increase minority enrollment in medical schools has not gone unchallenged. There has been and still is internal resistance by medical school faculties to enrolling students with lower grades and MCAT scores. External challenges have come in the form of law suits. The most widely circulated being *Bakke v. the University of California.*

The impact of these challenges have had some effects. The internal challenge has created an aura of disdain for the minority students often spreading to the medical student body. It has manifested in unwillingness to participate in tutorial and other special programs even if the money to pay for services was available. From this unwillingness, it seems that justification for this feeling amongst faculties is to help fulfill their prophecies. Many minority students can identify overt and subtle put-downs.

For example, a minority student at our school would have his grade, if he had failed the examination, spread in red pencil covering the entire front page while his majority peers would have their failing grade in a small letter at the corner of the front page. It is a form of a "Scarlet Letter."

In the clinical setting, the minority student is often viewed as an inferior student with an "inadequate fund of knowledge." These tales of horror can be cited from all facets of encounters with the educational system and have been well-documented. I bring them up to remind you that though affirmative action seems to be working, living through the process is hell for minority students.

The Effects of Bakke on Minority Enrollment

Beginning with the *deFunis v. Odegaard* case in Washington, many medical schools became cautious in implementing affirmative action programs. This was particularly true where there was an inherent reluctance to comply to begin with; but minority enrollment continued to rise as medical schools attempted to reach the minority representation goal set by the AAMC Task Force on Minority Opportunities in Medicine.

This task force had set a 12 percent goal for minority enrollment. Unfortunately, this was representative only of the black population and neglected to include Chicanos, mainland Puerto Ricans, and Native Americans. A more realistic goal would have been closer to 14 percent.

By 1974 first year minority enrollment had reached 10.1 percent and enrollment of 8.1 percent of the total medical student enrollment. Then the California courts decided in favor of *Bakke*. This set a sort of panic, a fear, in medical schools as witnessed by the numerous national conferences concerned with the ramifications of the decision. Minorities and other concerned individuals reacted to defend minority programs and admissions. This was evident from the many *amicus curiae* submitted to the U.S. Supreme Court.

The overall net effect while the U.S. Supreme Court pondered the *Bakke* case was caution, leading to a decrease in minority enrollment. First year minority enrollment declined to 9.1 percent in 1975 on to 9.0 percent in 1977. However, the first year enrollment of women increased from 19.7 percent to 24.7 percent during these 3 years. By 1978 first year enrollment of minorities had declined further to 8.7 percent, while the enrollment of women rose to 25.6 percent. Apparently the admission of women was felt to be either more defensible or less threatening since no lawsuits had been filed or there were no special programs aimed at women specifically. The focus was more on the disadvantaged.

After the U.S. Supreme Court ruled that quotas were out but that ethnicity could be considered a factor in the admission process, those medical schools demonstrating commitment resumed their quest of increasing minority enrollment. The figures for first year enrollment of minorities in 1979 has now risen to 9.1 percent but it is too early to establish whether this will continue. It will be interesting to see what happens in the next 5 years. It is reasonably safe to say that uncommitted schools will use the *Bakke* decision to avoid making affirmative action a part of their admissions policy. I should point out that the first year enrollment of women has now risen to 27.8 percent (1979).

Role of the Federal Government in Minority Medical Education

Since the enactment of the Health Professions Educational Assistance Act in 1963, Federal assistance to U.S. medical schools in the form of capitation and Physician Augmentation Grants has led to an expansion in medical student enrollment but a decrease in scholarship financial assistance. This financial effort seems to have been originally designed to increase health manpower but, more recently to distribute it to underserved areas. For instance, during this period, 1963–1979, 40 new medical schools and osteopathic schools of medicine have opened and the medical student enrollment has doubled.

To reach the accepted ratio of 600 patients per physician, minorities would have to have had a combined number of 67,000 minority physicians by 1976. Minorities are still a long way from reaching the desired ratio while the current enrollment of medical students is projected to have caused an oversupply of physicians. The projected supply of physicians is expected to rise from 379,000 (1975) to 519,000 in 1985 for a 222 physician per 100,000 population.(3) Unfortunately, this projection does not hold minority physicians when enrollment seems to have plateaued rather than rising to reach an equitable physician to patient ratio. The current graduation rate of minorities is 1,058 (1978–1979). This represents an increase of 260 from 1974.(3) At this rate, we will never reach the 600 to 1.0 ratio.

The Bureau of Health Manpower, formed in 1967, has been responsible for administering some $6 billion to support expansion in training facilities and enrollment. During this time, the Bureau has had several major accomplishments in health manpower development and distribution. 1) It has increased the number of National Health Service Corps Scholarships, NHSC, of recipients to 5,249 in 1978; 2) has issued new criteria for identifying and designating nearly 4,000 new health manpower shortage areas; 3) involved local planning agencies in reviewing health manpower training grant applications; 4) initiating training programs for primary care practitioners; 5) expanded area Health Education Centers to 20 projects in 22 States; 6) launched new scholarships for students with exceptional financial needs; 7) awarding $15 million for projects to assist disadvantaged students enter health careers; and 8) has formed two divisions to administer student assistance and manpower analysis.(3)

Thus, though the shortage areas have been largely identified with the minority population, financial assistance in the form of scholarship has declined.

Financial assistance to medical students in the form of Health Professions Scholarships, initiated in 1967, originally designed to be administered part as a scholarship grant, has now become totally a loan program for all medical students. For instance, at our school in 1973–74 we were awarded $29,480 as scholarship money and $69,375 for loans. Now in 1979 we were awarded only $25,624 for loans alone. This is a school that has had, since 1970, an average of 25 percent minority enrollment. The University of New Mexico, not unlike other committed medical schools, is now being stretched to the limit to support its minority medical students.

With the decline of scholarship support and a stronger reliance on loan money, compounded by the rise in medical school tuition, minority students are having second thoughts about pursuing a career in medicine. This in part may be responsible for the decline in the minority applicant pool.

Minority students currently enrolled, somewhat reluctantly, are now enrolling in the NHSC. Part of their reluctance is their fear of having to pay back their financial support in an underserved area removed from their environment. They also feel that the majority student is more capable of "buying out" of their committment leaving them "holding the bag." They view this as a debt as well and, coming from a lower socioeconomic background, the debt is out of their realm of reality. They also question whether, because of their financial need, they are being channeled to help solve the maldistribution problem to areas which are largely minority population.

In concept, the Exceptional Financial Need program could address the financial need of minority students; however, in design it only supports a student for one year, and insufficient money has been appropriated. It seems to address the first year when a "high risk" student may be more susceptible to failure but it leaves him financially insecure as he must seek support for the second year.

A second problem with EFN is in the way it's administered at medical schools. The student receives a monthly stipend which is issued by the financial aid office, but it also places the financial aid officer in the role of a parent doling out an allowance for the purchase of books, supplies, etc. While a sensitive financial aid officer can administer the funds, there is a large potential for placing the student in a demeaning posture. The support would be less demeaning if the student could receive the money personally and be allowed the responsibility to spend it to meet his/her needs.

An expansion of this program to include the second and perhaps the third year would be highly desirable. Minority students would have little difficulty qualifying for the program and could safely rely on continuing support and minimizing their debt commitment. The appropriation for support of EFN should be significantly increased.

Another loan support program, the Health Education Assistance Loan (HEAL), provided loans up to $10,000 per year but at a 12 percent interest rate compounded semiannually. A student participating in HEAL cannot participate in any other Federal support program. The interest rate is prohibitively high. For example, a student borrowing $32,000 from HEAL will have to repay $148,709 or $812 per month for 15 years. This is a heavy financial burden on any young physician beginning to practice medicine.

For other reasons financing medical education is a heavy burden on minority students from low socioeconomic backgrounds. Being considered a "high academic risk" the probability of failing and being burdened with a large debt scares them. In addition to the fear of incurring a large debt, and because of their educational preparation, they have to devote their entire energy and time to their studies. Thus they cannot afford the distraction, because of worry of high debts and the day-to-day living expenses, while going through medical school. Any relief from this worry will release them to concentrate on their medical studies.

In short, the Federal Government has not provided financial assistance specifically to support minority students. They have to compete with the rest of the students. The only organization which supports minority medical students is the National Medical Fellowship Foundation. Perhaps Federal support should be channeled to the NMF for administering financial assistance to minority students.

Minority students are becoming more dependent on loan programs, thereby incurring greater indebtedness than the nonminority counterparts. Financing a medical education is a heavy burden on minority students and there is little Federal assistance for them. This is ironic, since, as our preliminary data indicates, about 70 percent of the minority graduates from New Mexico are returning to practice in New Mexico. These are students finishing their residencies and NHSC committments.

Indirect Federal Support for Minority Students

Indirect support for increasing minority representation in medical schools has been coming from an unexpected source, the Minority

Biomedical Support Program administered out of the Division of Research Resources of the NIH.

This program was designed to increase minority participation in biomedical research by providing financial assistance in the form of salaries to minority students working in research laboratories. Many of the undergraduates (over 30 percent) participating in this program are electing to apply to medical school, and with this background in science they have been very successful in getting accepted. Unfortunately, the funding for this program is restricted to minority institutions and is funded at a low level when compared to the total NIH budget.

The Office of Health Resources Opportunities, Health Careers Opportunity Program, has also been very helpful in assisting minorities to pursue careers in medicine. HCOP funds mostly undergraduate programs to create awareness of health professions among minorities; programs designed to improve the academic preparation of minority undergraduates; programs to help or assist in retaining medical students in medical schools, and programs for increasing recruitment efforts by medical schools.

Here again the HCOP budget has only $15 million compared to the overall budget and does not provide financial assistance to minority medical students. Their budget should be significantly increased to meet the demands.

In summary, there has been some increase in minority and women medical school enrollment. This has been the direct result of government affirmative action policies and financial support to improve the health care of the American people. Women have made more significant strides in approaching parity in the medical profession than have minorities. The *Bakke* case had an initial effect in minority enrollment prior to the U.S. Supreme Court decision. The trend after the *Bakke* decision in 1978 seems toward increasing efforts to enroll more minorities in medical school and it did not affect women enrollment. With the decline of scholarship support through Health Professions Scholarship and Loans, more money should be appropriated to the Exceptional Financial Need Program to assist minority students in meeting the rising costs of a medical education. Alternatively, the Federal Government could award funds to the National Medical Fellowship Foundation to support more adequately minority medical students. Medical schools should be encouraged to continue their efforts in enrolling more minority students through a capitation grant mechanism specifically designed to reward their efforts in increasing minority enrollment and retention. More Federal support should be appropriated to the Minority Biomedical Science Support

Program at the NIH and to the Office of Health Resources Opportunity division of the Health Resources Administration.

To increase the meager number of minority faculty in medical schools, the Federal Government could help by financing career development awards to minority graduates from medical schools and biomedical science schools.

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Exhibit 1

Urban Hospital Closings in the Face of Racial Change

a statement on

Hospital Financing Problems

to

The Sub-committee on Health
Committee on Ways and Means
United States House of Representatives,

Federal Building, New York City

14 March 1980

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Mr. Chairman (and members of the Sub-committee:) I am honored to have the opportunity to appear before you today, and thank you for this chance to present my views on a problem which, I believe, threatens the delivery and financing of hospital and physician care in many of our nation's cities.

I feel qualified to speak on urban hospitals by virtue of training in city planning; research on urban hospitals since 1973, using published data and original field-work; and active membership on the Board of the Boston HSA. I do, however, represent only myself.

Introduction and Overview

The problem of urban hospital closings and relocations has become a visible political issue both nationally and particularly in certain cities the last two-three years. Actually, this has been an important phenomenon in this country at least since the 1950's. It has attracted special attention recently for three principal reasons.

First, many urban public hospitals have been closing. The particular cases we have seen in recent years have been hospitals located in northern St. Louis, in Philadelphia, in San Antonio, and in New York City. Public hospital closings in California have been a problem for several years also.

The second reason why hospital closings and relocations have recently become a visible issue has to do with the fact that, for the first time since perhaps the depression, large voluntary hospitals in cities have been either closing or in danger of closing. I regard these two phenomena of public hospital closings and the dangers to large voluntary hospitals as dramatic indicators of the magnitude of the problem which has been quietly borne for several decades by smaller voluntary hospitals.

The third reason why the problem of hospital closings and relocations has attracted visible attention in the last few years has to do with some very important litigation in cities as Gary, Indiana; Wilmington, Delaware; and East St. Louis, Illinois. In these cities, closings or relocations have been challenged on legal grounds having to do with violation of Title VI of the Civil Rights Act and/or Section 504 of the Rehabilitation Act of 1973. Indeed, this visible litigation may bring to the health field some of the attention focused on education by the landmark Supreme Court case of Brown vs Board of Education of Topeka, Kansas in 1954.

My purpose today is to analyze objectively the phenomenon of urban hospital closings and relocations. Following this introduction, the second section of my statement explores the extent of closings and relocations. The third section examines the nature of the closings and relocations themselves: For example, which types of hospitals close or relocate? Also, where are they located? The fourth section explores the dynamics of hospital closings and relocations -- both apparent and underlying causes. The fifth section considers the consequences of hospital closings and relocations for 1) access to care; 2) cost of urban health care; and 3) employment in important selected central city neighborhoods. Finally, the sixth section of this statement considers alternatives to closings and relocations. It examines short-term survival strategies which might be adopted by individual hospitals when appropriate, and then it considers larger issues of social policy which should in many cases be addressed in order to come to grips with the important causes of inappropriate closings and relocations.

A note on the relative importance of fact, demonstrable evidence, and interpretation in this statement is important. While I have proceeded carefully as a researcher and as a policy analyst, the importance of values and beliefs in areas where adequate factual documentation do not exist cannot be ignored in this important field. For this reason, I should indicate at the beginning certain beliefs or interpretations of mine that affect the weaving together of the available objective evidence in the statement that follows. First, I believe with Cochrane that "all effective care should be free" at the time of provision. Given the questionable evidence on the efficacy of much expensive "half-way technology" I believe it makes good sense to substitute in many cases a goal or systems criterion for health care that would consider equal access to services known to be effective.

Magnitude of the Problem:

Nationally, dozens of hospitals close or relocate each year. For example, over the three years, 1975 - 1977, 231 hospitals closed or relocated according to data collected by the American Hospital Association. This means about 80 hospitals per year. Apart from this national data, I have studied 18 cities in the northeast and midwest United States for the years 1937 to 1977. These are all the large central cities located from Kansas City, east; and from roughly Washington D.C., north. I found that of 326 voluntary hospitals located in these cities in 1937, 57 -- or 18% -- had closed by 1977 and an additional 38 -- or 12% -- had relocated by 1977. Thus, 95 hospitals, or about 30% of the hospitals in those cities in 1937 had closed by 1977. Because these hospitals were slightly smaller than average, the closing or relocation of 30% of the hospitals meant the departure of only about 20% of the beds. (These data are now being updated from 1977 to 1980. It is estimated that between 15 and 25 additional voluntary hospitals closed or relocated during this time.)

Of course, during the 40 year study, existing hospitals that remained open expanded in the cities examined and new hospitals were built. Thus, the total number of beds in these cities did not change all that much on average. The number of beds rose in some cities and fell in others.

In this case it must be asked, why be at all concerned about the phenomenon of hospital closings or relocations? The answer is perhaps three-fold. First, we should be concerned about the pattern of hospital closings and relocations -- and simultaneously about the construction and expansion of other hospitals -- because of the spatial and demographic correlates of both the subtraction and the addition of beds: *Closings and relocations appear to have been disproportionately by certain types of hospitals located disproportionately in certain types of neighborhoods.* Second, we should be concerned about the pattern of contraction and expansion in the urban hospital care system because of what I suspect to be the associations of this pattern to increased cost of urban hospital care and of urban physician care in this country. The third reason for being concerned about this phenomenon has to do with the selective impact on employment of the pattern of hospital closings and relocations in central cities.

Nature of Closings and Relocations

We have some data on the size of hospitals that closed, relocated, or remained open. Looking at the 18 cities studied, the average size of the 326 hospitals found in those cities in 1937 was about 189 beds. Hospitals that closed over the 40-year period studied had only 108 beds in 1937. Hospitals that relocated during the period studied had 178 beds in 1937 and hospitals, finally, that stayed open throughout this period averaged about 211 beds in 1937.

The demographic correlates of closing, relocating or staying open are of strong interest as well. I have found that the percent minority of the area around the hospital is directly related to the proportion of hospitals closing or relocating from that area.

A glance at Table 1 indicates that as the minority proportion of the neighborhood around the hospital increases, so does the proportion of hospitals closing or relocating from 1937 to 1977. In neighborhoods 0-25% black in 1970, for example, only 14.2% of the 1937 hospitals had closed or relocated by 1977. But in neighborhoods 76-100% black in 1970, fully 46.9% of hospitals -- almost half -- had disappeared.

The area around the hospital was defined for this analysis as the census tract in which the hospital was located plus all census tracks contiguous to that initial tract. Thus, the area around the hospital, the demography of which was considered, was defined consistently across all hospitals studied. Moreover, the area was defined before it was known whether the hospital had closed, relocated, or remained open.

These two bi-variate analyses clearly indicate that size and neighborhood demography are separately clearly associated or correlated with the different proportions of hospitals remaining open, relocating, or closing. To understand this issue and what we might wish to do about it, it is useful to go beyond these snapshots to a dynamic model explaining likely causes of relocation or closure. I am developing such a quantitative model, using multiple regression and logit analyses. (A sketch of this model and its usefulness is appended to this statement.)

Table 1

Percentages of hospitals closed or relocated by racial characteristics of area

	1970 racial composition of original neighborhood				
hospital status 1937-1977	0-25% black	26-50% black	51-75% black	76-100% black	total
closed	9.0%	15.0%	23.5%	31.3%	17.5%
relocated	5.2	11.6	20.6	15.6	11.7
ongoing	85.8	73.3	55.9	53.1	70.9
total	100.0%	99.9%	100.0%	100.0%	100.1%
closed or relocated	14.2%	26.6%	44.1%	46.9%	29.2%

The Dynamics of Hospital Closings and Relocations:

To understand the importance of hospital closings and relocations, and what we might wish to do about them, we need a better understanding of the reasons why hospitals close or relocate.

One version explaining hospital closings and relocations is provided by members of American Hospital Association research staff in an article appearing in Hospitals on December 1st 1978. This reports the results of a survey done by mail questionnaire to former administrators of closed or relocated hospitals. These are the 231 hospitals identified as having closed or relocated nationally between the years 1975 and 1977. These administrators said that 27% of hospitals closed or relocated because of financial reasons, 23% were replaced by a new facility, 14% were closed because of low occupancy rate, 13% were closed because of outdated facilities and 10% were closed because of an inadequate supply of physicians. These reasons cover 203 of the 279 reasons (or 73% of those advanced by administrators) for the closings or relocations of the 231 hospitals.

But to really understand closings and relocations, we must ask: Why wasn't there enough money? Why replace the hospital? Why did occupancy rates fall? Why was the physical plant outdated? Why weren't there enough doctors?

The model of hospital closings and relocations described in the appendix to this statement is designed to consider the importance of these and other variables in a comprehensive analysis. Lacking the solid quantified data such a model will soon provide us, I would like to offer in its place, at this time, a story. This story is designed to capture the elements surrounding hospital closings and relocations which I believe to be important. This story is not a fantasy.

Hospital A has 200 beds. It was built in 1910 in a neighborhood whose residents were middle-class or working-class whites. Until thirty years ago, in 1950, most of the physicians admitting patients to the hospital maintained their offices in the surrounding community, and almost all patients lived within two miles of the hospital. M.D.'s were general practitioners, pediatricians, general surgeons, and obstetricians, leavened with few specialists. There was no house staff of interns and residents at the hospital, and the small out-patient clinics and accident room were staff by attending physicians who "volunteered" their time in exchange for admitting privileges.

The hospital's finances were sound. Although the physical plant was old, it was fully paid for. A new operating suite had been built with funds raised in the local community, by volunteer businessmen, civic leaders, and physicians. A Hill-Burton grant covered one-third of the cost. Most operating costs were covered by charges to patients, one-third of whom had Blue Cross insurance. Almost all the rest paid out-of-pocket. Those (5%) who could not pay were covered by slightly higher charges on the remaining 95% and by small philanthropic contributions. Many neighborhood residents who could not pay used the city hospital, located 4 miles away.

In 1980, circumstances have changed. Most of the former residents have departed; the hospital's traditional service area is about 80% black. Only 12 attending physicians admit patients to the hospital. Their mean age is 62. To supplement their efforts, the hospital has established teaching programs in family practice, internal medicine, and general surgery. House staff care for over half of the patients, whom they admit through the emergency room or out-patient department.

The hospital's position is precarious -- medically, physically, and financially. Physicians are in short supply; no new attendings are applying to the hospital and house staff positions are beginning to go unfilled.

The physical plant is generally obsolete and unattractive. In some respects, it is dangerous. JCAH accreditation will probably be withheld next year.

Occupancy rates are low and falling. Residents of the surrounding community need care, but they are increasingly seeking it elsewhere. The reasons for this are not well understood. It seems partly due to restricted out-patient clinic hours (because of shortage of physicians and the hospital's inability to recover the costs of the OPD), partly due to the emergency room's poor reputation, and partly because the hospital must refuse to admit some of the patients it could care for (because they cannot pay their own way and the hospital cannot afford to offer them free care).

Today, unable to secure enough paying patients to cover even the low costs of keeping this hospital open, the administration and board of trustees must decide whether to close the hospital, relocate it to the suburbs, or find some way to keep it open in place.

Let us contrast Hospital A with Hospital B which, although not in superb physical condition, appears to be able to stay open for some time to come. Hospital B has 550 beds. Located in a black neighborhood, it is near a highway and close to the downtown business district. There is considerable amount of parking and good bus service. It appears that the hospital is able to attract a wide range of patients. Its occupancy rate is high. The hospital has a major medical school affilition, with over 140 house staff at the hospital.

Hospital B has a wide mix of patients across economic and racial groups. Thus, it is able to subsidize the care of some patients by recovering surplus money from the care of other patients. Parenthetically, it should be noted that in large teaching hospitals subsidization is believed to be both by income group and by diagnosis. The importance of the two kinds of subsidies will be explored at some length below.

Hospital B offers basic or "secondary" hospital care to local residents and it offers specialty care (or "tertiary" care) to both local residents and to suburbanites.

Finally, and this is most important, Hospital B has strong economic and political access to public and private capital markets and to Certificate of Need, which allows the hospital permission to put new capital in place. New construction or acquisition of equipment is vitally important to urban hospitals which care for some proportion of patients who are unable to pay for their hospital services. New construction, new capital equipment, mean depreciation. In most states, depreciation does not have to be funded. Thus, this money is available in budget to be applied to the care of patients who lack the economic resources to pay for their own in-hospital services.

Still, Hospital B faces growing problems of bad debts from uninsured patients and from the uncovered cost of caring for patients insured by such third parties (as Medicaid, in particular), which pay below cost. Further, Hospital B has been hurt indirectly in recent years by the closing of some small hospitals which were located nearby and were forced to shut their doors because they lacked the ability to attract enough patients with adequate insurance.

It is believed that the medical and financial weaknesses particularly afflicting hospitals and forcing some to close or relocate are simply made manifest first in their effects on relatively small institutions. It is believed further that these problems are likeliest to affect hospitals in states which have a high proportion of patients covered by third parties which reimburse at cost or below: Medicare, Medicaid and Blue Cross.

Such states, located especially in the northeast and midwest, are likely to contain hospitals which will be among the first to experience the financial shocks leading to closings or relocations. Hospitals located in parts of the south and in the west are likely to be relatively insulated from these pressures for some time. Thus, it may be that the political and economic interest of different groups of hospitals may come to diverge.

In considering hospital closings and relocations in the perspective offered above, it appears that a minority neighborhood is likely to be associated with absence or departure of physicians in private practice. This is meant to indicate that racial change accelerates the departure of physicians in private practice (particularly in primary care) from urban neighborhoods. It should be noted that the departure of private physicians in primary practice in urban neighborhoods is a generic problem, one which is accelerated by demographic change. The difference in the supply of private practitioners in black central city neighborhoods vs. white central city neighborhoods may be largely a matter of timing -- a difference of years or decades. In the city of Boston, for example, the availability of private practitioners in primary care in white working-class neighborhoods appears to be little different from that in black or Hispanic working-class neighborhoods.

The dynamics of physician departure are important to the process of hospital closings and relocations. It seems that physicians in primary care private practice are usually fairly sensitive to the changes in residence of their patients. As the residents of a neighborhood begin to suburbanize, physicians seem to establish part-time offices in some geographic center of the suburban neighborhood. As more of their patients shift their residences to the new location, the physicians come to devote higher proportions of their office hours to those new sites, until finally, they close their offices in the old neighborhood.

The second way in which demographic change accelerates an existing trend or exacerbates an existing problem has to do with the way in which demographic change leads to problems for hospitals. This sometimes happens through either reduced in-patient census (and the need to cover the cost of expensive out-patient and emergency room care attendant on the departure of private physicians). Or, in many cases, it happens through reduced insurance coverage. Demographic change is usually associated with lower ability to cover the cost of in-patient care itself. The hospital may be faced then with either low in-patient census or an adequate census, but one which contains many patients who are unable to pay for the cost of their care.

Thus, it is possible to view hospital closings and relocations as partial symptoms, first of deficiencies in physician availability and distribution (both geographically and by specialty) and second, of an underfunding of health services of the poor.

Not only is hospital closing or relocation a symptom of these two deficiencies, but the consequences of recent closings and relocations are believed to be problems in their own right.

To be able to do something effective about hospital closings, it is important to understand the causes. To be willing to do something about hospital closings, when appropriate, it is important to understand the consequences.

Consequences of Closings and Relocations of Hospitals

The first adverse consequence of hospital closings and relocations has to do with access to care. This is believed to be a particular difficulty regarding access to primary care or out-patient care. This problem has several manifestations. First, the closing of a hospital may lead to the departure of the few remaining primary care physicians in private practice from the neighborhood around the hospital. These physicians may have held on as long as they could but, when faced with the departure of the hospital which has been the base of their practices, they themselves often choose to either retire or relocate their practices. Second, the hospital's closing or relocation may mean the loss from a given neighborhood of out-patient clinics and emergency rooms as sites of out-patient care. While these out-patient departments and emergency rooms might have suffered from deficiencies in the quality of the care they offered, they nonetheless were available to the residents of the nearby neighborhood, as a proximate source of out-patient care. We know that increased travel time is associated with marked reductions in the use of out-patient services. This is a particular problem in preventive or non-emergency care. Thus, we may see a patient ignoring a symptom until it becomes serious enough to rate a visit to the emergency room. Often, problems that might have been addressed successfully have become too serious to handle easily -- or at all.

The second consequence of hospital closing and relocation has to do with changes in the cost constellations in urban health care delivery. This affects both out-patient care and in-patient care. The closing of an out-patient department or an emergency room, attendant on the closing or relocation of the hospital it was located in, may deprive the residents of that neighborhood of relatively inexpensive organized out-patient facilities. Lost also are the private physician offices, where care was even less expensive. Patients formerly served by those out-patient departments and private practitioners instead go to organized out-patient clinics of other hospitals, where they tend to face higher costs of care. So, too, do the third parties which typically reimburse the cost of that care.

A similar phenomenon may be found on the in-patient side. While the quality of in-patient care offered by the smaller community hospitals -- which tend to close or relocate disproportionately -- may indeed be uncertain in many cases, there does exist considerable evidence that it is possible to organize and run economically a small, high-quality hospital. The departure, relocation,or closing of smaller and mid-sized voluntary non-profit hospitals is removing these hospitals from central cities as a source of relatively inexpensive hospital care. Thus, the departure of these hospitals obliges patients and physicians to seek and deliver in-patient care at facilities which tend to be more expensive -- where even <u>basic</u> in-patient care tends to be more expensive.

One important reason why even such basic care as surgery for an appendectomy tends to be more expensive at a larger teaching hospital in central city than in a smaller community hospital has to do with the cross-subsidization by diagnosis which is common in larger teaching hospitals. (This occurs in other hospitals as well, but it is probably a more important phenomenon in larger teaching hospitals.)

The cross-subsidization occurs by charging all patients the same per diem fee. This fee, which covers room and board and basic nursing services, is charged equally even though patients with different diagnoses tend to consume the resources involved at markedly different rates. In this way, it seems that many hospitals under-price many forms of expensive specialized tertiary care. Thus, patients, physicians, health planners, administrators of third party insurors, public administrators, and legislators often do not perceive the true costs of much expensive tertiary care.

Given the difficulties of evaluating the effectiveness of much health care, to understate the cost of much tertiary care may lead to an inappropriately high rate of use of such services. It appears that the closing of relatively small hospitals in central cities leads to a higher patient supply for larger tertiary hospitals. These hospitals supply secondary services as needed to the patients who flock to them by virtue of the closing of smaller facilities. However, the secondary services are reimbursed above cost of the care, and the surplus available thereby subsidizes the cost of the tertiary services which may be of particular professional interest to the physicians, and indeed perhaps to the administrators and trustees of the larger teaching hospitals. Certainly it is these services that lie at the frontiers of medicine and may legitimately be argued as the proper concern of tertiary hospitals.

The third kind of consequence of hospital closings and relocations has to do with the jobs lost. Simply, a hospital closing costs jobs. A hospital relocating moves jobs. Many workers, particularly those with low pay and low skills, find it difficult to commute the distance to the new site of their jobs. This is an important phenomenon when hospitals closing or relocating are very significant employers both city-wide and in particular districts. In such districts, hospitals may constitute the economic foundation of a neighborhood, providing jobs and generating incomes which support hosts of small businesses and indeed local housing markets and more largely the lives of thousands of people.

The question that must be addressed of course is: how significant are these consequences for access, for cost of care, and for employment? Certainly, arguments to the contrary can be advanced. It can be argued that the hospitals closing did not provide high quality care and should have been closed. It could also be argued that by closing these hospitals, members of minority groups who would have been cared for disproportionately at these hospitals -- such a hospital might be 80-90% black -- would instead seek care at a larger race- and class-integrated facility. It can be argued as well that all patients should be treated at the best hospitals. Each of these points should be addressed individually.

First, I believe that the loss of access is a serious problem and I believe it is unfair for low-income groups and members of racial and ethnic minorities be deprived of hospitals near where they live, especially as a basis for out-patient care.

Second, I believe that excellent in-patient care can be provided at relatively small facilities. The purchase by the Harvard Community Health Plan (a Boston pre-paid group practice) of a 96-bed hospital testifies to that Plan's belief that it can provide excellent secondary care at a very small institution.

Further, I think that the integration of patients in a hospital does not in itself guarantee equal provision of services. Some evidence has been compiled, such as that by Duff and Hollingshead, having to do with the discrimination by diagnosis--and perhaps by racial and economic status as well--of patients at a large teaching hospital. Basic secondary care is not the focus of a large teaching hospital and it may well be that patients with routine problems do not receive the full benefit of being in a large hospital. It may well be that such patients should be cared for at relatively small hospitals which focus on good medical care and good surgical care -- combined with good nutrition, good nursing, easy access for visitors, and the things which we used to call tender, loving care. It may well be that patients with ordinary secondary care problems are more in need of these services than they are in need of the very expensive and elaborate and complex resources of a large teaching hospital. Such patients may well be better off medically at a decent secondary hospital. We should look carefully at any organizational or technological quick fix of the traditional under-serving and under-provision of compassionate and well-organized and decent services to poor people. Simply moving people from one hospital located near their homes to another located downtown may indeed do little to improve the actual services they receive.

The closing of relatively small hospitals with relatively low costs tends to mean that patients who have been cared for there are instead served at larger and more expensive facilities. This particularly has affected Medicare and Medicaid -- a disproportionate number whose beneficiaries reside in central cities. Thus, it may be that a marked share of the unexpectedly high cost of Medicare and Medicaid is attributable to changes in the hospitals serving members of racial and ethnic minorities, and old people, who reside in central cities. This cost has certainly reduced our willingness to remove financial barriers to equal access to health care. (The work of Davidson and Wacker in Chicago suggests this although closings and relocations were not involved.)

Not all small community hospitals actually serve members of racial and ethnic minorities. These relatively small hospitals tend to be of two types. The first was usually founded under philanthropic auspices and was traditionally devoted to providing care to many people who could not pay. Such hospitals tend to try to accept members of racial and ethnic minorities who move into the neighborhood around the hospital, though such hospitals may run into financial difficulties on that account. Other relatively small hospitals located in neighborhoods which change racially or ethnically may simply try to keep out the members of the new racial or ethnic group. As a result, institutions often come to face declining occupancy rate as they lose their physicians and as former patients are reluctant to be served at the hospital. As a result, such hospitals often close or relocate rather than even try to adapt to meeting the needs of the new residents.)

The question of cost of hospital care needs to be considered within another context as well. This has to do with the possible over-supply of urban hospital beds in this country and the appropriate vehicles for reducing bed-to-population ratios. McClure has argued that significant savings on hospital costs can best be won by closing entire institutions. This may suggest that it makes sense on financial grounds to close relatively small, ill-equipped, and decrepit facilities that tend to be located in black, other minority or racially changing neighborhoods. Such hospitals are relatively small and relatively easy to close, lacking physical and medical viability and political support. Thus, McClure's argument on financial grounds certainly runs with other threats to these small and old facilities. However, McClure's assertion deserves examination in the context of the work of Martin Feldstin, Ralph Berry, and Lave and Lave regarding the long-run average cost curve of hospitals. These authorities generally point to a relatively shallow (that is, flat) long-run average cost curve for hospitals offering a given scope of services. The example cited earlier of the purchase of a 96-bed hospital by the Harvard Community Health Plan testifies to the Plan's belief that it can offer decent, low-cost secondary care at quite a small facility. It also testifies to the Plan's unwillingness to allow its members, when hospitalized, to subsidize care for other patients. Thus, in other words, the Harvard Community Health Plan is pulling its patients out of the secondary-to-tertiary subsidization market: The Plan's patients now being served at the 96-bed facility had formerly been cared for at one of several large and expensive teaching hospitals in the city of Boston.

A final point needs to be made concerning the relation of closed hospitals to over-supply of hospital beds. An examination was made of the correlation between the proportion of hospitals closing from 1937 to 1977, in 18 cities studied, and the 1937 bed-to-population ratios. It was expected that the cities with relatively high 1937 bed-to-population ratios would be the very cities which would exhibit the closing or relocation of a relatively high proportion of hospitals. However, the reverse was found. It was learned that the cities with high bed-to-population ratios experienced a low proportion of hospital closings or relocations. This suggests that the very forces that engender relatively high bed-to-population ratios, including medical, political and economic factors, are the forces that seem to engender perpetuation of that very pattern.

Alternatives to Closings and Relocations

What can be done to keep a hospital open if it is decided that this is appropriate? This subject needs to be addressed both at the level of the individual institution and also at the level of national policies regarding hospital finance and physician distribution.

We have a measure of evidence about the range of strategies; and about their short -, and mid-run success in keeping hospitals open in racially changing or racially changed neighborhoods. One option is that of pairing existing hospitals: something like the idea advanced in the 50's and 60's of pairing public schools to maintain a racial or ethnic mixture at both institutions. We see pairing at hospitals in the Philadelphia area as that between Misericordia Hospital in West Philadelphia and its suburban counterpart. Both of these hospitals are owned by the same Catholic order and they share a common management, budget, and house staff. Some special services are located only at one site.

This arrangement seems to have worked for several years with excellent success. Medical and organizational innovations and vigorous management have helped the central city facility remain afloat. Further, the suburban division, in effect, helps support the central city facility financially.

Other strategies are aimed specifically at attracting physicians. The physicians are vital if there do exist patients who could be cared for at the hospital, and whose care could be paid for. One route a hospital can take is to secure or expand an affiliation with a medical school, or indeed to set up its own hospital-based teaching program. Medical school affiliations may be costly financially and non-medical school affiliated teaching programs may experience some range of difficulty in attracting house staff.

Another hospital-based strategy is to set up or sponsor a hospital-based group of physicians. These might be salaried by the hospital and the fees they might earn are turned over to the hospital. An extension of this is to hire a group of physicians on contract and, in effect, franchise the out-patient department, or the emergency room (or both), plus associated in-patient care to those physicians.

Yet, another alternative is to set up a hospital-based pre-paid group practice. This may attract physicians interested in working for salary. Such an arrangement is sometimes linked to a set of suburban out-patient facilities or group practice clinics where suburban patients are seen and then referred when appropriate to the central city facility. This arrangement may succeed in securing for a central city hospital some number of suburban patients. It should be noted, however, that generally only larger hospitals that offer one or more specialized services will be able to lure suburban patients from a distance to obtain care at a central city facility.

A somewhat different approach has been taken by St. Francis X. Cabrini Hospital, in Chicago. Under the hospital's "City Doctor Program," eight physicians in private practice have been recruited. The hospital obtains office space (usually near the hospital, but in one case seven miles away), and guarantees their salaries for five years. In exchange, physicians agree to hospitalize their in-patients needing basic secondary care at Cabrini.

Initially, advertisements and a brief story in Time Magazine yielded 100 applications. The eight primary care physicians selected for the program are graduates of U.S. medical schools who held residencies at Columbus Hospital, a sister-facility of Cabrini.

The program appears to have been most successful: physicians are buying their offices and remaining beyond the contract period. They continue to hospitalize at Cabrini, though no longer obliged to do so. In total, the program provides fully a third of all in-patients. I believe that this innovation has worked well. It testifies to the importance of keeping smaller community hospitals open throughout cities, as bases for organizing ambulatory care.

Other marketing strategies designed to attract patients may focus on either a cosmetic or a more extensive reconstruction of a facility, often making available parking nearby. A large extension of such a strategy was adopted by a few hospitals during the 1950's and 60's. These hospitals used urban renewal programs to secure land adjacent to the hospital, demolish "unattractive" or perceived-to-be-dangerous neighborhoods around the hospital, and erect either additional hospital facilities (including parking) or moderate-income housing designed to make the hospital appear a safe island in a minority neighborhood -- such that suburban patients would be willing to come to the facility.

These tactics are no longer tenable, both because it is not considered legitimate to grant the hospitals what amounts to the power of eminent domain and also because the residents of neighborhoods who once allowed demolition have been actively mobilized and appear to remain so (to the extent that any land acquisition for any purpose by almost any level of government, particularly in central cities, which tend to evict poor people or members of racial minorities, are looked on -- often justifiably -- with strong suspicion).

These short-run strategies may work for some hospitals in some locations. Factors unique to an institution's particular location, physician-staff attitudes, administrative strengths, outlook of trustees, and the city-wide need for particular hospitals can be potent factors.

In general, however, it can be said that strategies focusing on individual hospital survival may work occasionally, but in the long-run usually will not work to help a small or mid-sized hospital survive in a minority neighborhood or in racially changing neighborhoods of central cities.

To save these hospitals in these neighborhoods, when appropriate, and to do something about the larger problem of inadequate medical care in central cities,it is probably necessary to address larger issues of physician availability and payment for health services in this country.

I believe that unless we confront these two issues systematically, the phenomenon documented earlier in this paper pertaining to the closure and the relocation of relatively small non-teaching hospitals located in minority neighborhoods will spread and we will see the closing or relocation (especially the closing) of ever-larger voluntary hospitals, including teaching facilities, and the closing as well of an increasing number of public hospitals. Given the unplanned, unsystematic pattern of past closings and relocations, we have reasons to fear for the consequences for access to care and cost of care which the continuation of past patterns of closings and relocations will cause.

Arguments have been advanced in recent years that we have too many physicians, too many hospitals, and that -- in general -- the association between health services -- the 200-odd billion dollars we spend on health care -- and medical status or health outcomes is uncertain. Therefore, the argument continues, we really have too much and can do without much of what we've got, and in the process we can save a good deal of money, particularly tax money. Such arguments may be legitimate in many cases. The problem often is that we do not know which services are effective and which are not. Lacking evidence on effectiveness, we should certainly insist on equality of access as a primary criterion on which services are either added or eliminated. In particular, the attempts by public officials or hospital administrators to cut services or to reduce access for some population groups, on the grounds that the services are not of demonstrable effectiveness, must be strongly challenged unless those same administrators or officials acknowledge that for themselves, for their families, colleagues and neighbors, such services should also be cut or reduced in accessibility.

To provide inexpensive ambulatory care in central city neighborhoods and to cover also the secondary-hospital care needs of the residents of those same neighborhoods, it is necessary to first seriously address the problem of physician distribution, both geographically and by specialty. The most reasonable approach is that advocated perhaps first by Rashi Fein: the notion of franchising physicians. This should be done both by specialty and location, meaning that there would be only so many slots available in an area to set up an office or acquire a hospital-based practice to deliver care in a particular medical specialty.

One practical vehicle for administering such a franchise scheme might be to enlist the cooperation of physicians before they became physicians. This might be done through a simple contractual agreement or quid pro quo that would be signed between each individual medical student, perhaps in the first year of medical school, and the party paying for that student's medical education. That party should clearly be acknowledged to the public, and a division of the Bureau of Health

Manpower might be authorized to conduct this program. All medical education for up to eight years, that is the four years of medical school and up to four years of residency, would be payed for by direct appropriation from the Treasury. A loan would be made from the U.S. Government to an individual medical student, who would then pay tuition covering full cost of medical education. No cost of medical education would be covered through research grants to medical school faculty, patient care, or other charges. The cost of medical education, particularly of residents, would need to be broken away from their patient care responsibilities. The cost of education would include the costs of tests and other procedures done principally as part of medical education. The segregation of cost is more difficult to undertake successfully in some areas than in others. However, some approximation of true cost of education should be possible.

By calculating the cost of medical education in this manner it might well be found that currently or perhaps quite soon the bill would run between one-quarter and one-half million dollars per student. The loan agreement which pays these costs should contain the provision that the loan would be forgiven upon completion of some years of primary care practice - perhaps 10 or 20 - in a particular district of a city or a particular rural area. The contractual agreement might state even more strongly that physicians would be educated only if they first guarantee their willingness to practice in a specialty and in the area where their services were needed. This need could be determined regionally by an impartial consumer-provider planning organization.

Having insured the availability of physicians appropriately distributed by practice, specialty and by location, it then remains to assure that the means exist to pay for all effective care on behalf of every patient in the United States. This can be accomplished either through a universal national health insurance scheme or through apportioning bad debts (accrued through care of patients lacking adequate insurance) to all third parties.

Other techniques involve providing institutions with defined catchment areas and annual budgets with which to provide needed services for all the residents of the catchment area. An alternative is enrollment of more patients in pre-paid group practices.

What are we likely to see in the absence of these attacks on the problems of physician availability and inadequate insurance? In the short run, we are likely to see a series of increased pressures to subsidize hospitals, particularly public hospitals and large voluntaries that are about to close their doors. The loss of such hospitals, their out-patient care, their emergency care, their employees is likely to be so visible and so dramatically and politically unpalatable that some form of bail-out may be expected. Such ad hoc arrangements may be necessary, but they should not be expected to most strongly advance the public interest.

A reasonable alternative is to begin considering what physician and hospital care is needed, where it should be located and the most desirable means to move our present system in that direction.

Thank you, Mr. Chairman, for the opportunity to appear before you today.

APPENDIX

A Model of the Forces Affecting Hospital Closing and Relocation

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The probability of an individual hospital closing or relocating is being analyzed in relation to a set of independent variables. These include hospital size (measured by the number of beds), scope of services, occupancy rate, and house staff. Several land-use variables are considered as well. These have to do with the kind of neighborhood the hospital is located in -- whether it is residential, commerical, mixed business or industrial. (Land-use is important because certain kinds of neighborhoods, certain districts are probably easier for people to mix in: They are considered neutral territory.) The model also includes a set of variables related to the city-wide hospital system and other nearby hospitals in particular. One independent variable is city-wide bed-to-population ratio. Also, distance to nearest hospital and occupancy rate of that hospital is considered. Demographic and economic characteristics of the residents in the area around the hospital are included. The minority proportion of the population, the rate of change in the minority proportion of the population, and the duration of minority presence in the population around the hospital are all examined in relation to hospital closings and relocations. Also, to control ethnic status for income, an additional independent variable of area income as a proportion of city-wide and SMSA-wide income is entered into the regression equation. On the financial side, the state-wide proportion of the private health insurance market held by Blue Cross is entered into the equation along with the proportion of low-income population covered by Medicaid state-wide, and the proportion of Medicaid-to-Medicare reimbursement rates. The last is of interest because Medicare reimbursement rates are calculated nationally according to a standard formula, but states have some measure of autonomy in setting their own Medicaid reimbursement.

The ratio of Medicaid to Medicare rates for a particular state would indicate the state's own likelihood of underpaying hospital care for its Medicaid recipients. An intervening variable is that of the hospital's finances. This data will be obtained for recent years from IRS form 990, which reports both expenditures and income of hospitals. It should be noted that the model will be run for four separate decades, roughly 1940-50, 50-60, 60-70 and 70-80. Thus, it will be possible to examine the relative changes and importance of different variables from decade to decade. (It is believed that the importance of state-wide regulatory factors such as Certificate of Need regulation will probably vary directly with the state's tightness in Medicaid reimbursement policy. This variable is being explored currently. Its importance was shown above when considering the problem of access to capital and the role of depreciation of paying for urban hospital services.)

This model is intended to identify the forces associated with hospital closings and relocations, and to help build a clear understanding of the strengths of these forces. Also, it should be useful in predicting the likelihood of future closings and relocations -- in sufficient time for long-range planning to stop them (when appropriate), and to help hospitals stay open when they are needed.

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Urban Voluntary Hospital Response to Racial Change

The attached tables report early results of a study of the relation of racial change to voluntary hospital closing and relocation. Also included are several statistical tests of this relation.

As noted in Tables 1 and 2, the proportion of hospitals closing or relocating from 1937 to 1977 increases directly with the 1970 black share of the population of the neighborhood around the hospital.

Table 3 indicates that a higher city-wide proportion black is associated with a higher percentage of hospitals closed or relocated.

Table 4, surprisingly, reports an inverse relation between a city's 1937 bed-to-population and the percentage of hosptals closed or relocated from 1937 to 1977.

Table 5 shows that the smallest hospitals are likeliest to close, that somewhat larger hospitals are more prone to relocate, and that the largest hospitals tend to remain in place. With one exception, this pattern holds across neighborhoods of varying black proportions.

Over the coming months, multi-variate analyses will be made of the associations of a variety of factors with the likelihood of hospital closing or relocation. The resulting paper will describe: 1) the variables which seem to explain hospitals' departures and 2) the apparent consequences of hospital closing or relocation for the accessibility and cost of primary care and secondary hospital care in central cities.

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Table 1

Chi-square test of the relation between neighborhood demography
and hospital locational decisions:
18 large northeast and midwest U.S. cities[1]

hospital status[2] 1937-1977	1970 racial composition of original neighborhood[3]				
	0-25% black	26-50% black	51-75% black	76-100% black	total
closed	12	9	16	20	57
relocated	7	7	14	10	38
ongoing	115	44	38	34	231
total	134	60	68	64	326

$\chi^2 = 33.60$

df= 6

test: one-tail

The probability that this would occur by chance is less than five in ten thousand.

Null hypotheses: closing/relocation unrelated to racial change: reject.

Notes and Sources

[1] Cities are Baltimore, Boston, Buffalo, Chicago, Cincinnati, Cleveland, Columbus (Ohio), Detroit, Indianapolis, Kansas City, Milwaukee, New York (Bronx and Brooklyn), Newark, Philadelphia, Pittsburgh, St. Louis, and Washington.

[2] Changes in hospital status were derived principally from the published annual Guide issues of the American Hospital Association, 1950, 1960, 1970, 1976. Data for 1937 were obtained from the second edition of American and Canadian Hospitals, Chicago: Physicians' Record Company, 1937. Hospitals 30 beds or smaller were excluded. Voluntary non-profit "acute general and other special hospitals" greater than 30 beds, built before 1950, constitute the study sample.

[3] "Neighborhood" is the census tract containing the hospital, plus all contiguous tracts. Neighborhood boundaries and black percentage were assigned before hospital status was known. Source: large-scale census tracts maps for each city, and the U.S. Bureau of the Census, Population Census, for each city, 1940-50-60-70.

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Table 2

Percentages of hospitals closed or relocated by racial characteristics of neighborhood

hospital status 1937-1977	1970 racial composition of original neighborhood				
	0-25% black	26-50% black	51-75% black	76-100% black	total
closed	9.0%	15.0%	23.5%	31.3%	17.5%
relocated	5.2	11.6	20.6	15.6	11.7
ongoing	85.8	73.3	55.9	53.1	70.9
total	100.0%	99.9%	100.0%	100.0%	100.1%

Notes and Sources:
See Table 1

Table 3

Pearson product moment correlation:

Ratio of percentage of voluntary hospitals
closed or relocated in each of 17 cities, 1937-1977,
to city-wide % black in those cities, 1970

r = .485

df = 15

t = 2.15

test: one-tail

Theory predicts a positive relation between the two variables (% of hospitals closed or relocated and % of black).

This t-score could be expected by chance fewer than 25 times in one thousand (.025).

Theory: confirmed; higher city-wide % black is associated with higher percentage of hospital closings or relocations.

Table 4

Pearson product-moment correlation:
Ratio of total short-term 1937 beds (public, voluntary, proprietary)
per 1000 population to percentage of voluntary hospitals
closed or relocated, 1937-1977

r = -.247

df = 15

t = -0.986

test: one-tail

Theory predicts a positive relation between the two variables.

Theory: rejected.

Note: Indianapolis was excluded as having only two hospitals eligible for this analysis. This correlation is therefore based on ratios for 17 cities.

Table 5

Mean bed size of voluntary hospitals in 18 cities
by status change and percent black of surrounding neighborhoods, 1937-77[1]

hospital status[2] 1937-1977	Mean beds, by neighborhood 1970 % black[3]				
	0-25%	26-50%	51-75%	76-100%	total
closed	111	125	112	93	108
relocated	179	139	164	221	178
ongoing	194	233	240	207	211
total	186	204	195	175	189

Notes and Sources: Same as Table 1

BALTIMORE

Hospitals Closed	Date	Beds (most recent recorded before closing)
1. Baltimore EET, Charity	1960-1970	68

Hospitals Relocated		
1. Franklin Square	1960-1970	175
2. St. Josephs'	1960-1970	240
3. Sinai Hosp. of Baltimore	1960-1970	308
4. H. for Women of Maryland	1960-1970	162
5. Presby. EET, Charity	1960-1970	40

BOSTON

Hospitals Closed	Date	Beds (most recent recorded before closing)
1. Mass. Women's	1950-1960	63
2. New Eng. H. for Women & Child.	1960-1970	122

Hospitals Relocated		
1. Carney	1937-1950	147

CHICAGO

Hospitals Closed	Date	Beds (most recent recorded before closing)
1. Chicago Memorial	1950-1960	92
2. Evangelical Deaconess	1937-1950	65
3. Evangelical H. of Chicago	1970	136
4. Lewis Mem. Maternity	1960-1970	131
5. Misericordia Home & H.	1950-1960	84
6. Post Grad. Hosp. & Med. Sch. (see Wesley Memorial)	1937-1950	85
7. St. Vincent's Infant & Mat.	1950-1960	235
8. University	1950-1960	133
9. Washington Boulevard	1937-1950	100
10. West Side H. of Chicago	1937-1950	150

Hospitals Relocated		
1. Alexian Brothers	1960-1970	258
2. Auburn Park (St. George's)	1960-1970	122
3. Lutheran Deaconess Home	1960-1970	186
4. St. Luke's	1950-1960	579
5. Wesley Memorial (see Post Grad.)	1937-1950	247

CINCINNATI

Hospitals Closed	Date	Beds (most recent recorded before closing
1. St. Mary	1960-1970	170

Hospitals Relocated

CLEVELAND

Hospitals Closed	Date	Beds (most recent recorded before closing
1. Provident	1937-1950	25
2. St. Anne's Mat.	1970	85

Hospitals Relocated

COLUMBUS

Hospitals Closed	Date	Beds (most recent recorded before closing
1. White Cross	1960-1970	339

Hospitals Relocated		
1. St. Francis	1950-1960	162

DETROIT

Hospitals Closed	Date	Beds (most recent recorded before closing)
1. Florence Crittenden H.	197	171
2. East Side General	1960-1970	86
3. Edythe K. Thomas Mem.	1950-1960	155
4. Parkside	1960-1970	52
5. Pinaree General	1937-1950	25
6. Wayne Diagnostic	1950-1960	67
7. Lincoln H.	1970	74

Hospitals Relocated		
1. Burton Mercy	1970	91
2. Delray Gen.	1970	64
3. Detroit Memorial	1960-1970	336
4. Martin Place	1970	174
5. Providence	1960-1970	396
6. St. Mary's	1937-1950	320
7. Trinity	1960-1970	140
8. Mercy	1970	50

INDIANAPOLIS

Hospital Closed	Date	Beds (most recent recorded before closing)
Hospital Relocated		
1. St. Vincent's H.	1970	315

KANSAS CITY

Hospital Closed	Date	Beds (most recent recorded before closing)
1. St. Vincent's Maternity	1960-1970	96
2. Wesley	1937-1950	95
3. Wheatley-Provident	1970	61

Hospital Relocated		
1. Research H.	1960-1970	254

MILWAUKEE --

Hospitals Closed	Date	Beds (most recent recorded before closing
1. Marquette Univ. EENT	1937-1950	45
2. Memorial	1960-1970	46

Hospitals Relocated		
1. Misericordia H.	1960-1970	177

NEWARK

Hospitals Closed	Date	Beds (most recent recorded bef closing
Hospitals Relocated		
1. Babies	1970	80
2. H. of St. Barnabus	1960-1970	234
3. Newark E.&.E.	1970	62
4. Newark Mem.	1950-1960	121

PHILADELPHIA

Hospitals Closed	Date	Beds (most recent recorded before closing)
1. Community	1960-1970	51
2. Mercy	1970	193
3. Stetson	1970	68
4. Woman's	1960-1970	165
5. Doctor's H.	1970	136

Hospitals Relocated		
1. American Oncologic	1970	60
2. Skin & Cancer	1960-1970	30

PITTSBURGH

Hospitals Closed	Date	Beds (most recent recorded before closing
1. Belvedere	1970	30

Hospitals Relocated		
1. Passovant	1970	142

ST. LOUIS

Hospitals Closed	Date	Beds (most recent recorded before closing
1. Park Lane Mem.	1970	75
2. People's	1960-1970	80
3. St. Mary's Infirm.	1960-1970	128
4. Barnard Free S & C	1950-1960	57

Hospitals Relocated		
1. Missouri Baptist H.	1970	336
2. St. Anthony's H.	1970	252
3. St. John's H.	1970	612

WASHINGTON

Hospitals Closed	Date	Beds (most recent recorded before closing
1. Central Disp. & Emergency H.	1950-1960	310
2. Episcopal E.E.& T. H.	1950-1960	100
3. Garfield Mem. H.	1950-1960	277
4. National Homeopathic H.	1950-1960	62

Hospitals Relocated		
1. Providence H.	1950-1960	297
2. Sibley Mem. H.	1960-1970	248

Exhibit 2

HS
DEPARTMENT OF HEALTH, E~~DUCATION, AND WELF~~ARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

MAY 22 1980

The Honorable Arthur S. Flemming
Chairman
U.S. Commission on Civil Rights
1121 Vermont Avenue, N.W.
Washington, D. C. 20425

Dear Mr. Chairman:

During the Commission's Health Care Consultation on April 15, the question was raised as to recent action of the Department in terminating Federal funding from health institutions because of Title VI violations. My staff has compiled the following information on HEW administrative enforcement action relative to health programs.

A. During the decade of the sixties, when many institutions were still openly segregated, a number of cases resulted in termination of Federal funding. According to the HEW Interagency Report, they included the following:

State		Institution	Date of Termination of Funds
Alabama	-	Dept. of Mental Health	October 20, 1967
		Dept. of Pensions & Security	January 26, 1968
		Choctaw Co. Gen. Hosp., Butler	August 18, 1967
		Fifth Avenue Gen. Hosp.	June 16, 1967
Georgia	-	Stewart-Webster Hosp., Richland	August 18, 1967
Louisiana	-	St. Francis Hosp., Monroe	June 16, 1967
Mississippi	-	Covington Co. Hosp., Collins	August 18, 1967
		East Bolivar Co. Hosp., Cleveland	June 16, 1967
		Kuhn Mem. Hosp., Vicksburg	May 8, 1969
		Matty Hersee Hosp., Meridian	May 8, 1969
		Natchez Charity Hosp., Natchez	May 8, 1969

State	Institution	Date of Termination of Funds
South Carolina	Clarendon Mem. Hosp., Manning	February 9, 1968
	Hampton General Hosp., Varnville	September 12, 1968
	Orangeburg Regional Hosp., Orangeburg	February 9, 1968
	Tuomey Hosp., Sumter	February 9, 1968
Texas -	Crockett Clinic and Medical Surgical Hosp., Crockett	June 16, 1967

By 1973, all of the above agencies had come into compliance with Title VI of the Civil Rights Act. Federal assistance was then duly restored.

B. In the decade of the seventies, considerably less use was made by HEW of the sanction of terminating Federal funds, either in health programs or in human services or education. Only one health case was resolved by actual termination of funds: the Odd Fellows Home of Saratoga, California, from which Federal funding was cut off in September 1973. Funding was restored after facility negotiated a change in policy and came into compliance with Title VI.
Administrative enforcement activity has been instituted during the past decade against several other health agencies, when negotiations did not produce compliance. Most of these institutions were brought into compliance before the final step of terminating Federal funds, while others are still under administrative action.

Administrative action in the past decade has been taken against the following institutions:

o California - Odd Fellows Home, Saratoga - Funds terminated.

o Connecticut - Park City Hospital, Bridgeport - Under administrative action from May 1977 to July 1978.

o Indiana - Indiana Masonic Home, Franklin - given notice and brought into compliance during March 1974.

o Louisiana - Three hospitals reviewed as part of the city-wide investigation are still under administrative action: Hotel Dieu, Mercy, and Southern Baptist Hospitals. They have filed exceptions to the Administrative Law Judge's ruling of noncompliance this year.

o Mississippi - In the following cases, the institutions were given notice in 1968 but the deferral was lifted, and they remain unresolved: Mississippi State Board of Mental

Institutions, Jackson; East Mississippi State Hospital, Meridian; Ellisville State School and Hospital, Ellisville; and Mississippi State Hospital, Whitfield.

I hope this information will be useful to you in assessing the status of health care and civil rights.

Very truly yours,

Roma J. Stewart

Roma J. Stewart
Director
Office for Civil Rights

Exhibit 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

JUL 17 1980

Ms. Caroline Davis Gleiter
Assistant Staff Director for
Program and Policy Review
United States Commission on Civil Rights
Washington, D.C. 20425

Dear Ms. Gleiter:

I appreciated the opportunity to participate as a presenter during the Commission's Consultation on Civil Rights Issues in Health Care Delivery.

I have reviewed the enclosed transcript and marked it for accuracy.

Allow me to supplement the transcript with the following information:

1. At page 102, Chairman Flemming asks how recently the Department has used its enforcement authority. On May 22, 1980, I wrote to the Chairman on that issue. A copy of the letter is enclosed.

2. At page 106, the Chairman asked for the number of nursing homes subject to Hill-Burton. Nationwide, there are 510 free standing nursing homes owned or operated by hospitals which recieved Hill-Burton funds. This represents 15 percent of the Nation's 18,900 nursing homes. Under the regulations, the uncompensated care obligation remains for 20 years, while the community service obligation is perpetual. Four hundred and fifty-six of these nursing homes are still responsible for providing uncompensated care and meeting community service obligations, while the remaining 54 need only meet their community service obligations.

I hope this information is helpful.

Very truly yours,

Ana Maria Martel for
Roma J. Stewart
Director
Office for Civil Rights

Enclosures

Exhibit 4

HEALTH SERVICES ADMINISTRATION

CONSUMER AFFAIRS PLAN

January 1981

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES ADMINISTRATION
5600 Fishers Lane
Rockville, Maryland
20857

CONSUMER AFFAIRS PLAN
HEALTH SERVICES ADMINISTRATION

December 1980

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CONSUMER AFFAIRS PLAN
HEALTH SERVICES ADMINISTRATION
SUMMARY

In order to achieve the Agency's consumer affairs objectives and to meet the requirements of Executive Order 12160, "Providing for Enhancement and Coordination of Federal Consumer Programs," the Health Services Administration established a Task Force to prepare a plan for a Consumer Affairs Program to be implemented throughout the Agency. The Consumer Affairs Plan calls for the following action:

1. Consumer affairs staff:

   The Health Services Administrator has established an Office of Consumer Affairs (OCA) within the Office of the Administrator to provide policy direction, coordination, and oversight for consumer affairs activity in the Agency. A director will be appointed.

   Each Bureau will have a Consumer Affairs Officer.

   Responsibility for carrying out the Program is to be placed on all managers and staff, from the Central Office to local service delivery sites.

   The role of OCA will be to assist the Bureaus in implementing the Consumer Affairs Program, to define policies and strategies, to monitor the Program, to represent the consumer point of view in decisionmaking, to act as an information resource, and to coordinate consumer affairs activities.

   OCA will participate in activities in connection with the International Year of the Disabled Person.

   An HSA Consumer Affairs Council composed of Agency consumer affairs staff will be established.

   OCA will call on a small consumer task group for consultation during the first two years of its operation.

2. Consumer participation. Action required:

   To work towards the establishment of mandates for consumer participation for those programs where they do not now exist, especially the state formula grant programs.

   To assure compliance with existing mandates for consumer participation by means of monitoring and program review.

2. Consumer participation - continued:

To reimburse consumers for expenses, as appropriate, in connection with attendance at meetings and other kinds of participation.

To encourage closer liaison between consumer board and committee members and their constituencies and community groups.

To consider the establishment of consumer consultative mechanisms above the local service delivery level.

To review consumer participation in rulemaking and consider what revisions in procedures may be necessary.

To promote participation by consumer board and committee members in monitoring and evaluation of services they receive and in the utilization and review of the complaints system.

3. Development of informational materials for consumers. Action required:

To review information materials about the Agency's services and responsibilities to determine to what degree consumer issues are covered and where a consumer perspective may be needed. To consider means of dissemination in the light of consumer information.

To provide materials to consumers on board membership and other ways they can participate.

To provide information to consumers about particular Agency actions or proposals that may affect them.

4. Education and training for Agency staff. Action required:

To provide general consumer affairs orientation to all Agency staff.

To provide special training to consumer affairs staff.

To promote staff training at the local service delivery level.

5. Education, training, and technical assistance to consumers. Action required:

To provide health education and health promotion programs for consumers at the State and local level as one means of enhancing consumer - provider communication and consumer participation.

To provide training to governing boards and advisory committees on administration and other matters to enable them to participate more effectively.

To provide technical assistance and support services when needed to enable consumers to participate effectively.

To assess training and technical assistance now offered to consumers at the local service delivery level to determine what kinds of programs for this purpose are needed.

6. Systematic Procedures for Complaint Handling. Action required:

To establish systematic procedures for complaint handling throughout the Agency that will 1) provide for appeal and 2) provide for reporting of complaints so that complaints data can be monitored, analyzed, and used in decisionmaking.

To ensure that the complaint system for each program has all the essential elements: 1) promotion of public awareness (making consumers aware of the complaint system and how to use it), 2) recording complaints, 3) responding to complaints, 4) tracking the handling of complaints, 5) provision of an appeals system, 6) reporting and monitoring complaints, 7) evaluation and utilization of complaints data in policymaking.

7. Patients rights. Action required:

To ensure that all consumers are aware of their rights as patients.

To ensure that all necessary provisions are contained in all patients' rights bills for each HSA program.

8. Reporting, monitoring, and evaluation. Action required:

To amend work plans, program guidance materials, and program review protocols to include consumer issues

To analyze data from such sources and the complaint system.

To ensure that consumer information is utilized in policymaking.

CONSUMER AFFAIRS PLAN
HEALTH SERVICES ADMINISTRATION

INTRODUCTION

The mission of the Health Services Administration, hereafter referred to as HSA or the Agency, is to build and maintain health care capacity in underserved areas, to provide high quality comprehensive health services to Federal beneficiaries, to promote effective and equitable public health preventive services, and to improve the organization and efficiency of health care delivery. The Agency has a long-standing commitment to consumer affairs and has sought to effect active consumer participation in its health services delivery programs. At the end of 1978, the HSA Administrator initiated an Agency-wide review of policies and practices in regard to consumer participation and existing sources of information on consumer needs, satisfactions, and dissatisfactions. The objective of this initiative was to increase the Agency's understanding of, and responsiveness to, consumer needs at all levels of decision-making, including the special needs of minority and handicapped groups.

Agency consumer affairs objectives are reinforced by the President's Executive Order, Number 12160, of 9/29/79. This Executive Order, "Providing for Enhancement and Coordination of Federal Consumer Programs," requires all agencies to review and revise their operating procedures "so that consumer needs and interests are adequately considered and addressed."

The minimum required elements for agency consumer affairs programs, as stated in the Executive Order are:

1. <u>A Consumer Affairs Perspective - An Identifiable Consumer Affairs Staff.</u>

   "Agencies shall have identifiable, accessible professional staffs of consumer affairs personnel authorized to participate, in a manner not inconsistent with applicable statutes, in the development and review of all agency rules, policies, programs, and legislation." E.O. (Executive Order) 1-401-a

2. Effective Procedures for Consumer Participation.

   "Agencies shall establish procedures for the early and meaningful participation by consumers in the development and review of all agency rules, policies, and programs. Such procedures shall include provisions to assure that consumer concerns are adequately analyzed and considered in decisionmaking. To facilitate the expression of those concerns, agencies shall provide for forums at which consumers can meet with agency decisionmakers. In addition, agencies shall make affirmative efforts to inform consumers of pending proceedings and of the opportunities available for participation therein." E.O. 1-401-b

3. The Development of Information Materials for Consumers.

   "Agencies shall produce and distribute materials to inform consumers about the agencies' responsibilities and services, about their procedures for consumer participation, and about aspects of the marketplace for which they have responsibility. In addition, each agency shall make available to consumers who attend agency meetings open to the public, materials designed to make those meetings comprehensible to them." E.O. 1-401-c

4. Education and Training for Agency Staff and Consumers.

   "Agencies shall educate their staff members about the Federal consumer policy embodied in this Order and about the agencies' programs for carrying out that policy. Specialized training shall be provided to agency consumer affairs personnel and, to the extent considered appropriate by each agency and in a manner not inconsistent with applicable statutes, technical assistance shall be made available to consumers and their organizations." E.O. 1-401-d

5. Systematic Procedures for Complaint Handling.

   "Agencies shall establish procedures for systematically logging in, investigating, and responding to consumer complaints, and for integrating analyses of complaints into the development of policy." E.O. 1-401-e

In January 1980 the Health Services Administrator established a Task Force to provide a plan for a Consumer Affairs Program to be implemented throughout the Agency, including its three Bureaus, the Bureau of Medical Services (BMS), the Indian Health Services (IHS), and the Bureau of Community Health Services (BCHS). A fourth Bureau has now been added, the Bureau of Health Personnel Development and Service.

The Consumer Affairs Plan will apply to all HSA services, either direct services or those provided by HSA funds through grants and contracts - the Public Health Service hospitals, clinics, and other services administered by BMS, facilities managed by the 8 IHS Area Offices and 4 IHS Program Offices, and the projects and programs administered through the 10 Department of Health and Human Services (DHHS) Regional Offices.* (For existing consumer participation requirements, see Appendix A)

The Consumer Affairs Program will be coordinated with those of the Public Health Service and the Department of Health and Human Services.

In order to achieve the Agency's consumer affairs objectives and to meet the requirements of the Executive Order, the Consumer Affairs Task Force was charged with developing proposals to:

1. Improve, reinforce, and widen opportunities for the participation of consumers in the development of policies and the evaluation of program operations and planning; to develop strategies and structures to achieve these goals.
2. Develop effective, assured, complaints procedures for consumers of the Agency's program services within the concept of a common patients' rights program and existing legislative mandates and regulations, and
3. Investigate ways to improve, and where appropriate, develop proposals to amend existing reporting, monitoring, and evaluation procedures in regard to consumer needs, preferences, and satisfactions, including the special concerns of minorities and handicapped groups.

In the development of proposals to implement the Executive Order, two areas received special study. First was patients' rights. In an agency that has a primary role as a provider of medical services, patients' rights is a critical area

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* For the sake of simplicity, the terms, "local service delivery level" and "local services" will be used throughout this document to denote PHS hospitals and clinics, local BMS prison, Coast Guard or Federal employee services, IHS hospitals and health centers, BCHS local projects, and projects administered by States.

for consumer concern. It is necessary to establish common Agency criteria for patients' rights bills and to ensure that these include a provision for a consumer complaints system.

Second was the Agency's reporting, monitoring, and evaluation activities. These are considered key processes in the ongoing assessment of program sensitivity and receptiveness to consumer needs and preferences and will be important tools for ensuring "that consumer concerns are adequately analyzed and considered in decision-making." (See Executive Order 1-401-b.) They are also mechanisms for receiving and analyzing input from consumers.

The Consumer Affairs Plan includes the following sections:

1. Consumer Affairs Perspective -- an Identifiable Consumer Affairs Staff
2. Effective Procedures for Consumer Participation
3. The Development of Information Materials for Consumers
4. Education and Training for Agency Staff
5. Education, Training, and Technical Assistance for Consumers
6. Systematic Procedures for Complaint Handling
7. Patients' Rights
8. Reporting, Monitoring, and Evaluation

The Agency will continue periodically to review, evaluate and improve this Plan. Unlike most rules and regulations that are generally regarded as fixed, this Program must be seen as a dynamic one, that will change over time as feedback is received from those it is intended to serve.

Each Bureau, in consultation with consumer affairs staff in the Office of the Administrator, and where appropriate with the Regional and IHS Area/Program Offices, will prepare an implementation plan for carrying out the Consumer Affairs Program as set forth in this document.

Consumer Workshop

In order to obtain consumer input to its planning, the Task Force held a workshop in July of 1980 with consumer representatives of HSA community health centers, PHS hospitals and clinics, and the various special programs from all parts of the country. The Consumer Affairs Plan takes into account their comments and recommendations.

1. CONSUMER AFFAIRS PERSPECTIVE - AN IDENTIFIABLE CONSUMER AFFAIRS STAFF

The Administrator, Health Services Administration, has amended the Agency's functional statement to create within the Office of the Administrator an Office of Consumer Affairs (OCA) to provide policy direction, coordination and oversight for consumer activities in the Agency. The Director of this Office will report directly to the Associate Administrator for Operations.

Each Bureau shall have a Consumer Affairs Officer to act as a liaison with the Office of Consumer Affairs and to assist in the implementation of consumer affairs policy throughout the Bureau. This officer should be a full-time senior staff member within the immediate office of the Bureau Director. It is recommended that each program designate a member of staff to work with the Bureau Consumer Affairs Officer in developing and overseeing program-related consumer affairs activities.

Responsibility for implementing the Consumer Affairs Program

It will be the responsibility of each Bureau Director to see that the Agency's Consumer Affairs Program is implemented in all Agency services - the promotion of consumer participation, the provision of informational materials to consumers, staff education, training and technical assistance to consumers, the patient complaint system, patients' rights policy, and the inclusion of consumer issues in reporting, monitoring, and evaluation.

The use of grant monies is authorized for all the purposes described. For direct services, line items should be included in budgets to cover consumer affairs activities.

Implementing the Program in each of the areas noted above will be the concern of managers at all levels. Ultimately program objectives must be met at the local service delivery level for the Plan to be a success.

Goals stated for each level are the following:

For Managers and staff at local service delivery site:

Consumer participation and consideration of consumer concerns

- To be receptive to consumer opinions and complaints at all times.
- To make consumers aware of the management's receptiveness to their opinions and complaints.
- To communicate with consumers (governing boards and advisory committee members, and others) in regard to consumer concerns and potential policy decisions.
- To encourage consumer participation on governing boards and advisory committees and in other ways; to encourage consumer board or committee member communications with constituency groups in the community.
- To see that governing boards and advisory committees have a meaningful part in monitoring and evaluation of the local service.
- To seek innovative ways of eliciting more and better information from consumers.
- To seek innovative ways of involving consumers in management decisions.

Provision of education, information, and assistance

- To provide timely information, simply stated, to governing boards and advisory committees on policy issues and other management concerns on which consumer input would be relevant.
- To provide education and technical assistance when needed to enable consumers to participate more effectively as board or committee members, to voice their opinions to management, etc.
- To provide material assistance, to consumer representatives, such as transportation costs, when needed and when it is possible to do so.

Local service deliverysite - Continued.....

Staff orientation

- o To provide orientation to local service staff concerning the consumer affairs policy of the Agency.

Complaint system (See Section 6.)

- o To ensure that the complaints system works effectively for the project or facility.

Patients' rights

- o To make sure that patients' rights are protected and that patients are aware of their rights.

For managers at Regional Health Administration Office and IHS Area/Program Office level.

- o To consider consumer concerns in decisionmaking.
- o To aid local services to achieve above goals, providing information on consumer affairs policy, guidelines and technical assistance.
- o To deal with complaints received at Regional or IHS Area/Program Office level. (See Section 6.)
- o To monitor information from local services on governing boards or advisory committee operations; on support provided to consumers such as informational materials, education and technical assistance, on staff orientation and education; on operation of the patient complaint system; on protection of patients' rights, etc.
- o To provide information as needed to Central Offices on consumer issues.
- o To communicate with consumer groups that relate to the Regional, or IHS Area/Program level.

For managers at Bureau level

- o To consider consumer concerns in decisionmaking.
- o To provide guidance to Regional or IHS Area/Program Offices on various functions described above.
- o To monitor the implementation of consumer affairs policy throughout the Bureau.

- To design systems necessary for implementation of consumer affairs policy, such as the complaints system, staff orientation programs, etc. (with aid of the Office of Consumer Affairs).

- To deal with complaints received at the Bureau level. (See Section 6.)

- To communicate with consumer groups that relate to the Bureau level.

Consumer affairs to be included in performance standards

In order to monitor Agency performance in meeting consumer affairs objectives, existing performance standards for individual positions will be revised, where appropriate, to include a section on employee responsibilities in regard to consumer affairs.

Role of the Office of Consumer Affairs

The major responsibilities of the Office of Consumer Affairs, a professional cadre of trained consumer affairs experts, shall be:

- Assisting the Bureaus in developing systems for the implementation of the Consumer Affairs Plan and for the efficient flow of information..

  The Office of Consumer Affairs will provide expertise, advice, and consultation and prepare expert documents on consumer issues.

  In addition, it will:

  1) Develop program guidance material on consumer affairs to include:
     a. Consumer involvement in decisionmaking.
     b. Patient satisfaction surveys;
     c. Complaint handling

  2) Make recommendations for issuance of policies on consumer affairs in relation to:
     a. Board or committee selection procedures
     b. Complaint procedures
     c. Patient satisfaction surveys
     d. Objective review procedures that will assess if there is adequate consumer involvement at the local level.

  3) Coordinate monitoring of compliance with consumer participation guidelines in connection with regular grant and program review.

- Defining policy for the Consumer Affairs Program.

  An ongoing activity will be defining and developing strategies for implementing the requirements of the Executive Order, the DHHS Consumer Affairs Plan, PHS policies, and the HSA Consumer Affairs Plan.

- Representing the consumer point of view in Agency deliberation and ensuring that consumer concerns are reflected in policy-making.

  In this role the consumer affairs staff will work to create and sustain a high level of awareness of consumer issues among all Agency staff. To enable it to fulfill this role, the OA Consumer Affairs Staff and other Agency consumer affairs staff will receive draft plans for policy changes, proposals for legislative changes, etc. and will participate fully in meetings concerned with policy development and review to ensure that consumer concerns are part of decisionmaking.

- Acting as an information resource on consumer affairs for the Agency.

- Coordinating consumer affairs activities and improving communications on consumer affairs throughout the Agency.

- Coordinating consumer affairs activities of HSA with those of other agencies and organizations.

  The Office of Consumer Affairs will coordinate HSA activities with those of PHS and DHHS, and the Director of OCA will serve as the Agency representative on the PHS Coordinating Committee, established by the Assistant Secretary for Health.

  The Office of Consumer Affairs will also be concerned with areas where consumer interests or populations served overlap with those of its sister agencies: the Health Resources Administration (local and state health services planning and resources development); the Alcohol, Drug Abuse and Mental Health Administration; the Health Care Financing Administration; the Department's Health Maintenance Organization program; and the Social Security Administration.

International Year of the Disabled Person (IYDP)

The OCA will have a major responsibility during its first year for organizing a series of meetings with disabled consumer groups as part of the Agency's participation in the PHS Interagency Committee for the IYDP.

HSA Consumer Affairs Council

A Health Services Administration Consumer Affairs Council will be established. Members of this Council will include all consumer affairs staff in the Office of the Administrator and the Bureaus (who will meet monthly) and Regional Office staff and other appropriate field office staff (who will meet at least semi-annually with Central Office consumer affairs staff).

The Council will assist OCA in formulating policy, in developing guidance on the implementation of the Consumer Affairs Plan, and in coordinating and improving communications on consumer affairs activities.

Consumer task group

During the first year of operation, the Office of Consumer Affairs will draw upon the advice and assistance of a small task group of program consumers. A procedure similar to that employed to recruit participants for the July consumer workshop will be used to ensure that members from the Agency's programs will be broadly representative. Consumer members of the existing national councils will be involved in the work of this task group.

The purpose of the task group will be:

- to assist the Agency in identifying consumer concerns and needs
- to provide the Agency with a channel for communication of Consumer policies to their fellow service users and community organizations and thus promote feed-back from consumers around the country.
- to assist the Agency in developing relationships with relevant consumer and consumer advocacy organizations at the local and state levels.

2. EFFECTIVE PROCEDURES FOR CONSUMER PARTICIPATION

Establishing mandates for consumer participation

HSA has the responsibility for assuring consumer participation in its programs through a variety of legislative mandates under the U.S. Public Health Service Act: Titles IV, V, X, XII, XVIII, XIX, and XX etc., or Federal Assistance programs which support services of designated HSA programs.

Requirements under the various Acts differ. However, most of the Bureau of Community Health Services, Indian Health Services, and Bureau of Medical Services programs are required by law to have governing boards or advisory committees with consumer representation.

The exceptions are the formula grant programs operated by the states, notably the Maternal and Child Health and Crippled Children's Programs. HSA will attempt, through both legislative proposals and negotiations, to promote the establishment of formal mechanisms for consumer participation in state operated grant programs.

Assuring compliance

Where consumer participation is mandated, compliance is monitored annually. Amongst those programs that have mandated consumer participation, it has been found that not all are in compliance. Preceding the issuance of this Plan, the HSA Administrator has requested in the annual Regional Work Plan, FY 81 for Regional Administrators, close monitoring and reporting of compliance with legislative mandates for consumer participation in the Agency's programs. This will be an ongoing process carrying performance evaluation criteria. In addition, program guidance materials will be issued to the Regional and IHS Area Offices and Central Office program managers for assessing how governing boards and advisory committees actually function.

Provision of material assistance

Participants at the July Consumer Workshop (see p.4) stressed the need for financial assistance, i.e. reimbursement for expenses in connection with attending meetings, such as transportation, child care, meals, etc. Without such support, many consumers are unable to participate. The Agency will foster the provision of such support by means of program guidance materials and provisions in grants and contracts. Grant monies will be used to the extent possible for this purpose, and such use is authorized by the Agency.

Consumer links with constituencies and community groups.

Consumer participation in project activities will be enhanced by encouraging and assisting board and advisory committee members to develop and strengthen their links to community groups and relevant patient groups. Consumers are more likely to be effective, and therefore influential, if they are "sponsored" by organized local consumer groups and required to report back to them as their "representatives." The consumer is also more likely to be a more effective advocate knowing that he or she has the backing of an active constituency.

Board and committee members will be encouraged and assisted in maintaining working links with their communities, and acting as vehicles for dissemination of information and health promotion efforts. (See Section 5 below.)

There is also a need to encourage cooperation and coalitions between HSA consumers and consumers of other programs, for instance, Community Mental Health Centers, Health Systems Agencies, drug addiction programs, etc. This will reinforce interagency health planning and collaboration in services delivery.

Consumer participation above the local service delivery level

Until now, consumer participation in HSA programs has been for the most part at the local service delivery level. With the exception of the two national advisory councils for Migrant Health and for the National Health Service Corps, there have been no institutionalized arrangements for consumer participation in Agency or Bureau level policymaking, management, or program evaluation.

The consumer task group described above will be one avenue for consumer participation at the national level.

The Agency will assess the need for consumer participation above the local level for each HSA program and consider the establishment of new consultative mechanisms at the Regional, IHS Area/Program or Central Office level.

Consumer participation in rulemaking.

The Agency will seek the most effective means to promote early and meaningful participation by consumers in rulemaking. The rulemaking process and a recent BCHS effort in obtaining governing boards' comments will be reviewed to determine what revisions in procedures may be necessary.

Consumer participation in monitoring and evaluation

Administrators of local services will be instructed to encourage participation by boards and advisory committees, and especially their consumer members, in monitoring and evaluating their own services. This will be accomplished through program guidance material to Agency officials, contractors, and grantees.

Consumers should participate in the work of HSA program evaluation teams, either as members or in consultation with them.

The Agency will encourage State MCH/CC programs, through negotiation, to provide for consumer participation and consumer input in the State reviews of these programs. Appropriate monitoring mechanisms will be developed by the Office of Consumer Affairs and officials responsible for these programs in the BCHS and Regional Offices.

Consumer participation in the complaints review process

Program guidance materials will be used as above to promote governing board and advisory committee review and utilization of the complaint system.

3. THE DEVELOPMENT OF INFORMATIONAL MATERIALS FOR CONSUMERS

The objective of the Consumer Affairs Program is to improve both the quality and distribution of consumer information materials.

These materials are of three kinds:

- o <u>Information about the Agency's services and responsibilities</u>. A variety of such materials already exist. These will be reviewed to determine to what degree consumer issues are covered and where a consumer perspective may be needed. Dissemination strategies will also be considered in the light of information from consumers.

- o <u>Information about ways consumers can participate</u>. An existing BCHS handbook, <u>Policy and Procedures Manual for Governing Board Members</u>, is currently being revised. In addition, opportunities for such membership and any other procedures for consumer participation will be described in pamphlets for distribution to patients locally or by whatever methods are deemed most appropriate for each program. Each Bureau will provide such materials.

- o <u>Information about particular Agency actions or proposals that affect consumers</u>. Consumers will receive early notice of specific actions and proposals so that they will have an opportunity to comment. Effective methods for achieving this objective must be developed for each program.

Care must be taken to see that all materials for consumers are clear and easy to understand, culturally relevant, and provided in languages other than English when appropriate.

Relationship between the Office of Consumer Affairs and the HSA Office of Communications and Public Affairs

There will be a close relationship between the Office of Consumer Affairs and Office of Communications and Public Affairs (OCPA). However, there should be a clear distinction between the Agency's public affairs/information activities and those of the consumer affairs staff.

The primary function of OCPA is to inform the public -- to represent the Agency, stating its purposes and policies, explaining action, and reporting public information. Its communications are directed to the general public, the medical community, health professionals within the Agency, and the research community, as well as to users of HSA programs.

Consumer affairs staff, on the other hand, communicates primarily with users of HSA programs in order to generate consumer inputs and participation in the Agency's planning and operations.

Communications of OCPA tend to be one-way and often on a one-time basis, while those of a consumer affairs office are two-way, on going, and long-term.

Finally, the consumer affairs staff, as advocate of the consumer point of view, has the responsibility of analyzing information obtained directly from consumers and of making sure consumer concerns are factored into management decisionmaking.

OCPA has the responsibility for the review processing, quality control, and dissemination of HSA communications materials, and assists the Bureaus in the development of program specific publications. Thus the consumer affairs staff will be a "client" of OCPA; relying on its services in the development of public information and information dissemination. OCA will also provide the consumer perspective to OCPA concept clearance and publication review processes and also to the evaluation of Agency public information efforts.

4. EDUCATION AND TRAINING FOR AGENCY STAFF

Goals of staff education and training are to:

- o Provide staff with a thorough knowledge of HSA and DHHS consumer affairs objectives, the requirements of Executive Order 12160, and legislative mandates for consumer participation.
- o Develop a practical understanding of the role and function of OCA, the plan of operations, and the duties and responsibilities of each staff position and office division.
- o Develop staff sensitivity to consumer concerns.
- o Develop staff management skills in developing effective methods for responding to consumer recommendations and complaints, and in maintaining a consumer complaint review system.

Particular importance is attached to the provision of consumer affairs-oriented training for clinical and administrative personnel working in the field -- for example, staff of the Public Health hospitals and clinics; members of the National Health Service Corps; and IHS service units, hospitals, and field units.

In the orientation of existing staff and new entrants special emphasis will be placed upon the need to increase sensitivity to the ethnic, cultural, social and economic conditions in the communities served.

It is recommended that two types of Agency consumer affairs training be provided for staff:

- o General staff training. As a general rule all staff will receive consumer affairs orientation as a regular component of Agency career development programs and in special seminars to be arranged periodically. This orientation will be for all grades and positions concerned with services and will be developed by the Office of Consumer Affairs in consultation with the Agency's career development staff.

- Consumer Affairs Staff Training. Training for consumer affairs staff will focus upon their specific responsibilities for implementing the Consumer Affairs Program. It will include the development of the special technical and management skills required to ensure effective interface with Agency management.

Staff education at the local service delivery level

Grants and contracts will be revised to include a provision for educating staff on the Agency's consumer affairs policies. Guidelines will be provided by each Bureau program.

5. EDUCATION, TRAINING, AND TECHNICAL ASSISTANCE TO CONSUMERS.

Education, training and technical assistance to consumers are essential to enable them to participate effectively. This was the most frequently mentioned need by participants at the July Consumer Workshop (see p.4)

Education is needed, first of all, for all consumers so that they can understand how to deal with the health care system and can participate effectively in their own treatment. There must be improved communications between consumers and providers. The provision of formal programs of health education and health promotion at the State and local service delivery level will be one vehicle for improving consumer and provider communication and consumer participation.

Specific training is needed to enable governing boards and advisory committee members to participate effectively in program governance, policy-making, and review activities. Training in the form of manuals, training sessions, workshops, and consultations will be provided in areas such as administration, complaint handling, and personnel management so that consumer input can be informed, knowledgeable, and effective. Training will also provide information on health care organization, disease prevention, and health promotion and on community relations and advocacy.

Where feasible and appropriate, technical assistance in the form of aid in the preparation of documents, planning meetings, etc. as well as support services such as typing, will be provided to meet specific needs.

Every opportunity will be sought to develop consumers' capabilities to participate. Board and committee members will be used to reach consumers as well as potential consumers in their communities. In addition, interested non-board members will be encouraged to observe board meetings, and to take part in subcommittees, to act as delegates to meetings of outside organizations, to attend educational sessions for board members, etc. Initially more attention will be given to the training of consumers already serving on boards or advisory committees.

There will be an over-all Agency review, coordinated by the Office of Consumer Affairs, of training and technical assistance now offered to consumers at the local service delivery level. A determination will then be made as to what new programs for this purpose are needed.

6. SYSTEMATIC PROCEDURES FOR COMPLAINT HANDLING

Systematic procedures for complaint handling will be established throughout the Agency. Success of the complaint handling system will depend on (1) how a complaint is perceived and (2) how the complaint system is supported by all levels of management. The fact that a consumer lodges a complaint is not in itself a problem. Considering the diverse beneficiary groups, differing individual and community health care needs, the scope and complexity of health care delivery systems, and the number of persons utilizing HSA services, it is inevitable and to be expected that complaints will occur. A serious problem can result, however, if a complaint is ignored and not properly handled. To make sure that all complaints that do occur are expeditiously and thoroughly addressed, it is essential that HSA program managers become fully aware of both the consumer's right to complain, to have a hearing and a thorough investigation, and of management's responsibility to respond and to achieve satisfactory and prompt resolutions.

Objectives

The objectives of the complaint handling system are:

- To make consumers of HSA services aware of the receptivity of the Agency staff at all levels to complaints and how and to whom to complain.
- To provide prompt and responsible replies to all consumer complaints received by the Agency,
- To assist in identifying and resolving problems.
- To provide Agency decisionmakers with accurate information about complaints and recommendations in regard to consumer concerns, so that the complaints system becomes a useful management tool.
- To assist in translating consumer needs into policies and procedures.

Complaints should generally be handled at the level where the service is provided - the outpatient clinics, field units, hospitals, and health clinics of HSA programs,[*] but there should also be a right to appeal when the complainant is dissatisfied with the response. Complaints must also be reported in order to make complaints data useful to decisionmakers, and they should be monitored and analyzed for the purpose of project review.

Each level of organization, from Central Office to local services, will have systematic procedures for handling complaints received at that level (including procedures for follow-up for any complaints referred to a lower level for action). Each level will also have procedures for monitoring complaint handling at lower levels. There must be sufficient standardization in reporting complaints to allow for Agency-wide review, as required by the DHHS Consumer Affairs Plan.

An early priority for OCA will be organizing an ad hoc Inter-Bureau Steering Committee to develop detailed guidance for implementing the complaints system.

A "complaint" is defined as a written or oral communication expressing dissatisfaction with an Agency project, program, policy, or service. Complaints should be distinguished from inquiries and suggestions. Also, provisions must be made for appropriate action should a complaint become the subject of a medical malpractice suit or any other legal petition. This matter will receive further study.

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[*] Congressional complaint mail will be handled in accordance with special procedures established for this purpose.

Elements of a complaint handling system

The essential elements that shall be required for every complaint system are:

1. Promotion of public awareness, i.e. making consumers aware of the complaint system and how to use it.
2. Recording complaints
3. Responding to complaints
4. Tracking the handling of complaints
5. An appeals mechanism
6. Reporting and monitoring
7. Evaluation and utilization of complaints data in policymaking

General guidelines are provided below. These will be refined by the Inter-Bureau Steering Committee. Because each HSA Bureau has a different organizational structure, unique programs and different geographical coverage, details of how the complaints system will be applied must be worked out for each program.

Guidelines for complaint handling

Staff responsibility for each of the functions described below shall be clearly fixed. It is extremely important, however, that all staff who come in contact with the public be made aware of the Agency's policy and methods for handling complaints and that all have a role and responsibility for both preventing and resolving complaints.

1. Public Awareness: To make consumers aware of the receptivity of their hospital, health center, or clinic to complaints and to encourage consumers to use the system, instructions on how to make complaints shall be provided to patients in leaflets or brochures. Information will be provided to community organizations in separate handbooks or in newsletters. Instructions shall provide names, titles, and telephone numbers of persons to whom complaints can be made.

2. Recording complaints: All complaints whether by letter, by telephone, or in-person, shall be logged-in upon receipt. The log shall provide all information needed for tracking and handling the complaint and for subsequent reporting - name, address, and telephone number of complainant, how complaint was received (by mail, telephone, or in-person), person receiving complaint, date, nature of the complaint, and to whom referred. After action is completed, date and nature of response shall be entered.

Many suggestions and complaints can be dealt with immediately to everyone's satisfaction. Generally, if a problem cannot be dealt with on-the-spot to the complainant's satisfaction, it should be fully investigated. A person who wishes to make a complaint should not be expected to put it in writing if he does not wish to do so. An adequate record must be made by the person receiving the complaint.

The system must provide for confidentiality, and measures must be taken to ensure that a complaint action does not become part of the complainant's medical record.

3. Responding to a complaint: When a complaint is received, it shall be immediately referred to the appropriate individual or office for investigation and response. If a complaint cannot be investigated and responded to within ten work days, a letter acknowledging that the complaint was received shall be sent to the consumer. The letter should give an approximate time when the consumer can expect a formal response. If a long delay is expected, the reason should be explained. The name, address and telephone number of contacts for further information should be included. However, it shall be the Agency goal to respond to every complaint within 30 days.

Each response shall be courteous, thoroughly researched, and concise. Every effort shall be made to resolve the complaint in a manner satisfactory to the complainant. If the decision is unfavorable to the complainant the rationale for the decision must be clearly explained in writing.

Complaints that do not fall within the purview of an HSA program or project shall be referred to the appropriate agency. A letter acknowledging receipt shall be sent informing the complainant to which organization the complaint has been referred. The name, address, and telephone number of the organization representative to whom the complaint was sent should also be provided.

If the complaint referred to another organiation in any way affects the consumer's ability to make use of HSA services, the matter shall be followed up with the other organization and every effort made to see that a satisfactory conclusion is reached.

4. Tracking the handling of complaints: Each local service as well as any Regional, Area, or Bureau Office where complaints are received, shall have a system for tracking and handling of complaints to make sure they are investigated and responded to expeditiously and to permit identification of any bottlenecks in the complaint-handling process. After a complaint is answered, the record will note whether the complainant is satisfied that he has been treated fairly. The consumer shall be fully informed of his right to appeal, how to initiate the appeal, and to whom to appeal.

5. Appeals Mechanism: If complaints are properly handled initially, there should seldom be a need for an appeal. However, if the complainant does not wish to accept the resolution offered and desires to pursue his complaint, each Bureau must see that

mechanisms are offered to the complainant for appeal to a higher administrative level. Because of differing mandates and administrative arrangements, however, appeal mechanisms will be worked out separately for each program.

The final decision shall be sent to the complainant in writing.

6. Reporting and Monitoring: At each local service site, data from the complaints record should be provided monthly to the administrator and the governing board or advisory committee if there is one: the number and type of complaints received, the number of complaints adjusted to the satisfaction of the consumer, the number of complaints remaining unresolved, and the number of unresolved complaints over 30 days old. On a less frequent basis, at least once a year, a narrative report should be provided with information on the nature of the complaints, complaint patterns, underlying problems, corrective actions needed and taken, potential policy-significant issues or indications for administrative change, possibilities for improving complaint handling, etc. These reports shall be available for the review by Regional or Area staff during regular project reviews. Annual reports for the Agency as a whole shall be made public. Complaints received at other levels - in the Regional, Area, or Central Offices - should be similarly reported to program managers. Regional and IHS Area/Program Offices should be able to provide periodic reports on the status of all complaints, with particular reference to those which appear to represent generalized problems and which persist and are generic to different programs.

7. Evaluation and utilization of complaints data in policymaking: Each local service shall see that complaints data is treated as an information base for decisionmaking. The Regional and IHS Area/Program Offices and Central Offices will in turn be responsible for seeing that this system is working and analyzing and assessing complaints

data available to them. The Office of Consumer Affairs will review data from Bureau programs in order to identify patterns and trends.

In addition, the Office of Consumer Affairs will periodically monitor the Bureaus' complaint handling systems to make sure they are fully operating.

7. PATIENTS' RIGHTS

Throughout the Agency's programs in the past, a number of patients' rights or consumers' rights "bills" or guidance materials on this subject have been issued. These have not, however been uniform in content or application.

First, it is essential that every Agency service or program make sure its consumers are aware of their rights as patients. As a first step, a patients' rights bill should be posted and openly visible at each HSA facility. Some programs have used innovative methods of disseminating patients' rights bills -- publishing bi-lingual pamphlets, reducing the bills to pocket size, etc. Some hospitals have patients rights' committees that distribute booklets and inform users not only of their rights but of on-going programs from which they might benefit. Information about effective methods for informing consumers of their rights will be made available throughout the Agency.

A model patients' rights bill will be developed by the Office of Consumer Affairs, in consultation with Bureau officials and program managers, and disseminated throughout the Agency and its services.

8. REPORTING, MONITORING, AND EVALUATION

The goals of the Consumer Affairs Program in relation to reporting, monitoring, and evaluation are:

- To see that the program is carried out at each level of the organization.
- To obtain information on how the Program is working and what works best.
- To obtain information on consumer concerns for consideration in decisionmaking.

Reporting, monitoring, and evaluation activities take place at every level of the organization -- from local community health centers to Central Office administration. Hence to achieve its objectives the Agency will seek to improve these processes at every level. Much has already been done, and a number of further improvements can be made without much expenditure of time or funds. Consumer input into these processes is discussed above under "Consumer Participation."

More specifically, the Agency will:

1) Amend annual workplans (Regional and other) to include monitoring of consumer participation at local service delivery level, staff effort to encourage such participation, staff support to consumers in terms of informational materials, technical assistance, reimbursement for expenses, etc., progress in achieving compliance with mandated consumer participation on governing boards and advisory committees.
2) Amend guidelines to grantees and contractors to include requirements for complying with consumer participation mandates and providing additional support as noted above

3) Amend program review protocols and evaluation protocols to include measures for achievement of objectives of consumer affairs policy.
4) Analyze data from these sources and the complaint system.
5) See that consumer affairs staff and other senior officials receive monitoring and evaluation reports pertaining to consumer affairs.
6) Promote research in monitoring and evaluation techniques.
7) Amend performance standards.
8) Find ways to collect qualitative information on consumer needs and satisfactions, including consumer evaluations of the quality, accessibility, and appropriateness of services.
9) Review and track monitoring and evaluation systems operated by program managers.
10) In the absence of firm mandates for consumer participation and complaints processes in the formula grant and other state based programs, the establishment of new requirements, and the extent to which these can be monitored and evaluated will be the subject of further study and negotiation.

The development of effective consumer oriented monitoring and evaluation procedures will require the close collaboration by the Office of Consumer Affairs with HSA's, Office of Planning, Evaluation and Legislation and the monitoring and evaluation components in the Bureaus, Regional and IHS Area/Program Offices.

APPENDIX "A"

CURRENT HEALTH SERVICES ADMINISTRATION CONSUMER PROGRAMS

Mission

The mission of the Health Services Administration (HSA) is to develop comprehensive systems of health care delivery for medically underserved and high priority populations, and to provide professional leadership in the delivery of health services. More specifically, the Agency's efforts are directly focused on:

- Improving the organization and efficiency of health care delivery,
- Building and/or maintaining primary health care capacity in underserved areas,
- Promoting effective and equitable public health and preventive services, and
- Providing high quality comprehensive health services to Federal beneficiaries.

The HSA is the second largest provider of civilian health services within the U.S. Government. It provides health care services for statutorily defined populations, but the predominant population served by HSA is comprised of socio-economically depressed people who lack adequate health and medical care services. Many of them are members of minority groups, come from large families, have low family income, and at any given time may experience long periods of unemployment. Thus, one of the Agency's primary objectives is to provide adequate health care services to such medically unserved and underserved individuals who might otherwise go without health care services, and a majority of the Agency's policies and programs are designed to attack the gaps and inequities in the Nation's health care system.

The Agency meets these responsibilities by providing direct and contract health services to Federal beneficiaries and by administering grant and contract programs designed to improve the health status of the population served.

Consumer Affairs Perspective

In promoting effective and equitable health services to all people, and as an important component of the major programs administered by HSA, consumers play a strategic role and in many of the programs consumer participation is a legislative requirement for compliance.

At the end of 1978, the Administrator initiated an Agency-wide review of consumer participation and sources of information on consumer needs and satisfaction, and patients' complaints. The findings and recommendations from this internal review are now being analyzed in the light of existing organizational arrangements and activities. A special concern is that the role of consumers be strengthened in policymaking and management decisionmaking of the Agency and its programs.

Below are descriptions of current HSA consumer participation programs:

I. HSA DIRECT SERVICE PROGRAMS

Program: Hospitals and Clinics

Authority: Agency Established Policy

The Division of Hospitals and Clinics has developed an oversight program to study consumer affairs and of issues which affect the quality and continuity of care provided to its beneficiaries. To date:

- Patient advisory councils have been set up in each hospital and free standing clinic for purposes of advising the director on improvement of the health status of beneficiaries served. The scope of the councils' activities include: informing patients of their rights; evaluating the range, quality, acceptability, and convenience of patient and client services offered; and providing patient advocacy and patient education programs (two of the hospitals have full-time patient advocates).
- In response to the Secretary's request for productivity standards, a request that objective measures for consumer satisfaction be considered in each facility planning/evaluation process has been submitted for the Secretary's consideration.

- Other consumer oriented activities underway include: the development and use of a consumer registry for inquiries and complaints; an automated data system for transient populations; a national around-the-clock, telephone access; and training programs for providers.

<u>Program:</u> Indian Health Service (IHS)

<u>Authority(s):</u> P.L. 83-568, P.L. 93-638, P.L. 94-437

The basic mandate regarding patient rights is essentially the same as the basic mandate of the program. Public Law 83-568, among other things, authorizes the Secretary to <u>conserve the health of the Indian people</u>. The Agency's program mission is expressed by the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) which authorizes the Indian tribes to assume operation of any portion or all of the IHS programs that directly involve their health care, and the Indian Health Care Improvement Act (P.L. 94-437) which provides the mechanisms to implement P.L. 93-638.

In the late 1950s, the IHS realized that it was difficult to conserve the health of patients or any population without their input into and involvement with their own health program. With IHS assistance, consumer health boards and community health representatives were elected, and consumer training provisions were established by the program. (The Community Health Representative program supplies over 2,200 patient advocates.)

- The importance of patient involvement and participants in policy and program development are addressed in all publications and budget statements. The IHS issuance manual, which assures that certain minimum activities regarding patient rights are in operation, requires that all area and local health boards be involved in the development of patient rights and grievance procedures.
- Unlike many non-Indian communities, Indian tribes have always assumed social and health responsibilities for their members. Thus, the Indian Health Service has the responsibility of assisting the consumers in preparing their own tribal health plans.
- The Agency's IHS program serves as the principal Federal health advocate for Indian people, in that it primarily educates other government institutions, providers, and the public regarding the rights and entitlements of Indian people.

Program: National Health Service Corps (NHSC)

Authority: PHS Act, Title III, Part D, Section 337

Section 337 establisheq a National Advisory Council on the NHSC which is comprised of fifteen members appointed by the Secretary. Four of those members are appointed from the general public to represent the consumers of health care, and at least two of those members must be individuals who are residents of or served by Corps members assigned to a health manpower shortage area. The community identifies or forms a nonprofit agency, applies for NHSC assistance, and then oversees the management of the practice once in operation.

II. HSA PROJECT GRANT SUPPORTED PROGRAMS

Program: Community Health Centers, Migrant Health

Authorities: PHS Act, Title III, Part D, Section 330, and PHS Act, Title III, Part D, Section 329

Governing boards are legislatively mandated for Community Health Center and Migrant Health programs. Sections 329/330 of the PHS Act require programs to establish governing boards, a majority of whom are individuals served by the centers. The statute also requires for the Migrant Health program that the Secretary give priority to community-based applicants representative of the populations to be served.

The size of governing boards is not to exceed twenty-five members and should be representative of the population in terms of such demographic factors as race, ethnicity, and sex. Process for selecting members is subject to approval of the Secretary. Specific board responsibilities include: establishment of center policy, approval for selection and dismissal of center directors; evaluation of center activities and adoption of health care policies and scope of services to be provided.

At the program level, considerable efforts are put forth to involve public individuals in the regulation and policy process. Direct bilingual contact is made with project boards. Regional telephone solicitation and project sampling are both part of the process of involving the recipients of service in policy development.

In the case of Migrant Health, P.L. 94-63 established a National Advisory Council on Migrant Health to advise the Department on migrant concerns, which requires that a majority be members of the governing boards of the migrant health centers.

Program: Family Planning

Authority: PHS Act, Title X

Title X requires that an approvable application must contain provisions of an opportunity for participation by persons broadly representative of all significant elements of the population to be served, and that the predominant participants be actual users of the services. The program also requires that approved applications contain sections which describe:

(1) how the applicant proposed to implement user and community participations,

(2) a time table for integration of new members, and

(3) a description of resources available for board member training and reimbursement of members for participation (wages lost, baby sitting, transportation, meals, etc.).

Section 1006(d) (1) (2) requires that all informational and educational materials be reviewed and approved prior to their distribution by an Advisory Committee established by the grantee or contractor in accordance with the Secretary's regulations. Such a committee must include individuals broadly representative of the population or community to which the materials are to be made available.

Program: Black Lung Clinics

Authority: Federal Mine Safety and Health Act of 1977, Section 427(a)

Applicants for this program must show a method for assuring participation in policy development by miners or miner-selected representatives, health care providers, and the general public.

Program: Comprehensive Hemophilia Diagnostic and Treatment Centers

Authority: PHS Act, Title XI, Part C

Program requires that a project must provide for community participation, through establishment of an advisory council, if feasible, to advise with respect to the overall management of the project. The membership of the advisory council must be representative of the population in the area served by the center.

Program: Genetic Disease Testing and Counseling Services

Authority: PHS Act, Title XI, Part A

Public Law 94-278 provides for community representation where appropriate in the development and operation of voluntary genetic testing or counseling programs, and for continuing community involvement in the development and operation of the project.

Program: Primary Care Research and Demonstration Projects

Authority: PHS Act, Title III, Part D, Section 340

This program provides for grants and contracts to demonstrate new and innovative methods for providing primary health and dental services and to conduct research on new or existing methods. For purposes of demonstrations, it is planned that this program will build on selected existing delivery systems which, among other characteristics, offer varying degrees of opportunity for consumer involvement. The impact of consumer involvement on successful delivery systems also is a topic for research.

Program: Technical Assistance Demonstration Grants and Contracts

Authority: PHS Act, Title II, Part D, Section 340A

This program provides grants and contracts for technical assistance to entities engaged in planning, developing and operating primary care centers. The development of consumer majority governing boards is an area where assistance is available.

Program: Sudden Infant Death Syndrome Information and Counseling Program

Authority: PHS Act, Title XI, Part B

A project community council shall be established by the grantee and shall consist of a minimum of nine and a maximum of fifteen members. At least one-third of such members shall be representatives of the community being served by the project, including representatives of parents' groups or other voluntary civic or community organizations.

Program: Hospital-Affiliated Primary Care Centers

Authority: PHS Act, Title III, Part D, Section 328

Opportunity for consumer involvement is made possible in this program through a hospital's establishment of a center as a distinct administrative unit with its own governance. A center's governing board or advisory board must be composed of a majority of individuals who are being served by the center and who, as a group, represent the individuals being served by the center.

III. STATE FORMULA GRANTS

Program: Maternal and Child Health Services

Authority: Social Security Act, Title V, Section 503

No public participation requirements for consumer involvement exist for the Agency's two formula grant programs, i.e., Maternal and Child Health (Social Security Act, Title V, Section 511) and Comprehensive Public Health Services, PHS Act III,

Par: D, Section 314D. The opportunity for achieving such involvement is largely dependent upon the grantees at the State level. Title V legislation, however, does suggest that grantees make a reasonable effort to solicit local project participation from health professionals, consumers, service providers and representatives from public or nonprofit private agencies for the development and operation of the project.

Program: Supplemental Security Income Disabled Children's Program

Authority: Social Security Act, Title XVI, Part A, Section 1615

This program requires that all State plans be made available to the public, and all interested persons be given an opportunity to comment on the plan development. All comments received are to be submitted with the State plan for consideration.

IV. REGIONAL PROJECT GRANT SUPPORTED PROGRAMS

Program: Emergency Medical Service (EMS)

Authority: PHS Act, Title XII, Section 1209

The EMS program is responsible for providing assistance and guidance in the development of comprehensive regional emergency medical service systems to States and local communities. The EMS program is required to solicit, by legislation, consumer participation and involvement in the making of policy for EMS management entities. All local EMS councils or advisory panels include consumer groups which influence the direction of the EMS programs and provide the focal points through which the public can access the EMS system with their complaints or recommendations.

Exhibit 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

September 25, 1980

Mr. Louis Nunez
Staff Director
United States Commission
  on Civil Rights
Washington, D. C.   20425

Dear Mr. Nunez:

This is in response to your letter to Secretary Harris requesting answers to four questions relating to the consultation the Commission sponsored on the civil rights aspects of health care delivery.

The answers are attached. If we can be of any further assistance, please let me know.

Sincerely,

Sylvia Drew Ivie

Sylvia Drew Ivie
Director
Office for Civil Rights

Attachment

Answers to Questions Submitted by the U.S. Civil Rights Commission

Question:

What is the policy of DHHS in terms of affirmative action to help promote the equitable representation of minorities and women on advisory committees and other bodies active in making decisions concerning distribution of Federal funds within a State; for example, State Boards of Health, State Medical Associations, and State Health Planning and Development Agencies?

Answer:

Section 80.3(b)(1) of the regulation implementing Title VI of the Civil Rights Act of 1964 provides, in part, that no recipient may on grounds of race, color, or national origin:

> (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.

Thus, Title VI prohibits discrimination in making appointments to advisory committees, planning agencies and State boards if these entities receive Federal funds and if their actions affect the allocation and expenditure of Federal funds. Advisory committees, planning agencies and State boards may not discriminate in selecting individual members. Nor may these entities adopt selection procedures which have the effect of discriminating against minority persons as a group. The selection process must provide minority persons with an equal opportunity to be considered for appointment.

Section 80.3(b)(6)(i) of the Title VI regulation provides that recipients must take affirmative action to overcome the effects of past discrimination. Section 80.3(b)(6) also provides that:

> (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 limited participation by persons of a particular race, color, or national origin.

In connection with this subject, the Office for Civil Rights (OCR) received a complaint alleging that the appointment of only white commissioners to the Mississippi Health Care Commission violates Title VI. The Mississippi Health Care Commission was designated by State statute as the State Health Planning and Development Agency (SHPDA). As a result of the complaint, OCR is investigating to determine whether the selection process was discriminatory or, if the Commission revises the process, whether the new procedures will ensure that minorities have equal access to membership. The Department has deferred full designation of the Commission as the Mississippi SHPDA pending the outcome of the investigation.

In response to another complaint, OCR investigated whether the appointment of members to the Mississippi State Board of Health violated Title VI. In the course of the investigation OCR received a report indicating that State law regarding the nomination process had been revised, resulting in the appointment of blacks to the Board as well as black appointments to nominating committees. OCR determined that the revision of the law and the subsequent appointment of blacks to the Board resolved the matter. We will continue to monitor the situation to ensure continued compliance.

The Commission also mentioned the representation of women on advisory committees, State boards, and planning agencies. OCR's jurisdiction to investigate a complaint alleging sex discrimination in this area is limited. Title IX prohibits sex discrimination only in federally assisted education programs and activities. Although a variety of education programs continue to receive assistance from this Department, most of the Federal grant programs were transferred to the Department of Education. However, if an alleged case of discrimination in this area falls within this Department's program jurisdiction, it could pursue the issue under the Fourteenth Amendment.

Question:

What remedial action can DHHS take in an instance where a disproportionate share of Medicaid funds is used by white beneficiaries? For example, during testimony it was noted that although only 25 percent of the eligible Medicaid recipients in the State of Mississippi are white, they receive more than half - 50.5 percent - of the Medicaid funds dispensed in that State.

Answer:

The remedial action the Department would require would depend on two factors: (1) whether the disproportionate expenditures were attributable, at least in part, to discriminatory practices; and (2) the nature of the discrimination. Thus, OCR would not be able to specify a remedy without conducting a review which disclosed that discrimination was a contributing factor in the disproportionate expenditures.

On January 21, 1980, OCR received a complaint alleging that the Mississippi Medicaid Commission provides services with patterns of utilization which result in the disbursement of Medicaid funds to beneficiaries in a ratio that is discriminatory in violation of Title VI. The complaint cited reports indicating that Medicaid funds are disbursed at a rate of $3.10 for white clients to $1.00 for black clients. The complainant also reported that the Commission was considering cutbacks in Medicaid services that would adversely affect black persons.

To make a determination, OCR examined statistics reflecting black and white utilization rates for Medicaid services as well as demographic data and data showing the number of Medicaid eligible persons by race and program. The OCR Regional Office in Atlanta concluded that the ratio of disbursements to black and white clients did not appear to be discriminatory. A copy of the letter to the Mississippi Medicaid Commission, summarizing the results of the investigation, is attached. In the letter, the Regional Office also reported that, at the time of the complaint investigation, no official actions had been taken to reduce Medicaid services. We understand that cutbacks have been announced since that time. If OCR receives information indicating that the specific Medicaid cutbacks announced would have a discriminatory impact in violation of Title VI, we would conduct an investigation.

Although OCR did not make a finding of discrimination in the above-mentioned complaint case, it should be emphasized that the disproportionate expenditure of Medicaid funds can be caused by discriminatory factors. For example, there could be illegal limitations placed on the amount, duration and scope of Medicaid services frequently used by blacks. Disproportionate expenditures could also result from a discriminatory selection of coverage groups to eliminate minority persons most likely to utilize services. To remedy these types of practices, a State could be required to alter eligibility groups, scope of services, reimbursement procedures, or methods of administration (such as Medicaid transportation). These remedies are distinct from an approach that might challenge discriminatory referral patterns to nursing homes or board and care facilities or discriminatory patterns in nursing homes.

Question:

What is the Department's position in the case Clark v. Mississippi State Medical Association, and does the Department intend to enter the case as a friend of the court?

Answer:

The Department has not examined or taken a position in this case. Nor has the complainant asked OCR for assistance or requested the Department to file an amicus brief.

According to our information, the case posed a challenge to a State statute requiring that members of the State Board of Health be nominated by the Mississippi State Medical Association. The Supreme Court of Mississippi held that the statute was valid and that it did not constitute an unconstitutional infringement on the Governor's appointment authority. We are not aware of any further appeal having been filed in the case.

However, the central issue may be moot at this point inasmuch as the State legislature has evidently changed the manner in which appointments to the Board are made. Our understanding is that the Governor may now appoint the thirteen members of the Board and is not required to accept nominations from the Association or any other organization. As indicated in answer to the first question, OCR found these changes acceptable under Title VI.

Question:

Have provisions been made to provide health services to immigrant communities, e.g., Miami? If so, is language being taken into account?

Answer:

Project grant funds awarded to the State of Florida for venereal disease control and childhood immunization have been supplemented by $10,246 and $32,505, respectively, to ensure the provision of appropriate services to Haitian refugees. In addition, a new target area was established in Miami with grant funding of $345,300 for the implementation of urban rat control activities in an area with a significant population of Haitian refugees. Through this supplemental award, approximately 12 Haitian refugees were hired to assist in bridging the cultural and language gaps.

Recently, $4.9 million has become available for project grants to assist States and localities in meeting the public health needs of the refugee population and in providing general health assessments of refugees. Grant awards will be issued by September 30, 1980, directed primarily to Indochinese refugees.

The Bureau of Community Health Services has allocated $1.7 million in supplemental funding to six Community Health Centers in the State of Florida in order to provide services to Haitians and Cubans, with the understanding that BCHS will also augment the Centers' grants in 1981.

The Haitians are being serviced by Haitian providers where possible and the Cubans by Cuban providers where possible. In circumstances where the providers do not speak the language, translators are readily available.

Exhibit 6

Memorandum of Understanding
Between
The Office for Civil Rights
and
Public Health Service

This Memorandum of Understanding between the Office for Civil Rights (OCR) and the Public Health Service (PHS) is designed to implement the Secretary's policy to make civil rights an essential and integral part of every program in the Department. The Office for Civil Rights is responsible for planning, coordinating, reviewing and appraising the department-wide initiative to incorporate civil rights activities into the program operations of the Principal Operating Components (POCs). This responsibility includes providing technical assistance and support services to POCs for civil rights implementation, preparing POC civil rights guidance materials, participating in training programs for POC staff and working with the POCs to identify broad issues hindering civil rights compliance and developing appropriate strategies to remedy problems identified.

Accordingly, the PHS has the responsibility to establish program policies and procedures which can assist in achieving affirmatively, the objectives of the civil rights statutes (Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973). In carrying out this responsibility the PHS will take positive action to remove barriers that tend to exclude people from the benefits of its programs because of race, national origin, sex or handicap. The purpose of the activities undertaken by PHS is to help prevent discrimination and to assist recipient compliance with the civil rights authorities.

In order to carry out this task effectively, the PHS and the Office for Civil Rights have certain reciprocal obligations.

The responsibilities of the Office for Civil Rights will be to:

1. Develop civil rights standards and procedures for inclusion in PHS regular program reviews and audits.
2. Oversee the establishment of a data collection system design to assess the participation and treatment of women, minorities, and handicapped persons in PHS grant programs.
3. Assist PHS to conduct training programs to carry out its civil rights responsibilities.
4. Establish guidelines for the review of POC program regulations, directives and instructions to assure support for the Department's civil rights authorities.
5. Supervise the development and award of contracts funded by OCR to provide civil rights technical assistance to PHS recipients.
6. Guide PHS in the establishment of programs to explain civil rights compliance to their recipients.
7. Assist PHS in the development of model financial assistance projects to support civil rights compliance.
8. Identify and refer existing civil rights agreements to be monitored by PHS.

9. Design a proposed PHS civil rights activity reporting system, review and appraise the activities conducted, and periodically submit progress reports to the Secretary.
10. Coordinate the development of a PHS Civil Rights Operating Plan to include priority selection of target activities and long-range planning to meet civil rights program requirements.

The responsibilities of PHS will be to:

1. Furnish technical expertise and assistance to their assigned recipients about policies, practices and procedures for civil rights compliance and refer unresolved or complex civil rights issues to OCR for resolution.
2. Initiate, in cooperation with OCR, orientation and training programs on civil rights requirements for selected program and recipient staff.
3. Utilize, to the extent feasible, financial resources to support civil rights equity, to prevent acts of discrimination and to assist in the remedy of past acts adversely affecting minorities, women and handicapped persons.
4. Monitor, in arrangement with OCR, existing civil rights compliance agreements.
5. Incorporate civil rights concerns into regular program review and audit activities to assure that benefits and services are delivered equitably to eligible minorities, women and handicapped persons.
6. Adopt systems for the collection of data on the participation of women, minorities and handicapped persons in its programs, to

enable program officials to determine if grant applicants or recipients are violating civil rights requirements.

7. Review, in cooperation with OCR, program regulations, directives and instructions to assure support for the Department's civil rights authorities.
8. Set up, in agreement with OCR, a management structure and information system to carry out civil rights activities and evaluate progress.

The attached Operating Plan details the specific civil rights activities to be carried out by PHS and OCR for the remainder of FY 79 and for FY 80. An Operating Plan for FY 81 will be developed and submitted to the Secretary for approval by July 1, 1980.

At the request of either PHS or OCR this Memorandum of Understanding and/or Operating Plan may be amended, as appropriate.

Signed by: Julius B. Richmond

Assistant Secretary for Health

Director, OCR

7-16-79

Date

Approved by:

Secretary, HEW

JUL 27 1979

Date

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO Dr. Julius B. Richmond
Assistant Secretary for Health
and Surgeon General

DATE: JUN 7 1979

FROM Director
Office for Civil Rights

SUBJECT: Review of Memorandum of Understanding and FY 79-80 Civil Rights Work Plan

When the Secretary approved the Three Year Plan for Civil Rights Activities in the POCs, he directed that we develop a Memorandum of Understanding (MOU) and detailed civil rights Work Plan for each POC, spelling out for each activity the tasks OCR and the POC will perform, and the projected dates for completion of activities.

The attached MOU and Work Plan have been developed jointly by OCR staff and members of your staff. I believe the Plan is workable and when fully implemented will make civil rights an integral part of the Department's programs.

I would like to ask your personal cooperation and support in getting the MOU and Work Plan in place as quickly as possible. To do so, I would like to meet with you and members of your staff sometime within the next two weeks. Gus Cheatham, Deputy Director for Program Review and Assistance, will be contacting you to make arrangements for the meeting. I hope that you and I can sign the MOU and Work Plan very soon so they can be forwarded to the Secretary for his review by the end of June. I appreciate your support for this initiative and look forward to finally getting it off the ground.

David S. Tatel
David S. Tatel

Attachment

Memorandum of Understanding
Between
The Office for Civil Rights
and
Public Health Service

This Memorandum of Understanding between the Office for Civil Rights (OCR) and the Public Health Service (PHS) is designed to implement the Secretary's policy to make civil rights an essential and integral part of every program in the Department. The Office for Civil Rights is responsible for planning, coordinating, reviewing and appraising the department-wide initiative to incorporate civil rights activities into the program operations of the Principal Operating Components (POCs). This responsibility includes providing technical assistance and support services to POCs for civil rights implementation, preparing POC civil rights guidance materials, participating in training programs for POC staff and working with the POCs to identify broad issues hindering civil rights compliance and developing appropriate strategies to remedy problems identified.

Accordingly, the PHS has the responsibility to establish program policies and procedures which can assist in achieving affirmatively, the objectives of the civil rights statutes (Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 and Section 504 of the Rehabilitation Act of 1973). In carrying out this responsibility the PHS will take positive action to remove barriers that tend to exclude people from the benefits of its programs because of race, national origin, sex or handicap. The purpose of the activities undertaken by PHS is to help prevent discrimination and to assist recipient compliance with the civil rights authorities.

In order to carry out this task effectively, the PHS and the Office for Civil Rights have certain reciprocal obligations.

The responsibilities of the Office for Civil Rights will be to:

1. Develop civil rights standards and procedures for inclusion in PHS regular program reviews and audits.
2. Oversee the establishment of a data collection system design to assess the participation and treatment of women, minorities, and handicapped persons in PHS grant programs.
3. Assist PHS to conduct training programs to carry out its civil rights responsibilities.
4. Establish guidelines for the review of POC program regulations, directives and instructions to assure support for the Department's civil rights authorities.
5. Supervise the development and award of contracts funded by OCR to provide civil rights technical assistance to PHS recipients.
6. Guide PHS in the establishment of programs to explain civil rights compliance to their recipients.
7. Assist PHS in the development of model financial assistance projects to support civil rights compliance.
8. Identify and refer existing civil rights agreements to be monitored by PHS.

9. Design a proposed PHS civil rights activity reporting system, review and appraise the activities conducted, and periodically submit progress reports to the Secretary.
10. Coordinate the development of a PHS Civil Rights Operating Plan to include priority selection of target activities and long-range planning to meet civil rights program requirements.

The responsibilities of PHS will be to:

1. Furnish technical expertise and assistance to their assigned recipients about policies, practices and procedures for civil rights compliance and refer unresolved or complex civil rights issues to OCR for resolution.
2. Initiate, in cooperation with OCR, orientation and training programs on civil rights requirements for selected program and recipient staff.
3. Utilize, to the extent feasible, financial resources to support civil rights equity, to prevent acts of discrimination and to assist in the remedy of past acts adversely affecting minorities, women and handicapped persons.
4. Monitor, in arrangement with OCR, existing civil rights compliance agreements.
5. Incorporate civil rights concerns into regular program review and audit activities to assure that benefits and services are delivered equitably to eligible minorities, women and handicapped persons.
6. Adopt systems for the collection of data on the participation of women, minorities and handicapped persons in its programs, to

enable program officials to determine if grant applicants or recipients are violating civil rights requirements.

7. Review, in cooperation with OCR, program regulations, directives and instructions to assure support for the Department's civil rights authorities.
8. Set up, in agreement with OCR, a management structure and information system to carry out civil rights activities and evaluate progress.

The attached Operating Plan details the specific civil rights activities to be carried out by PHS and OCR for the remainder of FY 79 and for FY 80. An Operating Plan for FY 81 will be developed and submitted to the Secretary for approval by July 1, 1980.

At the request of either PHS or OCR this Memorandum of Understanding and/or Operating Plan may be amended, as appropriate.

Signed by:

Assistant Secretary for Health	Director, OCR	Date

Approved by: ______________________ ______________

Secretary, HEW Date

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

____________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To manage FY 78 Supplemental Budget contracts to provide Section 504 Technical Assistance to 3,100 recipients of PHS funds.

3. PHS Resources Needed: (Program $____ S&E $____ Person Years: ____

4. OCR Resources Needed: (Program $____ S&E $____ Person Years:______)

5. Description: (Narrative description of the approach to be taken.)
OCR has approved and funded contracts with the Public Health Service to provide technical assistance to their grant recipients in the implementation of Section 504. These contracts were approved as part of HEW's Long Range 504 Technical Assistance Plan. OCR and PHS are co-monitoring the deliverables which include the logistical planning,training package, instructional approach, follow-up technical assistance and final evaluation of these contracts.

   There are separate contracts with the Health Resources Administration (HRA) the Health Services Administration (HSA) and the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

CIVIL RIGHTS OPERATING [illegible] -- FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To manage FY 78 Supplemental Budget contracts to provide Section 504 Technical Assistance to 850 recipients of (PHS) funds. (HRA)

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
Phase I																					
1. Effective date of contract, October 1, 1978. Logistics plan developed, conference material approved and pilot presentation held.	PHS/OCR/ NIAS	—																			
2. Present ten (10) training and orientation sessions for HRA recipients in each regional office.	PHS/OCR NIAS		—	—	—	—	—	—	—												
3. Summary report and list of participants within one week of date of conference	NIAS	—	—	—	—	—	—	—	—												
4. Quarterly progress reports	NIAS			—			—			—											
5. Submit draft report on Phase I, with detailed activities, evaluation results, and recommendations, to be reviewed by Project Officer.	NIAS							—													

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service (POC) and **Office for Civil Rights**

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To manage FY 78 Supplemental Budget contracts to provide Section 504 Technical Assistance to 850 recipients of (PHS) funds. (HRA)

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
6. Final report on Phase I	NIAS								—												
Phase II																					
7. If necessary, contact may be extended for 6 months from date of option.	PHS/OCR																				
8. OCR evaluates impact of training and submits report to Director, OCR.	OCR																				

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

B

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To manage FY 78 Supplemental Budget contracts to provide Section 504 Technical Assistance to 1800 recipients of (PHS) funds. (HSA)

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. Effective date of contracts, October 1, 1978. Logistics plan developed, conference material approved and pilot presentation held.	PHS/OCR/ P&HS																				
2. Implement twenty (20) training sessions to recipients.	PHS/OCR P&HS	—	—	—	—	—	—	—	—												
3. Training of Contractor	CRC		—																		
4. Follow-up TA	P&HS	—	—	—	—	—	—	—	—												
5. Monthly progress reports	P&HS	—	—	—	—	—	—	—	—												
6. Final report from contractor	P&HS								—												
7. OCR evaluates impact of training and submits reports to Director, OCR.	OCR																				

C

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To manage FY 78 Supplemental Budget contracts to provide Section 504 Technical Assistance to 250 recipients of PHS funds, (ADAMHA)

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. Effective date of contract (9/30/78-subject to change) Logistics plan and conference material development begins.	PHS/OCR RG																				
2. Award of Sub-Contractor	PHS/OCR																				
3. Contractors attend 504 training in Denver.	RG																				
4. Materials in No. 1 above approved and pilot presentation held.	PHS/OCR RG					—															
5. Implement 10 training sessions for recipients 2½ days each.	PHS/OCR RG						—	—	—	—	—	—	—	—	—						
6. Monthly progress reports	RG				—	—	—	—	—	—	—	—	—	—	—						
7. Final report	RG														—						
8. ADAMHA provides follow-up TA to assess effectiveness of training.	PHS/RG					—	—	—	—	—	—	—	—	—	—						

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To manage FY 78 Supplemental Budget contracts to provide Section 504 Technical Assistance to 250 recipients of PHS funds. (ADAMHA)

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
9. OCR evaluates training impact and submits reports to Director, OCR	OCR																				

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ________________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To provide 504 technical assistance to 1500 recipients through the development, award and monitoring of contracts.

3. PHS Resources Needed: (Program $____ S&E $_____ Person Years:______)

4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)

5. Description: (Narrative description of the approach to be taken.) HEW's 504 Technical Assistance Plan calls for 504 TA to be provided through contracting with non-Federal experts since the HEW recipients which must comply with 504 requirements comprise a diversity of institutions and organizations with complex needs. These needs cannot be met with in-house resources presently available. OCR and the PHS will work together to identify recipient 504 TA needs, develop the RFPs, award and monitor the contracts.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To provide 504 Technical Assistance to 1500 recipients through the development, award and monitoring of contracts.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. PHS and OCR review and identify 504 TA needs of recipients.	PHS OCR/OPRA		—																		
2. Establish impact goals to meet the Section 504 TA needs of recipients.	OCR/OPRA			—																	
3. Based on #1 and 2 above, assist PHS in drafting proposed 504 TA RFPs.	OCR/OPRA			—																	
4. Develop and transmit MOU to PHS transferring OCR monies to fund contracts.	PHS OCR/OPRA				—																
5. Approve RFPs for issuance by PHS.	PHS OCR/OPRA					—															
6. Participate in review panels leading to the award of contracts.	PHS OCR/OPRA					—	—	—													
7. Approve award of contracts.	OCR/PHS						—	—	—												

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To provide 504 Technical Assistance to 1500 recipients through the development, award and monitoring of contracts.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
8. Participate with contractor and PHS personnel in initial conferences to discuss statements of work required by contract provisions.	OCR/OPRA									—											
9. Assist PHS project officer in the development of procedures to evaluate progress of contracts.	OCR/OPRA										—	—									
10. Monitor contract recipient training.	PHS/OCR												—	—	—	—	—	—			
11. Monitor and assess recipient progress in meeting established impact goals.	PHS/OCR																			—	—
12. Based on 10 and 11 above, prepare a report evaluating training and achievement of impact goals.	PHS/OCR OPRA																			—	—

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

____________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To design civil rights discretionary pre-grant review standards and procedures and incorporate into 100 grant programs.

3. PHS Resources Needed: (Program $____ S&E $____ Person Years:____)

4. OCR Resources Needed: (Program $____ S&E $____ Person Years:____)

5. Description: (Narrative description of the approach to be taken.) The Department of Justice Title VI Coordinating Regulations (Sec. 42.407 (b)) require, prior to approving the award of a grant of Federal financial assistance, that a written compliance determination be made based upon data supplied by the applicant. Similar, although less explicit, requirements exist under the other major civil rights statutes administered by the Department (Title IX and Section 504), and provide the Department with authority to investigate applicants' compliance with these statutes prior to the time grants are awarded. To bring the Department into conformity with the Justice Department Title VI Regulation and to assure that grant applicants are in compliance with Title IX and 504, pre-grant application review procedures need to be developed, field tested and implemented. This is a major undertaking and will have a substantial impact since HEW funds over 60,000 discretionary grants a year. OPRA will work closely with C&E, SP&R and OGC and the OS Division of Grants Policy and Regulation Development and the POCs to design and implement such a system.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To design civil rights discretionary pre-grant review standards and procedures and incorporate into 100 grant programs.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. Conduct exploratory discussions with Justice Department.	OCR/OPRA		—																		
2. Assemble pre-grant review work groups (reps. from POCs, OS Div. of Grants Policy, OGC, C&E and SP&R).	↓			—																	
3. Work group identifies issues that need to be researched and makes small group/individual work assignments.	↓			—																	
4. Work group reassembles and drafts discretionary pre-grant review procedures proposal.	↓					—															
5. Pre-grant review proposal, formally circulated to POCs, OS Div. of Grants Policy, OGC, C&E and SP&R for comments.	↓							—													
6. Comments incorporated into a revised draft,	↓									—											

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To design civil rights discretionary pre-grant review standards and procedures and incorporate into 100 grant programs.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
7. Proposal submitted to Dir. OCR for approval	OCR									——											
8. Director, OCR approves pre-grant review and submits procedures to the Secretary for approval.	OCR										——										
9. Secretary approves, Pre-grant review procedures published in Federal Register.	OCR												——								
10. OPRA works with PHS to draft RFPs.	OCR/OPRA												——								
11. Contract awarded.	OCR																				
12. PHS implements pre-grant application review procedures for select discretionary grants.	PHS	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——→ FY 81	
13. OPRA monitors progress and prepares periodic evaluation reports.	OCR/OPRA	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——	——→ FY 81	

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ________________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights

________________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To train 88 staff to complete 500 Section 504 regulation briefings in FY 80.

3. PHS Resources Needed: (Program $___ S&E $____ Person Years:_____)

4. OCR Resources Needed: (Program $___ S&E $____ Person Years:_____)

5. Description: (Narrative description of the approach to be taken.)
The Director OCR has requested that PHS participate in OCR's contract to prepare selected program monitors to conduct 504 regulation briefings of its recipients. Briefing reports will be forwarded to OCR/OPRA. OCR will use the reports to identify recipients with the greatest needs for follow-up briefings, will discuss with them their self-evaluation studies, transition plans, grievance machinery and the assignments of responsibility to manage the 504 requirements and outreach efforts. Printed materials will be left with the recipient to encourage greater understanding and receptivity to compliance with 504.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

PHS and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To train 88 staff to complete 500 Section 504 regulation briefings in FY 80

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. Training contract awarded.	OCR/OPRA			COMPLETED -- September 1978																	
2. Pilot for basic training course conducted and TA materials approved.	OCR/OPRA		—																		
3. PHS staff trained to conduct 504 regulation briefing	Contractor				—																
4. Contractor submits final report to OCR.	Contractor								—												
5. PHS conducts 504 briefings with grant recipients.	PHS					←					ON-GOING						→				
6. PHS assesses results of briefings and prepares impact evaluation reports.	PHS					←					ON-GOING						→				
7. PHS submits briefing impact evaluation reports to OCR.	PHS					←					ON-GOING						→				

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ________________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

________________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To integrate Title VI and Section 504 into Health System Agency (HSA) and State Health Planning and Development Agency (SHPDA) programs.

3. PHS Resources Needed: (Program $____ S&E $_____ Person Years:______)

4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)

5. Description: (Narrative description of the approach to be taken.) The General Accounting Office, as part of its Title VI Federal-wide study, is conducting an in-depth review of Title VI aspects of Health Planning Programs. Pre-liminary discussions with GAO staff indicate that by April, 1979 they will propose substantial Title VI administrative changes in Health Planning Programs.

PHS Title XV regulation changes have already been proposed by OCR. OCR and PHS will work together to establish and support a Title VI and Section 504 management system for health planning agencies. The program will correspond to the GAO recommendations and the Department's civil rights initiative with POCs.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To integrate Title VI and Section 504 into Health System Agency (HSA) and State Health Planning and Development Agency (SHPDA) programs.

ACTION STEPS	RESPONSIBILITY	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. Final GAO Health System Agency (HSA) Title VI report completed				—																	
2. Incorporate GAO report recommendations into draft HSA Guidelines	OCR/OSPR				—	—															
3. Circulate Guidelines for comment	"						—														
4. Revise Guidelines as appropriate	"								—												
5. Forward Guidelines to Executive Secretary	"								—												
6. Secretary approves publication of HSA Guidelines for comment	"										—										

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To integrate Title VI and Section 504 into Health System Agency (HSA) and State Health Planning and Development Agency (SHPDA) programs.

ACTION STEPS	RESPONSIBILITY	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
7. HSA Guidelines published in Federal Register for comment	OCR/OSPR																				
8. Revise HSA Guidelines	OCR/OSPR																				
9. HSA Guidelines published in final	OCR/OSPR																				
10. Joint PHS/OPRA work group prepares Training curriculum	PHS/OCR/ OPRA																				
11. Train PHS (HRA) staff	OCR/OPRA																			FY 8	
12. Conduct HSA checklist reviews	PHS/HRA																			FY 8	
13. Evaluate and assess impact of reviews	OCR/HRA																				
14. Prepare periodic reports with specific recommendations for improvement of programs.	OCR/HRA																				

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ______________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

______________ Office of Program Review and Assistance.
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To increase the program accessibility of recipient facilities.

3. PHS Resources Needed: (Program $____ S&E $_____ Person Years:______)

4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)

5. Description: (Narrative description of the approach to be taken.) "Program Accessibility" is perhaps the key term in Section 504. Programs and activities must be accessible if discrimination is to be eliminated and handicapped persons are to be afforded equal opportunities for full participation.

A checklist of items to be used by HEW staff who visit recipient facilities will be developed and approved. A management system to coordinate the results of the checklist visits will be established; a training program to prepare staff will be conducted; technical assistance will be provided by OCR and monitoring conducted. Violations of Section 504 which cannot be resolved by PHS will be referred to OCR.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To increase the program accessibility of recipient facilities.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. OSPR/C&E and PHS develop a program accessibility checklist.	PHS/OCR					—	—	—													
2. Secure approval of checklist from OCR and PHS.	PHS/OCR								—	—											
3. Develop program accessibility RFP.	PHS OCR/OPRA										—										
4. Select contractor to train PHS staff.	"													—							
5. Train POC staff to conduct accessibility reviews.	"																				—
6. PHS conducts accessibility reviews of recipients.	"														ON-GOING	—	—	—	—	—	→
7. PHS requires recipients to take remedial action to meet checklist standards.	"														ON-GOING	—	—	—	—	—	→
8. PHS prepares brief report outlining actions taken by recipients.															ON-GOING	—	—	—	—	—	→

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights

rogram bjective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

perational bjective: To increase the program accessibility of recipient facilities.

ACTION STEPS	ESPONSIBILITY	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
9. PHS forwards reports and any unresolved accessibility issues to OCR, C&E for follow up action	PHS OCR/OPRA														ON-GOING →						

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

______________________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To develop at least one financial assistance proposal for PHS to help its recipients comply with civil rights statutes.

3. PHS Resources Needed: (Program $____ S&E $_____ Person Years:______)

4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)

5. Description: (Narrative description of the approach to be taken.)
The Secretary has asked OCR to research financial assistance proposals to assist HEW recipients in complying with the civil rights authorities. Presently, two OE programs (ESAA and Title VI) provide funds for activities related to Titles VI and IX. New funds to help recipients implement Title VI in higher edcuation and Title IX have been proposed to the Secretary for inclusion in the FY 80 budget. Two studies are presently under contract to evaluate recipients' needs for financial assistance to implement Section 504. (Title V of the 1978 Rehabilitation Act Amendments requires that HEW estimate the cost of barrier removal to States and their political subdivisions.) There is a major need for such financial assistance programs, especially in light of accelerated policy development and other new compliance requirements.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service (POC) and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To develop at least one financial assistance proposal for PHS to help its recipients comply with civil rights statutes.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. Assemble a Financial Assistance Proposal Task Force composed of representatives of the Education Division (OE, NIE, IHS and ASE) and OCR (OPRA, OSPR, OCE and OMA).	ED/OCR					—															
2. Determine the most beneficial, cost-effective and politically feasible proposal to assist Education Division recipients.	ED/OCR						—														
3. Determine whether present legislation can be expanded to include proposal.								—													
4. If "yes", circulate to Education Division and OCR for comment, revise as appropriate and develop strategy for implementation.										—	—	—	—								

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To develop at least one financial assistance proposal for PHS to help its recipients comply with civil rights statutes.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
5. If "no" work with OSPR and OHA to develop legislative proposal and submit to Congress through channels.	ED/OCR									—	—	—	—								
6. Based on experience of the Education Division Financial Assistance proposal Task Force, assemble a Task Force composed of representatives of OCR (OPRA, OSPR, OCE, OHA) and HDS, HCFA, PHS and SSA.	OHDS HCFA PHS,SSA OCR													—							
7. Determine the most beneficial, cost-effective and politically feasible proposals, and select one for PHS. If possible, these should be in the ESAA format (financial assistance with built-in incentives).	PHS/OCR														—						

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service (POC) and Office for Civil Rights

rogram bjective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

perational bjective: To develop at least one financial assistance proposal for PHS to help its recipients comply with civil rights statutes.

ACTION STEPS	RESPONSIBILITY	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
8. PHS/OCR determine whether present legislation can be expanded to include proposal.	PHS/OCR															—					
9. If "yes", circulate through PHS and OCR for comment, revise as appropriate, and develop strategy for implementation.	PHS/OCR																—	—	—	—	—
.0. If "no", work with OSPR and OHA to develop legislative proposal and submit to Congress through channels.	PHS/OCR																—	—	—	—	—

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ________________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

________________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To integrate Title VI into the Community Mental Health programs.

3. PHS Resources Needed: (Program $____ S&E $____ Person Years:_____)

4. OCR Resources Needed: (Program $____ S&E $____ Person Years:_____)

5. Description: (Narrative description of the approach to be taken.)
The National Institute of Mental Health through its program bureau and it Minority Center have been focusing for some time upon the Title VI aspects of its program with Community Mental Health Centers. The recent report of the President's Committee on Mental Health pinpointed the need for more equitable delivery of service to minorities. Recently, OCR was requested to review proposed guidelines to community mental health centers about their special responsibilities to serve minorities. These discussions continue.

For these reasons it is proposed that a Title VI management system be implemented with community mental health centers. PHS, (ADAMHA/NIMH) and OCR will work together to complete this project.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To integrate Title VI into the Community Mental Health programs.

ACTION STEPS	RESPONSIBILITY	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. OCR develops draft Community Mental Health Center Guidelines	OCR/OSPR					—															
2. Circulate Guidelines for comment	"						—														
3. Revise Guidelines as appropriate	"								—												
4. Forward Guidelines to Executive Secretary	"								—												
5. Secretary approves publication of CMHC Guidelines for comment											—										
6. Guidelines published in Federal Register for comment	OCR/OSPR												—								
7. Revise CMHC Guidelines	OCR/OSPR														—						

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Public Health Service and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the PHS.

Operational Objective: To integrate Title VI into the Community Mental Health programs.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
8. CMHC Guidelines published in final	OCR/OSPR																—				
9. Joint PHS/OPRA work group prepares training curriculum	OCR/OPRA/ PHS																	—	—		
10. Train staff	PHS/ADAMHA																				
11. Conduct CMHC checklist reviews	PHS/ADAMHA																		FY	81 FY 81	
12. Evaluate and assess the impact of reviews.	OCR/ ADAMHA																			— FY 8 —	— —
13. Prepare periodic reports with specific recommendations for improvement of programs.	OCR/ADAMHA																				

CIVIL RIGHTS OPERATING PLANS - FY79-80 9

Date: ______________

MANAGEMENT OBJECTIVES

Public Health Service and Office for Civil Rights
POC

Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the PHS.

2. Operating Objective: To develop and monitor the Indian Health Agreement.

3. PHS Resources Needed: (Program $____ S&E $_____ Person Years:______)

4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)

5. Description: (Narrative description of the approach to be taken.)

In 1974, officials from the Office for Civil Rights, the Indian Health Service of PHS, and the Social and Rehabilitation Service signed a memorandum of agreement entitled Provision of Medical Services to Indians and other Native Americans. The purpose was to establish the IHS as a residual rather than a primary health service resource. Since then SRS has disbanded and HCFA has assumed the responsibility for their part of this agreement. The MOA has never been rewritten to reflect this fact.

A group of persons from OCR, PHS, and HCFA will redraft the MOA. After its signing, the POCs will be trained to monitor the agreement. The actual monitoring by the POCs and the reporting of violations to the Director, Office for Civil Rights is scheduled for FY 1980.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Public Health Service (POC) and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the

Operational Objective: To Develop and monitor the Indian Health Agreement.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. POCs/OCR reach agreement on monitoring role/functions and reporting procedures.	OCR HCFA PHS				—																
2. POCs/OCR draft new IHS agreement.						—															
3. Agreement signed by POCs/OCR.							—														
4. Establish measureable performance standards to monitor agreement implementation.							—														
5. Estimate staff required to monitor agreement.									—												
6. Prepare and train OCR/POC staff to monitor agreement.										—	—	—	ON-GOING	—	—	—	—	—	—	—	→
7. Monitor agreement against performance standards and prepare periodic assessment reports on the quality of implementation.										—	—	—	ON-GOING	—	—	—	—	—	—	—	→

Exhibit 7

Memorandum of Understanding
between
The Office for Civil Rights
and
The Health Care Financing Administration

This Memorandum of Understanding between the Office for Civil Rights (OCR) and the Health Care Financing Administration (HCFA) is being implemented to carry out the Secretary's policy to make civil rights an essential and integral part of every program in the Department.

Accordingly, HCFA has the responsibility to seek and select program policies and procedures which can assist in achieving affirmatively, the objectives of the civil rights statutes (Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973). In carrying out this responsibility, HCFA will take positive action to remove barriers that tend to exclude people from the benefits of its programs because of race, color, national origin or handicapped status. The purpose of the activities undertaken by HCFA is to help prevent discrimination before it occurs and to assist recipients of HCFA funds (Medicaid/Medicare providers and Medicaid State agencies) in compliance with the civil rights authorities prior to the initiation of complaint investigations or other reviews by OCR.

The Office for Civil Rights is responsible for planning, coordinating, reviewing and appraising this department-wide initiative to incorporate civil rights activities into the program operations of the Principal Operating Components (POCs). In order to carry out this most important task effectively, the HCFA and the OCR will have certain reciprocal obligations.

It shall be the responsibility of HCFA, with OCR assistance, to:

1. Incorporate civil rights concerns into regular program review and audit activities to assure that benefits and services are delivered equitably to eligible minority and handicapped persons.
2. Establish or adopt systems for the collection of data on the participation of minority and handicapped persons in its programs to enable program officials to determine if grant applicants or recipients are violating civil rights requirements.
3. Furnish technical expertise and assistance to its assigned recipients about policies, practices and procedures for civil rights compliance and refer unresolved or complex civil rights compliance issues to the Office for Civil Rights.
4. Review program regulations, directives and instructions to assure support for the Department's civil rights authorities. Procedures to accomplish this activity have been established.
5. Identify recipients' civil rights technical assistance (TA) needs and approve contracts to meet those needs.
6. Initiate orientation and training programs on civil rights requirements for selected program and recipient staff.
7. Utilize, to the extent feasible, financial resources to support civil rights equity, to prevent acts of discrimination and to assist in the remedy of past acts adversely affecting minority and handicapped persons.

8. Monitor, in arrangement with OCR, existing civil rights compliance agreements.

It shall be the responsibility of the Office for Civil Rights, with assistance from HCFA, to:

1. Develop civil rights standards and procedures for inclusion in HCFA regular program reviews and audits.
2. Develop guidelines for systems HCFA will establish for the collection and review of civil rights data to identify civil rights compliance problems.
3. Conduct training programs to carry out HCFA's civil rights responsibilities.
4. Establish guidelines for review of HCFA program regulations, directives and instructions to assure support for the Department's civil rights authorities.
5. Develop and award contracts funded by OCR to provide civil rights technical assistance to HCFA recipients/providers.
6. Establish programs to explain civil rights compliance to HCFA recipients/providers.
7. Develop model financial assistance projects to support civil rights compliance.
8. Identify existing civil rights agreements to be monitored by HCFA.
9. Design and propose a HCFA civil rights activity reporting system; review and appraise the activities conducted, and periodically submit progress reports to the Secretary.

10. Coordinate the development of a HCFA Civil Rights Operating Plan to include priority selection of target activities and long-range planning to meet civil rights program requirements.

HCFA is responsible for administering its program for the following categories of recipients and providers: State Medicaid agencies, hospitals, skilled nursing facilities, and intermediate care facilities. OCR's Office of Program Review and Assistance (OPRA) is responsible for coordinating POC civil rights activities that involve multi-funded State agencies to avoid possible conflicts in civil rights jurisdiction.

The attached Operating Plan details the specific civil rights activities to be carried out by HCFA and OCR for the remainder of FY 79 and for FY 80. An Operating Plan for FY 81 will be developed and submitted to the Secretary for approval by July 1, 1980.

To promote HCFA/OCR coordination, OCR regional offices will inform their counterpart HCFA regional offices of upcoming OCR compliance reviews and complaint investigations pertaining to HCFA providers and furnish HCFA with copies of Letters of Findings. HCFA will provide OCR with provider agreement renewal dates and copies of the review schedules of state survey agencies.

Either HCFA or OCR may request amendments to this MOU and/or Operating Plan and such amendments will be effective when HCFA and OCR concur in the proposed changes. After one year, this MOU will be reevaluated by HCFA and OCR to determine if amendments are needed.

Signed by:

HCFA ADMINISTRATOR

OCR DIRECTOR

7-23-7

DATE

Approved by:

HEW SECRETARY

JUL 27 1979

DATE

CIVIL RIGHTS OPERATING PLANS - FY 79-80

Date: ________________

MANAGEMENT OBJECTIVES

Health Care Financing Administration and the Office for Civil Rights

Health Standards & Quality & Medicaid
Agency/Bureau — Office of Program Review & Assistance

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.

2. Operating Objective: To train Medicaid & HSQB staff to complete Section 504 regulation briefings to HCFA recipients and providers in FY 80.

3. HCFA Resources Needed: (Program $_____ S&E $_____ Person Days____)

4. OCR Resources Needed: (Program $_____ S&E $_____ Person Days____)

5. Description: (Narrative description of the approach to be taken.)

The OCR Director has requested that HCFA participate in OCR's contract to prepare selected program monitors to conduct Section 504 regulation briefings of its recipients.

Briefing reports will be forwarded to OCR/HCFA. OCR will use the reports to identify recipients with the greatest needs for follow-up.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and **Office for Civil Rights**

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To train Medicaid and HSQB staff to complete Section 504 regulation briefings to HCFA recipients and providers in FY 80.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980									
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY
The following steps 1-5b are completed;																			
1. Negotiate the deliverables of HEW contract with CRC.																			
2. OCR/OPRA will establish, in conjunction with HCFA, a management system for the 504 regulation briefings.																			
3. OCR/OPRA will monitor the development of the Section 504 briefings & materials.																			
4. OCR/OPRA will coordinate with the OCR Office of Standards, Policy and Research to develop guidelines, policies & procedures for conduct of the Section 504 briefings.																			
5. Basic course deliverables to be monitored, evaluated & approved by OCR: a. training objectives. b. tests.																			

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To train Medicaid and HSQB staff to complete Section 504 regulation briefings to HCFA recipients and providers in FY 80.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980									
		FEB	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR	MAY	JUNE	JULY
c. Text, materials, methods and media.																			
d. Validation results and the proposed course.																			
e. Implementation of basic course.	OCR HCFA					—													
f. Evaluation of classroom training.	OCR HCFA					—													
g. Final report from Contractor to OCR.	Contractor						—												
HCFA provides Section 504 technical assistance information to recipients/providers.	HCFA						—												

CIVIL RIGHTS OPERATING PLANS - FY 79-80

Date: ________________

MANAGEMENT OBJECTIVES

Health Care Financing Administration and the Office for Civil Rights

Health Standards & Quality and Medicaid
Agency/Bureau Office of Program Review & Assistance

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.

2. Operating Objective: To provide 504 technical assistance to HCFA recipients and providers through the development, award and monitoring of contracts.

3. HCFA Resources Needed: (Program $_____ S&E $_____ Person Days____)

4. OCR Resources Needed: (Program $_____ S&E $_____ Person Days____)

5. Description: (Narrative description of the approach to be taken.)

HEW's Section 504 Technical Assistance Plan calls for Section 504 TA to be provided through contracting with non-Federal experts since the HEW recipients which must comply with Section 504 requirements comprise a diversity of institutions and organizations with complex needs. These needs cannot be met with in-house resources presently available. OCR and HCFA will work together to identify recipient and provider Section 504 needs, develop the RFPs, award and monitor the contracts.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To provide 504 technical assistance to HCFA recipients and providers through the development, award and monitoring of contracts.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980									
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY
1. OCR & HCFA review & identify 504 TA needs of recipients & providers.	OCR HCFA	- - -	—	—															
2. Based on #1 above, assist HCFA in drafting proposed 504 TA RFPs.	OCR			—															
3. Develop & transmit MOU to HCFA transferring OCR monies to fund contracts.	OCR			—	—														
4. Approve RFPs for issuance by HCFA.	OCR					—													
5. Participate in review panels leading to the award of contracts.	OCR HCFA					—	—	—											
6. Approve award of contracts	OCR HCFA						—	—	—										

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Health Care Financing Administration (POC) and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To provide 504 technical assistance to HCFA recipients and providers through the development, award and monitoring of contracts.

ACTION STEPS	RESPONSIBLE	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
Participate with contractor and HCFA personnel in initial conferences to discuss statements of work required by contract provisions.	OCR HCFA									—											
8. Assist HCFA project officer in the development of procedures to evaluate progress of contracts.	OCR HCFA										—	—									
9. In conjunction with the project officer, approve all deliverables for which these contracts are obligated.	OCR HCFA												—	—	—	—	—	—			
10. Prepare report evaluating contract success.	OCR HCFA																			—	—

CIVIL RIGHTS OPERATING PLANS - FY 79-80

Date: ____________

MANAGEMENT OBJECTIVES

Health Care Financing Administration and the Office for Civil Rights

Medicaid & Health Standards & Quality
Agency/Bureau
Office of Program Review & Assistance

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.

2. Operating Objective: To explain Title VI Civil Rights Guidelines to State Medicaid agencies.

3. HCFA Resources Needed: (Program $_____ S&E $_____ Person Days____)

4. OCR Resources Needed: (Program $_____ S&E $_____ Person Days____)

5. Description: (Narrative description of the approach to be taken.)

The OCR, Office of Standards, Policy and Research will issue health and social services Title VI Guidelines within the next few months. These Guidelines will contain substantial new policy as well as clarify existing policy, and will initially need explanation and technical assistance thereafter. OCR and HCFA will develop a program to provide technical assistance to HCFA's Medicaid State agencies and major providers and will assist in setting up a program to monitor Medicaid State agencies and major providers' progress and report possible problem areas.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and **Office for Civil Rights**

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To explain Title VI Civil Rights Guidelines to State Medicaid Agencies.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980									
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY
1. Complete draft of Health and Social Services Guidelines.	OCR					—													
2. Circulate draft Guidelines for comment.	OCR						—												
3. Revise Guidelines as appropriate.	OCR								—										
4. Forward to Executive Sec'y.	OCR								—										
5. Secretary approves publication of HSS Guidelines for comments.	Secretary										—								
6. HSS Guidelines published in Federal Register.	OCR												—						
7. Revise HSS Guidelines	OCR														—				
8. HSS Guidelines published in final.	OCR																—		
9. Joint HCFA/OCR work group prepares RFPs.	HCFA OCR																		—

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and **Office for Civil Rights**

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To explain Title VI Civil Rights Guidelines to State Medicaid Agencies

ACTION STEPS	RESPONSIBILITY	FY 1979											FY 1980						
		FEB	MAR	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR	MAY	JUNE	JULY
10. Contract awarded.	OCR	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	FY 81
11. HCFA's Medicaid/HSQB staff trained in Title VI Health and Social Services Guidelines requirements.	Contractor OCR HCFA	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	FY 81

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________________

MANAGEMENT OBJECTIVES

Health Care Financing Administration and Office for Civil Rights

POC

______________________ Office of Program Review and Assistance

Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.
2. Operating Objective: *To assist State Medicaid agencies to submit acceptable Title VI and Section 504 Methods of Administration.*

3. POC Resources Needed: (Program $____ S&E $_____ Person Years:______)
4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)
5. Description: (Narrative description of the approach to be taken.)

State agencies receiving Federal financial assistance are required to develop and submit to HEW for approval "Methods of Administration" (MOA) which detail how they will implement the requirements to Title VI. These "methods" are an important tool for assuring State agency civil rights compliance.

OCR will issue, within the next several months, a regular amendment concerning MOA requirements under Title VI and will expand the MOA requirement to cover Section 504. State agencies will be expected to update their MOAs to meet the new requirements. Each HCFA, with assistance from OCR, will work with their State agency counterparts and provide technical assistance necessary to develop acceptable Title VI and 504 MOAs. The MOAs will then be formally submitted to the HCFA for review, comment and a recommendation to approve or disapprove. OCR will make the final determination of acceptability.

Health Care Financing Administration and **Office for Civil Rights**
(HCFA)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the *Health Care Financing Administration.*

Operational Objective: *To assist State Medicaid agencies to submit acceptable Title VI and Section 504 Methods of Administration.*

ACTION STEPS	RESPONSIBLE	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. *HCFA/OCR workgroup to develop amendments to Title VI and Section 504 MOA requirements for Medicaid State agencies.*																					
2. *Amendments to Title VI and Section 504 MOA requirements published.*	*OCR/OSPR*							—													
3. *OCR/ HCFA prepare RFP for MOA training.*	HCFA *OCR/OPRA*				—																
4. *Contractor selected to conduct MOA training.*	"							—													
5. *HCFA staff trained in MOA requirements.*	"													—							
6. *HCFA conducts MOA technical assistance with State agency counterparts.*	"														—	—	—				
7. *OCR/OPRA works with HCFA in providing TA to staff agencies.*	"														—	—	—				
8. *States submit updated MOAs to HCFA for review.*	"																	—	—	—	
9. *HCFA submits its recommendations to OCR.*	"																				*FY 81*

Health Care Financing Administration (POC) and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the *Health Care Financing Administration*

Operational Objective: To assist State Medicaid agencies to submit acceptable Title VI and Section 504 Methods of Administration (All POC).

ACTION STEPS	RESPONSIBLE	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
10. *HCFA monitor MOA implementation.*	HCFA *OCR/OPRA*																				*FY 81*

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________________

MANAGEMENT OBJECTIVES

Health Care Financing Administration ____________ and Office for Civil Rights
POC

Medicaid ____________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.
2. Operating Objective: HCFA to monitor Section 504 and Title VI Methods of Administration required of the 53 State Medicaid agencies and monitor other civil rights agreements and report unresolved violations of these agreements to OCR.
3. POC Resources Needed: (Program $____ S&E $_____ Person Years:______)
4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)
5. Description: (Narrative description of the approach to be taken.)

Over the years OCR has implemented many civil rights compliance agreements with recipients and providers. Because of limited resources and court directed activity, OCR has not had staff available to review recipient performance of these agreements. HCFA will primarily monitor Title VI and Section 504 MOAs, submitted by Medicaid State agencies and other agreements selected by OCR for HCFA monitoring. Only the Medicaid State agencies are required to submit Title VI and Section 504 MOAs. Besides the MOA's, HCFA's responsibilities to monitor other CR agreements will be determined on a case-by-case basis and depend upon HCFA's ability to assume additional CR responsibilities.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Health Care Financing Administration and Office for Civil Rights
(POC)

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: HCFA to monitor 504 and Title VI Methods of Administration required of the 53 State Medicaid agencies and monitor other civil rights agreements and report unresolved violations of these agreements to OCR.

ACTION STEPS	RESPONSIBLE	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. HCFA & OCR develop and agree upon standards and procedures for evaluating performance of State agencies in light of Title VI and 504 MOAs.	OCR HCFA														—						
2. HCFA and OCR determine training needs.	OCR HCFA																—				
3. HCFA and OCR design training program (Contracted training will include all steps related to contracting process).	OCR HCFA																	—	—		
4. Train HCFA staff.	OCR HCFA Contractor																			—	
5. HCFA conducts monitoring and reporting systems.	HCFA OCR																				ON-GOING
6. OCR works with HCFA to evaluate [illegible] of monitoring civil rights agreements.	OCR HCFA																				ON-GOING
7. HCFA and OCR prepare periodic reports for the HCFA Administrator and OCR Director.	OCR HCFA																				ON-GOING

CIVIL RIGHTS OPERATING PLANS - FY 79-80

Date: ________________

MANAGEMENT OBJECTIVES

Health Care Financing Administration and the Office for Civil Rights

OMB, OPPR & Grants Management
Agency/Bureau

Office of Program Review & Assistance

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.

2. Operating Objective: To design civil rights discretionary pre-grant review standards and procedures and incorporate into HCFA discretionary grant programs.

3. HCFA Resources Needed: (Program $_____ S&E $_____ Person Days____)

4. OCR Resources Needed: (Program $_____ S&E $_____ Person Days____)

5. Description: (Narrative description of the approach to be taken.)

The Department of Justice Title VI Coordinating Regulations (Sec. 42.407 (b)) require, prior to approving the award of a grant of Federal financial assistance, that a written compliance determination be made based upon data supplied by the applicant. Similar, although less explicit, requirements exist under the other major civil rights statutes administered by the Department (Title IX and Section 504), and provide the Department with authority to investigate applicants compliance with these statutes prior to the time grants are awarded. To bring the Department into conformity with the Justice Department Title VI Regulation and to assure that grant applicants are in compliance with Title IX and Section 504, pre-grant application review procedures need to be developed, field tested and implemented. This is a major undertaking and will have a substantial impact since HEW funds over 80,000 discretionary grants a year. OPRA will work closely with Compliance & Enforcement, Standards, Policy and Research and Office of General Counsel and the OS Division of Grants Policy and Regulation Development and the HCFA to design and implement such a system.

NOTE: Estimate for implementation of the review process cannot be made until first 9 action steps are completed.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To design civil rights discretionary pre-grant review standards and procedures and incorporate into HCFA discretionary grant programs.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980										
		FEB	MAR.	APR.	MAY	JUNE	JULY.	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR	MAY	JUNE	JULY	A
1. Conduct exploratory discussions with Justice Department.	OCR/OPBA		—																	
2. Assemble pre-grant review work groups (reps. from OS Div of Grants Policy, OGC, C&E and S,P&R and HCFA - ORD and OPPR.	OCR HCFA			—																
3. Work group identifies issues that need to be researched & makes small group/individual work assignments.	OCR HCFA			—																
4. Work group reassembles and drafts discretionary pre-grant review procedures proposal.	OCR					—														
5. Pre-grant review proposal formally circulated to ROCs, OS Div of Grants Policy and other members of group for comments.	OCR HCFA							—												
6. Comments incorporated into a revised draft & pre-grant review proposal field tested	OCR HCFA									—										

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To design civil rights discretionary pre-grant review standards and procedures and incorporate in HCFA discretionary grant programs.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980									
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY
7. Proposal submitted to OCR Director for approval.	OCR									—									
8. OCR Director submits procedures to the Secretary for approval.	OCR										—								
9. Secretary approves & pre-grant review procedures published in Federal Register.	Secretary												—						
10. OPPA works with HCFA to draft RFPs.	OCR/OPPA HCFA												—						
11. Contract awarded.	OCR																	—	
12. HCFA implements pre-grant application review procedures for all discretionary grants.	HCFA	—	—	—	—	—	—	On-going	—	—	—	—	—	—	—	—	—	— FY	81
13. OPPA monitors progress and prepares periodic evaluation reports.	OCR/OPPA	—	—	—	—	—	—	On-going	—	—	—	—	—	—	—	—	—	— FY	81

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________

MANAGEMENT OBJECTIVES

Health Care Financing Administration and Office for Civil Rights
POC

______________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.
2. Operating Objective: To develop financial assistance proposals to help recipients comply with civil rights statutes.

3. POC Resources Needed: (Program $____ S&E $____ Person Years:_____)
4. OCR Resources Needed: (Program $____ S&E $____ Person Years:_____)
5. Description: (Narrative description of the approach to be taken.) The Secretary has asked OCR to research financial assistance proposals to assist HEW recipients in complying with the civil rights authorities. Presently, two OE programs (ESSA and Title IV) provide funds for activities related to Titles VI and IX. New funds to help recipients implement Title VI in higher education and Title IX have been proposed to the Secretary for inclusion in the FY 80 budget. Two studies are presently under contract to evaluate recipients' needs for financial assistance to implement Section 504. (Title V of the 1978 Rehabilitation Act Amendments requires that HEW estimate the cost of barrier removal to States and their political subdivisions.) There is a major need for such financial assistance programs, especially in light of accelerated policy development and other new compliance requirements.

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Health Care Financing Administration (HCFA) and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To develop financial assistance proposals to help recipients comply with civil rights statutes.

ACTION STEPS	RESPONSIBLE	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
1. Based on experience of the Education Division Financial Assistance proposal Task Force assemble a Task Force composed of representatives of OCR (OPRA, OSPR, OCE, OHA) and HDS, HCFA, PHS and SSA.	OHDS HCFA PHS SSA OCR													—							
2. Determine the most beneficial cost-effective and politically feasible proposals, and select one for HCFA. If possible, these should be in the ESA format (financial assistance with built-in incentives).	HCFA OCR														—						
3. HCFA and OCR, determine whether present legislation can be expanded to include proposal.	HCFA OCR															—					
4. If "yes", circulate through HCFA and OCR to comment, revise as appropriate, and develop strategy for implementation.	HCFA OCR																—	—	—	—	—

CIVIL RIGHTS OPERATING PLAN - - FISCAL YEARS 1979 & 1980

Health Care Financing Administration (POC) and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To develop financial assistance proposals to help recipients comply with civil rights statutes.

ACTION STEPS	RESPONSIBLE	FY 1979											FY 1980								
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG	SEPT
5. If "no", work with OSPR and OMA to develop legislative proposal and submit to Congress through channels.	HCFA OCR																—	—	—	—	—

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________

MANAGEMENT OBJECTIVE

Health Care Financing Administration and Office for Civil Rights
POC

Health Standards and Quality Bureau Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.
2. Operating Objective: To transfer Title VI Medicare initial certification reviews from OCR to HCFA (HSQB).

3. POC Resources Needed: (Program $___ S&E $____ Person Days :_____)
4. OCR Resources Needed: (Program $___ S&E $____ Person Days :_____)
5. Description: (Narrative description of the approach to be taken.)

OCR regional staff presently conducts Title VI eligibility reviews of hospitals and nursing homes applying for Medicare certification. Approximately 332 new providers were certified by HCFA in 1978. Standards for the conduct of these reviews are to be revised by OCR and HCFA and this function will be transferred to HCFA in FY 1980. OCR will work with HCFA staff to establish a plan for implementation that will include training, technical assistance and monitoring.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To train HSQB staff to complete Title VI Medicare initial certification reviews.

ACTION STEPS	RESPONSIBILITY	FY 1979 FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	FY 1980 OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.
1. Review content & process employed by regional offices in Medicare certifications.	OCR			—	—	—															
2. Review patterns of Title VI complaints & explore possible relationships to disparities in certification standards region-to-region.	OCR				—	—															
3. Prepare summary showing patterns of compliance.	OCR				—	—															
4. In consultation with OGC, P,PEB and HCFA (HSQB), prepare uniform Medicare certification review standards & procedures & submit for approval.	OCR						—	—	—												
	HCFA							—													
5. Develop Medicare certification review training program for key HSQB staff.	OCR									—	—										
	HCFA																				

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration (HQ) and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: HSQB staff to complete Title VI Medicare initial certification reviews.

ACTION STEPS	RESPONSIBLE	FY 1979 FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	FY 1980 JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.
6. Train key HCFA staff (HSQB).	OCR HCFA Contractor												—								
7. Transfer of responsibility to complete Title VI certification reviews to HSQB.	HCFA														—	—	ON-GOING	—	—	—	—
8. Provide on-going technical assistance to HSQB staff completing reviews.	HCFA OCR														—	—	ON-GOING	—	—	—	—
9. Evaluate and assess impact of review results.	HCFA OCR														—	—	ON-GOING	—	—	—	—
10. Prepare periodic reports with specific recommendations for improvements.	HCFA OCR														—	—	ON-GOING	—	—	—	—

CIVIL RIGHTS OPERATING PLANS - FY 79-80

Date: ________________

MANAGEMENT OBJECTIVES

Health Care Financing
Administration
________________ and Office for Civil Rights
POC
Equal Opportunity Staff and
Health Standards and Quality Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.
2. Operating Objective: To conduct Section 504 and Title VI checklist reviews of Medicare/Medicaid providers.

3. POC Resources Needed: (Program $___ S&E $____ Person Days :_____)
4. OCR Resources Needed: (Program $___ S&E $____ Person Days :_____)
5. Description: (Narrative description of the approach to be taken.)

To promote voluntary compliance with Section 504 and Title VI requirements, HCFA and OCR will develop a process for reviewing Medicaid/Medicare providers. A work group, comprised of staff from OCR (CSE, OPRA, OSPR, OGC) and HCFA (HSQB & EOS) will develop recommendations for OCR/HCFA reviews. These recommendations will encompass training, delineation of staff responsibilities, cost projections, review standards, methods for evaluating effectiveness of review program, and the interrelationship among the 504 TA Unit staff in the RD's office, HCFA, and OCR. Additionally, the work group will develop strategies for incorporating Title VI reviews and required training into the HCFA review program.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and **Office for Civil Rights**

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To conduct Section 504 & Title VI checklist reviews of Medicare/Medicaid providers.

ACTION STEPS	RESPONSIBILITY	FY 1979 FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	FY 1980 OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.
1. Form work group comprised of staff from OCR (OPRA, CLE, OSFR, OGC) & HCFA (HSQB & COS) to develop proposed 504 & Title VI review standards & procedures for Medicare/Medicaid providers.	OCR HCFA	—																			
2. Circulate recommendations for comments.	OCR HCFA							—													
3. Revise proposal as appropriate.	OCR HCFA								—												
4. HCFA Administrator approves review process recommendations.	HCFA									—											
5. OCR Director approves review standards.	OCR											—									
6. Prepare 504 and Title VI review kits for training.	OCR/OPPA HCFA												—								
7. Select contractor to train review staff.	OCR HCFA															—					

CIVIL RIGHTS OPERATING PLAN — FISCAL YEARS 1979 & 1980

Health Care Financing Administration. and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To conduct Section 504 & Title VI checklist reviews of Medicare/Medicaid providers.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.
8. Contractor trains review staff on Section 504 and Title VI.																				----	
9. Review staff begins to conduct Section 504 and Title VI checklist reviews.	HCFA																				Y 81
10. OCR provides ongoing technical assistance to review staff.	OCR/HCFA																				Y 81
11. Evaluate and assess impact of review results.																					Y 81
12. OCR/HCFA prepare periodic reports with specific recommendations for improvements.																					Y 81

CIVIL RIGHTS OPERATING PLANS - FY79-80

Date: ____________________

MANAGEMENT OBJECTIVES

Health Care Financing Administration
PCC ______________ and Office for Civil Rights

______________ Office of Program Review and Assistance
Agency/Bureau

1. Program Objective: To carry out the Secretary's initiative to make civil rights an integral part of the mission of the Health Care Financing Administration.
2. Operating Objective: To develop and monitor the Indian Health Agreement.

3. PCC Resources Needed: (Program $____ S&E $_____ Person Years:______)

4. OCR Resources Needed: (Program $____ S&E $_____ Person Years:______)

5. Description: (Narrative description of the approach to be taken.)

In 1974, officials from the Office for Civil Rights, the Indian Health Service of PHS, and the Social and Rehabilitation Service signed a memorandum of agreement entitled Provision of Medical Services to Indians and other Native Americans. The purpose was to establish the IHS as a residual rather than a primary health service resource. Since then SRS has disbanded and HCFA has assumed the responsibility for their part of this agreement. The MOA has never been rewritten to reflect this fact.

A group of persons from OCR, PHS, and HCFA will redraft the MOA. After its signing, the HCFA will be trained to monitor the agreement. The actual monitoring by the HCFA and the reporting of violations to the Director, Office for Civil Rights is scheduled for FY 1980.

CIVIL RIGHTS OPERATING PLAN -- FISCAL YEARS 1979 & 1980

Health Care Financing Administration and Office for Civil Rights

Program Objective: To carry out the Secretary's initiative, to make civil rights an integral part of the mission of the Health Care Financing Administration.

Operational Objective: To develop and monitor the Indian Health Agreement.

ACTION STEPS	RESPONSIBILITY	FY 1979								FY 1980											
		FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.
1. HCFA/OCR reach agreement on monitoring role/functions and reporting procedures.	OCR HCFA IHS				—																
2. HCFA/OCR draft new IHS agreement.	"					—															
3. Agreement signed by HCFA/OCR.	"						—														
4. Establish measurable performance standards to monitor agreement implementation.	"						—	—													
5. Estimate staff required to monitor agreement.	"						—	—													
6. Prepare/train OCR/HCFA staff to monitor agreement.	"								—												
7. Monitor agreement against performance standards and prepare quarterly assessment reports on the quality of agreement implementation.	"									—	—	—	—	ONGOING	ONGOING	- -	- -	- -	- -	- -	- - →

Exhibit 8

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION

FULL DESIGNATION AGREEMENT BETWEEN HEALTH, EDUCATION, AND WELFARE AND

____
(Name and Address of the Applicant for HSA Designation)

Project No.

In accordance with the provisions of Section 1515 of the Public Health Service Act (hereinafter referred to as the "Act"), the Secretary of Health, Education, and Welfare (hereinafter referred to as the "Secretary") and the ____ (hereinafter
(Applicant Entity)
referred to as the "Agency") hereby agree as follows:

I. DEFINITIONS
As used hereinafter, all terms shall have the meanings given them in 42 CFR Part 122 (hereinafter referred to as the "Regulations").

II. DESIGNATION
The Agency is designated as the fully designated Health Systems Agency for ______________________________
(Geographic Designation of Area)
____ for the term

set forth in paragraph IX of the Agreement (hereinafter referred to as "the period of this Agreement").

III. FUNCTIONS TO BE PERFORMED BY THE AGENCY

(a) *General*
During the period of this Agreement, the Agency shall meet and continue to meet the requirements of Section 1512(b) of the Act with respect to its organization and operation and perform the functions prescribed by Section 1513 of the Act and 42 CFR Part 122, Subpart B.

(b) *Performance According to Work Program*

(1) The Agency shall, during the period of this Agreement, carry out the responsibilities and perform the agreed to functions of a health systems agency at such time and in such manner as set forth in the approved work program which is appended hereto as Appendix A and is incorporated by reference and made a part of this Agreement as though fully set forth herein.

(2) Where an Agency determines that it cannot at the time agreed to and in the manner specified in the approved work program perform a function(s), it shall so notify the Secretary at the earliest practicable date. The Secretary may then agree to modify the work program in a manner consistent with the Act, the regulations and the purpose of Part B of Title XV of the Act as determined by the Secretary.

IV. GOVERNING BODY

The Agency shall, during the entire period of this Agreement, maintain a governing body and executive committee, if any, which meets the requirements of Section 1512(b)(3) of the Act and 42 CFR 122.109. The Agency shall inform the Secretary in writing as changes in governing body and/or executive committee membership occur.

V. ORGANIZATION CHANGES

The Agency shall promptly notify the Secretary and the State Agency for each State in which the Agency's health service area is located of changes in its legal status, organization or executive director which occur during the period of the Agreement.

VI. STAFF

The Agency shall maintain a staff which meets the requirements of 42 CFR 122.110 and report on a quarterly basis to the Secretary concerning recruitment and maintenance of staff resources as projected in the approved work program.

VII. REPORTS

The Agency will make reports, in such form and containing such information concerning its structure, operations, performance of functions, and other matters as the Secretary may from time to time require, and keep such records and afford such access thereto as the Secretary may find necessary to verify such reports; Provided, that at a minimum the Agency shall provide quarterly reports on all aspects of its operations.

VIII.COMPLIANCE WITH THE ACT AND REGULATIONS

The Agency will comply with the relevant provisions of the Act and such rules, regulations and general instructions as the Secretary may prescribe to carry out the purposes of this Agreement, including those set forth in 42 CFR Part 122.

IX. TERM OF AGREEMENT

This Agreement shall be effective on ______________________________

(Date of Signature of Agency)

and shall expire on ______________________________.

(12 - 36 Months from the Date of Signature of Agency)

X. TERMINATION OF AGREEMENT

1. This Agreement may be terminated by the Agency prior to the expiration of its term upon 90 days written notice to the Secretary which shall set forth the reasons for such termination and its effective date.
2. This Agreement may be terminated by the Secretary prior to the expiration of its term upon his determination, after having given the Agency at least 90 days written notice of its deficiencies and the corrective actions required and an opportunity for a hearing before an officer or employee of the Department designated for such purpose by the Secretary, that the Agency is not complying with or effectively carrying out the provision of the Agreement.

XI. RENEWAL

This Agreement may, at the option of the Secretary and in accordance with the requirements of 42 CFR 122.108(b)(1), be renewed for an additional term of not to exceed 36 months, provided that he/she determines that the Agency has fulfilled in a satisfactory manner the functions of a health systems agency as prescribed by Section 1513 and continues to meet the requirements of Section 1512(b) of the Act and applicable regulations (42 CFR Part 122, Subpart B). Where the Secretary determines not to renew such agreement, that determination will be made only after he/she has provided the Agency with written notice of the reasons for such failure to renew and the opportunity for a hearing before an officer or employee designated for such purpose by the Secretary.

This Agreement is entered into by ____,
(Name)

______________________________________, acting herein for the Secretary of Health, Education,
(Title)
and Welfare, and the ____
(Applicant)

acting herein through ____.
(Individual Acting for the Agency)

By: ____
(Administrator, Health Resources Administration for the Secretary of Health, Education, and Welfare)

By: ______________________ ______________________
(Name) (Title)

APPENDIX A

Attach the approved work program subject to conditions, if any.

APPROVED WORK PROGRAM

The attached is approved subject to the following conditions:

1. ____

2. ____

3. ____

NOTE:

An approved work program is a necessary prerequisite to entering into a designation agreement.

The effective date of the agreement is the date that the designation agreement is consummated. The Administrator, HRA, sends the applicant a signed agreement and an approved work program subject to conditions, if any. The applicant agrees to the conditions, signs the designation agreement and dates it. This consummates the agreement. The date the applicant signs it becomes the effective date of the designation agreement.

PUBLIC HEALTH SERVICE

GENERAL INFORMATION AND INSTRUCTIONS FOR GRANT APPLICATION FORM PHS 5161-1

(Rev. 3-79)

The enclosed application form, PHS 5161-1, is used for a variety of grant programs administered by the Public Health Service (PHS). The basic format is prescribed by OMB Circular A-102 for use by State and local government applicants. PHS supplementary instructions are included to extend use of the form to encompass nongovernmental applicants for health services programs and to amplify or clarify the standard instructions where necessary. Unless otherwise directed, applicants are to respond to the standard instructions and to the PHS supplementary instructions.

The PHS 5161-1 is intended for use by governmental and nongovernmental applicants seeking support for health services projects.

This application consists of a General Information and Instruction section followed by five Parts of the standard application. It also contains a Checklist which must be submitted with the completed application.

The General Information and Instruction section contains information about PHS policies and procedures.

Part I consists of the Standard Form - 424 which is a multipurpose form that requests basic information about the applicant and the project. It also can be used as the Notification of Intent to State and areawide clearinghouses for projects covered by OMB Circular A-95. PHS will provide the Report of Federal Action to State Central Information Reception Agencies for projects covered by Treasury Circular - 1082.

Part II, Project Approval Information, requires that the applicant respond to questions concerning various types of approval by non-Federal agencies. PHS has supplemented this Part with instructions setting forth the procedures to follow for obtaining comments from A-95 Clearinghouses and approval from Health Systems Agencies.

Part III, Budget Information, requests information on the applicant's financial plan for carrying out the project or program. Both the Federal and non-Federal shares are to be included in the financial plan. Please note carefully the PHS supplementary instructions to this Part.

Part IV, Program Narrative, requests the applicant to describe the objectives of the program and how these objectives will be reached. For projects funded beyond the first year, this Part serves as the progress or performance report.

Part V, Assurances, sets forth certain requirements with which applicants must comply if a grant is awarded. These assurances are certified when an authorized official of the applicant organization signs the face page of Part I.

Before completing the application, it is advisable to refer to relevant program guidelines supplied in the application kit. The kit may also contain additional supplementary instructions necessary to satisfy unique program requirements set forth in legislation or regulations.

For information about, or copies of, material referred to in the application, contact the grants management office which supplied the application kit.

TYPE OF APPLICATIONS

Form PHS 5161-1 may be used for any of the following types of applications:

1. **New**

   A new application is a request for financial assistance for a project or program not currently receiving PHS support. If recommended for approval it must compete with other new applications, competing continuation applications, and competing supplemental applications for any available funds in accordance with Federal awarding office funding priorities.

   A complete submission of all information requested on Form PHS 5161-1 is required for new applications.

2. **Noncompeting Continuation**

   A noncompeting continuation application is a request for support beyond the initial budget period[1] within a previously approved project period[2]. These applications do not compete with other applications, and the level of support is determined by the awarding office after considering the previously recommended level of support and the progress of the project.

   A complete resubmission of the material contained in the initially approved application is not necessary, but the continuation application should include: a detailed budget for the budget period requested including justification as necessary; information on the qualifying experience of key personnel added since the previous submission; a report of progress relative to approved objectives; and a narrative discussing any significant changes to the originally approved project plan. Refer to Part IV, item 5.b, Program Narrative Instructions, and to program guidelines for additional guidance on preparing the progress report.

3. **Competing Continuation**

   A competing continuation application is a request for the extension of support for one or more budget periods of a project period which would otherwise expire. These applications are subject to the same review and analysis as new applications and they compete for available funds with other competing continuation applications, new applications, and competing supplemental applications.

   The information requirements applicable to competing continuation applications are the same as those that apply to new applications.

4. **Supplemental**

   A supplemental application is a request for additional funding within an approved budget period for program expansion or administrative increases. Applications for funds for the expansion of the project scope are subject to the same review procedures as new or competing continuation applications. Applications for funds to meet increased administrative costs that take effect during a current budget period, such as fringe benefits or organizational or other salary increases not included in the grant applications are usually noncompeting, but are subject to the approval of the awarding office and the availability of funds.

   An application for supplemental funds must delineate the need for the supplement. It should describe how the supplement or the lack of it will influence the aims of the program.

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[1] Budget Period - The interval of time (usually 12 months) into which the project period is divided for funding and reporting purposes.

[2] Project Period - The total time for which support of a project has been programmatically approved. A project period may consist of one or more budget periods.

On the budget sheet(s) show only the supplemental funds required and the proposed matching/cost participation amounts, if appropriate. As part of the budget justification, however, include a statement as to whether any changes have been made or are intended in the allocation of funds among categories for the previously approved budget.

PROJECT DEVELOPMENT

All new applicants are urged to discuss their interests and ideas for developing projects early in the planning stages with State, regional, and local planning agencies and/or health departments. Community support should be ensured through provision of opportunities for public and private participation in the planning and development phases. When applicable, comments must be sought from A-95 clearinghouses, and approval obtained from Health Systems Agencies. (See PHS Supplementary Instructions to Part II.)

Staff of the administering office from which funds are being requested are also available to assist applicants.

COMPLETING THE APPLICATION

Type, using dark typewriter ribbon, single-spaced where practicable. Instructions for the printed forms appear on the reverse side of the page and on the supplementary pages.

If more space is needed than that provided on the form, use a blank sheet of paper and complete the information item using the same format. Properly identify the information item and the sheet of paper as a continuation page and attach it behind the appropriate application page.

ASSEMBLING AND MAILING

To facilitate awarding office review and processing of the application, all pages of the application should be numbered and preceded by an index which indentifies the content of the application. Assemble the materials with the printed forms on top followed by the project narrative and biographical sketch and then any remaining documents.

Completed applications should be signed in ink by an authorized official of the grantee organization and duplicated in accordance with the requirements of the awarding office or 45 CFR 74 for State and local government applicants. Mail completed applications to the appropriate grants management office in time to meet the deadline date for receipt established by the awarding office.

ACKNOWLEDGEMENT

Applicants will be sent a written acknowledgement by PHS administering offices within 3 working days of receipt of the application.

LATE APPLICATIONS

New/Competing Continuation:

Applications received after close of business of the deadline date for receipt may not be accepted for processing and review. Those not accepted for processing will either be returned to the applicant or the applicant will be notified that the application is being held until the next regularly scheduled review cycle.

Noncompeting Continuation:

Applications which are not received in time to permit an orderly review, processing, and award issuance on or before the beginning date of the continuation budget period, may result in: (1) an extension of the current budget period *without additional Federal funds*, and (2) a delay in the beginning date of the new budget period.

NONCONFORMING APPLICATIONS

Applications that are determined to be nonconforming shall not be accepted for processing and shall be returned to the applicant. A grant application may be classified as nonconforming if it does not meet the requirements of the program announcement to which it is responding.

APPLICATION REVIEW

Applications will be evaluated and rated according to criteria and priorities established for the relevant grant programs, and described in program announcements and guidelines.

UNSUCCESSFUL APPLICANTS

After a decision has been reached either to disapprove or not fund a grant application during a given review cycle, a written notice shall be sent the unsuccessful applicant within 30 days after that decision.

PRIVACY ACT

The Privacy Act of 1974 (5 U.S.C. 552a) gives individuals the right of access to information concerning themselves and provides a mechanism for correction or amendment of the records. The Privacy Act also provides for protection of information pertaining to an individual, but it does not prevent disclosure of such information if required to be released under the Freedom of Information Act. The Privacy Act requires that a Federal agency advise each individual whom it asks to supply information of the authority which authorizes the solicitation, whether disclosure is voluntary or mandatory, the principal purpose or purposes for which the information is intended to be used, the use outside the agency which may be made of the information, and the effects on the individual, if any, of not providing all or any part of the requested information.

PHS is requesting the information called for in this application pursuant to its statutory authority for awarding grants. Provision of the information requested is entirely voluntary. The collection of this information is for the purpose of aiding in the review of applications prior to grant award decisions and for management of PHS programs. A lack of sufficient information may hinder PHS's ability to review applications, monitor grantee performance, or perform overall management of grant programs.

This information will be used within the Department of Health, Education, and Welfare, and may also be disclosed outside the Department as permitted by the Privacy Act, including disclosures to the public as required by the Freedom of Information Act, to the Congress, the National Archives, the Bureau of the Census, law enforcement agencies upon their request, the General Accounting Office, and pursuant to court order. It may also be disclosed outside the Department, if necessary, for the following purposes:

1. To the cognizant audit agency for auditing.
2. To the Department of Justice as required for litigation.
3. To a congressional office from the record of an individual in the response to an inquiry from the congressional office made at the request of that individual.
4. To qualified experts not within the definition of Department employees as prescribed in the Department regulations (45 CFR, Part 5b.2) for opinions as a part of the application review process.
5. To a Federal agency, in response to its request, in connection with the letting of a contract, or the issuance of a license, grant, or other benefit by the requesting agency, to the extent that the record is relevant and necessary to the requesting agency's decision on the matter.

6. To individuals and organizations deemed qualified by PHS to carry out specific research related to the review and award processes of PHS.
7. To organizations in the private sector with whom PHS has contracted for the purpose of collating, analyzing, aggregating, or otherwise refining records in a system. Relevant records will be disclosed to such a contractor. The contractor shall be required to maintain Privacy Act safeguards with respect to such records.
8. To the grantee institution relative to performance or administration under the terms and conditions of the award.

FREEDOM OF INFORMATION ACT

The Freedom of Information Act and the associated Public Information Regulations (45 CFR Part 5) of the Department of Health, Education, and Welfare require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant related reports are generally available for inspection and copying except that information considered to be an unwarranted invasion of personal privacy will not be disclosed. For specific guidance on the availability of information, refer to 45 CFR Part 5.

PART I

PHS SUPPLEMENTARY INSTRUCTIONS

Item 4 - If the payee will be other than the applicant, enter in the remarks section on the back of the SF-424 facesheet, the payee's name, department or division, complete address, and employer identification number or DHEW entity number. If an individual's name and/or title is desired on the payment instrument, the name and/or title of the designated individual must be specified.

Item 5 - If the applicant organization has been assigned a DHEW entity number consisting of the IRS employer identification number prefixed by "1" and suffixed by a two-digit number, enter the full DHEW entity number in block 5.

PART II

PROJECT APPROVAL INFORMATION
PHS SUPPLEMENTARY INSTRUCTIONS

Applications for many health services grants must undergo reviews by outside review bodies prior to review by PHS awarding programs. Information on the reviews performed by State and areawide clearinghouses and Health Systems Agencies is provided below.

PROJECT NOTIFICATION AND REVIEW SYSTEM

Refer to the relevant program guidelines or Appendix 1 of the Catalog of Federal Domestic Assistance to determine whether OMB Circular A-95 requirements are applicable.

The purpose of the system is to facilitate coordination of State, areawide, and local planning and development through the establishment and use of a network of State and areawide clearinghouses. The functions of the clearinghouses are to identify the relationship of any project to Statewide or areawide comprehensive plans and to evaluate the significance of projects to the plans or programs of particular State agencies or local governments. Clearinghouses will also assure that public agencies responsible for environmental standards or civil rights have an opportunity to review and comment upon proposed projects. The system is the means of carrying out the policies and directives of Title IV of the Intergovernmental Cooperation Act of 1968 and the requirements of Section 204 of the Demonstration Cities and Metropolitan Development Act of 1966.

APPLICANT'S RESPONSIBILITY

A. New Applications

1. As soon as an applicant decides to request support from PHS for a proposed project, the applicant must notify *both* the State and appropriate areawide clearinghouses of the intent to apply for Federal assistance. The notification must contain sufficient information to enable the clearinghouses to review the proposed activity and to determine those other agencies within the clearinghouses area which would have an interest in the proposed project. In the absence of any contrary instructions from clearinghouses, applicants shall use Standard Form 424 to notify clearinghouses of their intent to apply for Federal assistance. A copy of the SF-424 is enclosed as the face page of this application.
2. Clearinghouses have 30 days after receipt of notification from the applicant in which to disseminate the information in the notification to other appropriate State, areawide, or local agencies, and in which to make their own review of the information. Within this 30-day period, the clearinghouse(s) should also arrange with the applicant conferences or consultations on any issues raised on the proposed project.
3. Clearinghouse(s) comments, but issues are not resolved.
   a. During this 30-day period, and, if necessary, during the ensuing period while the application is being written, the applicant must confer with the clearinghouse(s) or other appropriate agencies when so requested to discuss any issues raised by the proposed project. An effort should be made to resolve issues in such a way that the application can be appropriately modified *before* it is submitted to PHS (or to a State agency if the State agency is responsible for final approval of project applications).
   b. If issues raised are not resolved through discussion, the clearinghouse may notify the applicant that it wishes to make comments on the completed application. Applicants must then submit the completed application to the clearinghouse(s) before it is sent to PHS and allow the clearinghouse(s) 30 days in which to file comments with the applicant.

c. Finally, the applicant must include with the application, when submitted to PHS (or to the State agency), any comments and recommendations made by or through clearinghouses along with a statement that such comments have been considered prior to submission of the application.

4. Clearinghouse(s) does not comment or all issues are resolved.

   a. If by the end of 30 days the applicant has received no comments and no requests from the clearinghouses for further consultation, or if all issues raised are resolved through discussion between the applicant and the interested agency, applicants may complete and submit the application to PHS.

   b. Applicants must include with the application a statement that the procedures outlined in this section have been followed and that: (1) no comments or recommendations have been received; or (2) the application has been modified in accordance with clearinghouse instructions.

5. Submission of Application

The notification to the clearinghouses, discussion to resolve issues while the application is under preparation, and the receipt of comments on the completed application (when necessary) are all actions to be completed *before* the application is submitted. The State Application Identifier (SAI) number assigned by the clearinghouse to all covered projects must be included in the application in item 3.a of the face page.

Applications that do not meet the documentative requirements set forth in paragraphs 3.c and 4.b above, shall either be returned to the applicant or held with no further action taken pending receipt of such information.

B. Competing Continuation, Noncompeting Continuation and Supplemental Applications

1. Competing continuation applications and noncompeting or supplemental applications requesting substantive changes to approved projects are also subject to the full notification and review requirements described above.

2. Noncompeting continuation and supplemental applications within an approved project period which do not contain substantive changes do not have to go through the Project Notification and Review System unless specifically requested by the State or areawide clearinghouse or unless the original application was not reviewed because the program was not then subject to the Project Notification Review System.

Addresses of Clearinghouses

A Directory of Clearinghouses is maintained in each PHS Agency and Regional Office. If the addresses are not provided in your application kit, applicants should request from the appropriate grants management office the name and addresses of the clearinghouses to which they must submit the notification.

NOTIFYING HEALTH PLANNING AGENCY OF APPLICATION FOR PHS GRANTS

Section 1513(e) of P.L. 93-641, National Health Planning and Resources Development Act of 1974, requires a fully designated Health Systems Agency (HSA) to review and approve or disapprove certain proposed uses, in its health service area, of funds authorized under the PHS Act; the Community Mental Health Centers Act; Sections 409 and 410 of the Drug Abuse Office and Treatment Act; and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. These proposed uses are reviewable if they are intended for the development, expansion, or support of health resources. In addition, the HSA is required to review and approve or disapprove proposed uses in its health service area of funds made available by the State from grants under these acts for the same purposes.

There are two exceptions to the general requirement for HSA review. Certain applications for projects that will serve Native Americans are reviewed and commented upon by HSA's but not approved or disapproved. This stipulation applies to applications for funds under these acts for projects located within or that specifically serve a federally recognized Indian reservation, or certain Indian-owned lands and land areas held in trust in Oklahoma, or in native villages in Alaska.

Section 1513(e) of the Act also provides for a general exception to review for proposed uses of funds appropriated for grants under Title IV (National Research Institutes), Title VII (Health Research and Teaching Facilities and the Training of Professional Health Personnel), and Title VIII (Nurse Training) of the PHS Act. However, uses of funds authorized under these titles are reviewable if the grants support: (a) the development of health resources intended for use in the health services area; or (b) the delivery of health services.

Applicants are requested to contact the appropriate HEW Regional Office or the awarding agency/bureau grants management office for additional information concerning the requirement for HSA review of applications for Federal assistance and the procedure for submitting the application to the HSA for review.

NOTE

In most areas A-95 Clearinghouses and Health Systems Agencies (HSAs) have developed agreements in the review of applications to avoid duplication of effort and overlap of responsibilities. Applicants are urged to contact their HSA and/or A-95 Clearinghouse to obtain information on how to submit applications for review.

PART III

BUDGET INFORMATION PHS SUPPLEMENTARY INSTRUCTIONS

General

The "budget" is the applicant's estimate of the total cost of performing the project or activity for which grant support is requested. It will normally include the amounts requested from PHS (Federal share) and any amounts proposed to meet the matching or cost participation requirements (non-Federal share).

Matching amounts are those required by legislation whereas cost participation amounts are administratively imposed by PHS officials on a program-wide basis or through negotiation on a project-by-project basis. Matching or cost participation amounts comprising the non-Federal share may also include any amounts voluntarily proposed by the applicant that are in excess of PHS requirements.

In preparing the budget, particularly in presenting the applicant's share, it is important to understand that any and all project costs which might be approved by PHS and documented on the Notice of Grant Award (NGA) as the total approved budget will be subject to the same Federal requirements of allowability and prior approval. PHS and the grantee, as a condition of award, will share in the approved cost according to the percentage of the Federal and non-Federal funds approved in the budget, excluding in-kind contributions.

While it is not the intent of the Federal Government to have applicant organizations participate in the budget to the extent that PHS would exercise unreasonable control over grantee resources, the intent of the applicant with respect to its non-Federal participation must be clearly established in the budget and in the narrative.

All proposed costs reflected in the budget, both Federal and non-Federal, must be necessary to the project, reasonable, and otherwise allowable under program legislation and regulations, grant policies, and the applicable cost principles described in Subpart Q of 45 CFR Part 74.

In negotiating the budget, PHS will take into account the applicant's potential for generating income from third parties (program income). This process becomes more important each succeeding year that PHS continues to support a project and as grantees become better able to assume a heavier financial responsibility for the total project.

Sections A thru D should provide budget estimates for a single budget period of 12 months unless program guidelines stipulate otherwise.

Direct Assistance -

Direct assistance is goods or services provided in lieu of cash. This type of assistance, which requires a prior agreement with the awarding agency, may include the assignment of PHS personnel or the provision of supplies or equipment. If Direct Assistance is requested in lieu of Financial Assistance enter the cash equivalent amounts in column (2) under Section B in the appropriate object class categories. Identify all Direct Assistance items under Section F.

Section A — Budget Summary

Columns (c) and (d) - For projects currently receiving PHS support, estimated unobligated funds should always be entered in these columns.

Section B — Budget Categories

Amounts entered by budget category in this section are for summary purposes only. Itemization and justification of specific needs by budget category are to be shown under Line 21, Section F.

Line 6.a - 6.h.—The budget amounts must reflect the total requirements for funds regardless of the source of funds. All amounts entered in this section are to be expressed in terms of whole dollars only after completing the requirements of Section F.

Line 6.j—Indirect costs are those costs related to the project that are not included as direct costs in a. thru h. To receive payment for indirect costs, the applicant must have the current indirect cost rate approved by HEW or have adequate documentation on file if the applicant is a local government agency. Information and advice on establishing indirect cost rate proposals may be obtained from the indirect cost negotiator in the HEW Regional Administrative Support Center.

Line 7.—Program income (grant related income) means gross income earned by the grantee from grant-supported activities. Grant-supported activities are those activities specified or described in the program narrative which are approved for PHS funding whether or not such PHS funding constitutes all or only a portion of the financial support necessary to carry out such activities. Grant-supported activities, therefore, are not just those activities performed with Federal grant funds, but are activities performed under the project which is being supported in whole or in part by PHS.

Program income includes but is not limited to income in the form of fees for services performed during the grant period, proceeds from the sale of tangible personal or real property, usage or rental fees, and patent or copyright royalties. Include on this line the total amount of program income expected to be generated from the project for the budget period requested from both the Federal and the non-Federal grant supported activities.

Income from fees and other income classified as "general program income" (see 45 CFR Part 74.42) may be proposed to satisfy a matching or cost participation requirement and included in the grant budget but may not actually be used for such purpose unless the terms of the grant expressly permit it. When proposed for matching or cost participation, such income must be separately identified under Section F, Line 23.

Section C — Source of Non-Federal Resources

Lines 8-11 — Enter amounts of non-Federal resources, if any, that will be used in conjunction with Federal grant funds to carry out the project. Explain in Line 23, Section F, showing the type of contribution, and whether it is cash or in-kind.

Section D — Forecasted Cash Needs

Whenever unusual differences are reflected in the quarterly projections, a justification should be furnished under Line 23, Section F.

Section E — Budget Estimates of Federal Funds Needed for Balance of the Project

Section E - Lines 16-19 — For projects requiring more than one year to complete, it is important that the awarding office and the applicant reach a mutual understanding as to the probable length of the project and approximate amount of financial support that PHS will provide.

The total time for which support of a project may be programmatically approved by awarding offices constitutes the "project period." This approval of a project period does not bind the Federal Government to support the project in future years but it does enable grantee and grantor to make budgetary projections and reduce certain administrative procedures. Future funding of the project is dependent on the availability of funds and satisfactory progress of the project.

Except where specifically permitted by legislation or regulation, awarding component approval of a project shall not exceed 5 years. Within the approved project period, projecta will be divided into "budget periods" (usually 12 months) for funding and reporting purposes.

For new applications and continuing grant applications, enter in the proper columns amounts of Federal funds for direct costs which will be needed to complete the project over the succeeding funding periods. Explain in Section F any unusual increases or decreases projected for subsequent years. Consider such factors which may change the level of any category in future years, such as promotions, reductions for nonrecurring items, etc.

Section F — Other Budget Information

Line 21. Direct Charges: Identify and explain all items or categories requested under Section B in accordance with the instructions set forth below. The itemization must reflect the total requirements for funding from Federal and non-Federal sources. Do not list here any items included in the indirect expenses entered on Line 22 below.

a. Personnel - Show salaries and wages only. Fees and expenses for Consultants should be included under h., Other. Salary amounts and percent of time or effort must be shown for each key individual and/or position identified by name or title in the program narrative and listed in the supplementary sheet titled Key Personnel. Place asterisks in front of Direct Assistance positions to separately identify them.

b. Fringe Benefits - Leave blank if fringe benefits applicable to direct salaries and wages are treated as psrt of indirect costs in the indirect cost rate negotiation agreement. *If your organization does not have a federally negotiated fringe benefit package, list each component included as a fringe benefit.*

c. Travel - Use only for travel (foreign and domestic) of project staff. Travel of consultants, board members, trainees, etc., should be itemized under item h., as should local transportation (i.e., where no out-of-town travel is involved.) Identify proposed *out-of-town* travel for project personnel and board members. Supporting data should include numbers of trips anticipated, costs per trip per person, destinations proposed, modes of transportation, and related subsistence expenses. All proposed travel costs must be consistent with the grantee organization's travel policies, or if none, should not exceed those limits described in the HEW travel regulations.

Any foreign travel requested must be separately identified and justified. Travel to be provided by Direct Assistance must also be separately identified.

d. Equipment - Use only for nonexpendable personal property, which is defined as follows:

Nonexpendable personal property means tangible personal property that is complete in itself, is of a durable nature, has an expected useful life of more than 1 year, and has an acquisition cost of $300 or more per unit.

List and estimate cost of each item of nonexpendable personal property to be purchased for use on the project. Justify items where project relatedness is not obvious. Equipment to be provided by Direct Assistance must be separately identified.

Items costing less than $300 should be shown under line e. - Supplies.

e. Supplies - Include all tangible personal property except that which is listed under Equipment. Requests whose aggregate costs are in excess of $500 per subcategory of tangible personal property (supply) must be separately identified and explained. Vaccine and other supplies to be provided by Direct Assistance must also be separately identified.

f. Contractual - Use for: (1) procurement contracts (except those which belong in other categories such as equipment, and supplies), (2) inpatient and outpatient care cost, and (3) contracts or other agreements with secondary recipient organizations such as affiliates, cooperating institutions, delegate agencies, political subdivisions, etc. Payments to individuals such as stipenda and allowances for trainees, consulting fees, etc. should be itemized under the category "Other"

Identify all proposed contractual activities included in this category.

For each proposed contract in (1) above in excess of $10,000 and each item in (2) and (3) above provide the following information:

1. A description of the activities or functions involved;
2. A justification for their performance by a third party;
3. A breakdown of and justification for the estimated costs;
4. The type of contract expected to be awarded;
5. The kinds of organizations or other parties to be selected; and
6. The method of selecting these parties.

g. Construction - Use for alterations and renovations only. Alterations and renovations may include work referred to as improvements, conversion, rehabilitation, remodeling, or modernization. Proposed costs that constitute new construction, relocation of exterior walls, roofs and floors, or completion of unfinished shell space to make it suitable for human occupancy are considered to be construction and are unallowable unless specifically authorized by legislation and defined in program regulations. A separate application is required for construction.

Consult the grants management office for guidance if funds are to be requested for this item.

h. Other - *Use for all direct cost items and Direct Assistance items not identified and explained under the above categories.* Include a description of the proposed costs. Examples of direct costs which should be included here are computer use charges, payments to individuals such as stipends or trainee allowances, consultant services, space or equipment rental, local transportation, communication, reproduction costs, recruitment of staff, audit expenses, etc.

Section F - Line 22. Indirect Charges: Enter the indirect cost "rate" claimed.

Section F - Line 23. Remarks: Identify as to amount and source of funding non-Federal resources previously entered in Section C that will be used in conjunction with Federal funds to carry out the proposed project. If in-kind contributions are proposed, show the basis for computation including: (1) numbers and types of volunteers and rates at which their services are valued: (2) valuation of donated space (use only) including number of square feet and value assigned per square foot; (3) determination of depreciation and use allowance for grantee-owned space; and (4) type and value of other in-kind contributions expected.

Identify separately costs proposed to meet matching or cost participation requirements. In general, matching or cost participation requirements may be met from any non-Federal source including cash or in-kind contributions. General program income may be used when authorized by the terms of the grant. Certain funds from Federal sources such as medicare and medicaid reimbursement and General Revenue Sharing may also be used. For specific information on the eligibility of proposed matching or cost participation sources, refer to the authorizing legislation and program regulations or consult with the appropriate grants management office.

PART IV

PROJECT NARRATIVE
PHS SUPPLEMENTARY INSTRUCTIONS

The narrative is a major means by which the application is evaluated and ranked to compete with other applications for available funds. It should be concise and complete. Supporting documents should be used where they can present information clearly and succinctly. Cross-referencing should be used rather than repetition. PHS is particularly interested in specific factual information and statements of measurable goals in quantitative terms. Narratives are evaluated on the basis of substance, not length. Extensive exhibits are not required. Pages should be numbered for quick reference continuing the numerical sequence of the printed form.

PROJECT DESCRIPTION

Due to the many and varied programs using this application form, it is not possible to provide specific guidance concerning project description that would be appropriate in all cases. One aspect of the description that is applicable to all proposals, however, is the requirement that all project information described in this part relate directly to the budget information included in Part III. As described in Part III, the budget consists of a combination of both Federal and non-Federal funds which the applicant estimates is required for the activities to be carried out under the proposed project.

In developing the narrative, the applicant may volunteer or be requested to provide information on the total range of health programs currently conducted and supported (or to be initiated) some of which may be outside the scope of the program announcement. In addition, applicants are encouraged to provide information on their organizational structure, staff, related experience, and other information considered to be relevant. Awarding offices use this and other information to determine whether the applicant has the capabilities and resources necessary to carry out the proposed project.

It is important, therefore, that this information be included in the proposal but it is equally important that the narrative distinguish applicant resources which are directly related to the budget in Part III from those which will not be used in support of the specific project for which funds are requested.

STAFF AND POSITION DATA

Some programs require a biographical sketch for key personnel appointed and a job-description for a vacant key position; others require both for all positions. Refer to appropriate program brochures for guidance in fulfilling this requirement. Generally, a biographical sketch is required for original staff and new members as appointed. Below are the suggested contents for the biographical sketch and job description where not otherwise set forth.

BIOGRAPHICAL SKETCH

Existing curricula vitae of project staff members may be used if they are updated and contain all information requested below. You may add any information listed below to complete existing documents. For development of new curricula vitae include items listed below in the format most suitable.

Name of staff member
Educational history - School, location, dates attended, degrees earned (specify year), major field of study
Professional experience
Honors received and dates
Recent relevant publications

JOB DESCRIPTION

Title of position
Description of duties and responsibilities
Qualification of position
Supervisory relationships
Skills and knowledge required
Prior experience required
Educational background required
Personal qualities
Amount of travel and other special conditions
Salary range
Hours per day or week

PART V

ASSURANCES
PHS SUPPLEMENTARY INSTRUCTIONS

No application for DHEW assistance is approved unless the applicant has on file with the Department an accepted assurance of compliance with 45 CFR 80 on Assurance of Compliance Form HEW-441. If a copy of Form HEW-441 is not already on file with the Department, it must be submitted with this application.

Attention is called to the requirements of 45 CFR 86, which provides that no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.

Attention is called to the requirements of 45 CFR 84, which provides that no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Accepted assurances of compliance with these regulations are required to be on file with the Office for Civil Rights, HEW.

DHEW policy requires that if any phase of this project will involve subjecting individuals to the risk of physical, psychological, sociological, or other harm, certain safeguards must be instituted and an assurance must be filed. If the applicant institution already has an assurance on file, complete the Protection of Human Subjects Certification, Form HEW-596. If no assurance has been filed, or if there is any question about application of requirements for protection of human subjects to this project, further information should be requested from the Office For Protection From Research Risks, National Institutes of Health, DHEW, 9000 Rockville Pike, Bethesda, Maryland 20014.

NOTE

The provisions of the Hatch Act, Item 5 of the assurances, do not apply to nongovernmental organizations. Nongovernmental applicants are subject to the requirements of Office of Management and Budget Circular A-110 as implemented by DHEW and PHS.

DEPARTMENT OF HEALTH, EDUCATIO.., AND WELFARE
PUBLIC HEALTH SERVICE

APPLICATION FOR FEDERAL ASSISTANCE *(NONCONSTRUCTION PROGRAMS)* OMB Approval No. 29–R0218

SECTION I—APPLICANT/RECIPIENT DATA

PART I

1. TYPE OF ACTION (*Mark appropriate box*)
- ☐ PREAPPLICATION
- ☐ APPLICATION
- ☐ NOTIFICATION OF INTENT (Opt.)
- ☐ REPORT OF FEDERAL ACTION

2. APPLICANT'S APPLICATION
a. NUMBER
b. DATE *Year month day* 19
Leave Blank

3. STATE APPLICATION IDENTIFIER
a. NUMBER
b. DATE ASSIGNED *Year month day* 19

4. LEGAL APPLICANT/RECIPIENT
a. Applicant Name :
b. Organization Unit :
c. Street/P.O. Box :
d. City :
e. County :
f. State :
g. ZIP Code:
h. Contact Person (*Name & telephone No.*) :

5. FEDERAL EMPLOYER IDENTIFICATION NO.

6. PROGRAM (*From Federal Catalog*)
a. NUMBER ☐☐•☐☐☐
b. TITLE

7. TITLE AND DESCRIPTION OF APPLICANT'S PROJECT

8. TYPE OF APPLICANT/RECIPIENT
- A–State
- B–Interstate
- C–Substate District
- D–County
- E–City
- F–School District
- G–Special Purpose District
- H–Community Action Agency
- I–Higher Educational Institution
- J–Indian Tribe
- K–Other (*Specify*):

Enter appropriate letter ☐

9. TYPE OF ASSISTANCE
- A–Basic Grant
- B–Supplemental Grant
- C–Loan
- D–Insurance
- E–Other

Enter appropriate letter(s) ☐☐

10. AREA OF PROJECT IMPACT (*Names of cities, counties, States, etc.*)

11. ESTIMATED NUMBER OF PERSONS BENEFITING

12. TYPE OF APPLICATION
- A–New
- B–Renewal
- C–Revision
- D–Continuation
- E–Augmentation

Enter appropriate letter ☐

13. PROPOSED FUNDING

a. FEDERAL	$ .00
b. APPLICANT	.00
c. STATE	.00
d. LOCAL	.00
e. OTHER	.00
f. TOTAL	$ .00

14. CONGRESSIONAL DISTRICTS OF:
a. APPLICANT
b. PROJECT

15. TYPE OF CHANGE (*For 12c or 12e*)
- A–Increase Dollars
- B–Decrease Dollars
- C–Increase Duration
- D–Decrease Duration
- E–Cancellation
- F–Other (*Specify*):

Enter appropriate letter(s) ☐☐☐

16. PROJECT START DATE *Year month day* 19

17. PROJECT DURATION *Months*

18. ESTIMATED DATE TO BE SUBMITTED TO FEDERAL AGENCY ▶ *Year month day* 19

19. EXISTING FEDERAL IDENTIFICATION NUMBER

20. FEDERAL AGENCY TO RECEIVE REQUEST (*Name, City, State, ZIP code*)

21. REMARKS ADDED ☐ Yes ☐ No

SECTION II—CERTIFICATION

22. THE APPLICANT CERTIFIES THAT ▶

a. To the best of my knowledge and belief, data in this preapplication/application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the attached assurances if the assistance is approved.

b. If required by OMB Circular A-95 this application was submitted, pursuant to instructions therein, to appropriate clearinghouses and all responses are attached:

	No response	*Response attached*
(1)	☐	☐
(2)	☐	☐
(3)	☐	☐

23. CERTIFYING REPRESENTATIVE
a. TYPED NAME AND TITLE
b. SIGNATURE
c. DATE SIGNED *Year month day* 19

SECTION III—FEDERAL AGENCY ACTION

24. AGENCY NAME

25. APPLICATION RECEIVED *Year month day* 19

26. ORGANIZATIONAL UNIT

27. ADMINISTRATIVE OFFICE

28. FEDERAL APPLICATION IDENTIFICATION

29. ADDRESS

30. FEDERAL GRANT IDENTIFICATION

31. ACTION TAKEN
- ☐ a. AWARDED
- ☐ b. REJECTED
- ☐ c. RETURNED FOR AMENDMENT
- ☐ d. DEFERRED
- ☐ e. WITHDRAWN

32. FUNDING

a. FEDERAL	$ .00
b. APPLICANT	.00
c. STATE	.00
d. LOCAL	.00
e. OTHER	.00
f. TOTAL	$ .00

33. ACTION DATE ▶ *Year month day* 19

34. STARTING DATE *Year month day* 19

35. CONTACT FOR ADDITIONAL INFORMATION (*Name and telephone number*)

36. ENDING DATE *Year month day* 19

37. REMARKS ADDED ☐ Yes ☐ No

38. FEDERAL AGENCY A-95 ACTION

a. In taking above action, any comments received from clearinghouses were considered. If agency response is due under provisions of Part 1, OMB Circular A-95, it has been or is being made.

b. FEDERAL AGENCY A-95 OFFICIAL (*Name and telephone no.*)

PHS-5161-1 (PAGE 1) Form Approved
(Rev. 3-79) OMB No. 68-R1379

STANDARD FORM 424 PAGE 1 (10-75)
Prescribed by OMB Circular No. A-102

SECTION IV–REMARKS *(Please reference the proper item number from Sections I, II or III, if applicable)*

GENERAL INSTRUCTIONS - PART 1

This is a multi-purpose standard form. First, it will be used by applicants as a required facesheet for pre-applications and applications submitted in accordance with Federal Management Circular 74–7. Second, it will be used by Federal agencies to report to Clearinghouses on major actions taken on applications reviewed by clearinghouses in accordance with OMB Circular A–95. Third, it will be used by Federal agencies to notify States of grants-in-aid awarded in accordance with Treasury Circular 1082. Fourth, it may be used, on an optional basis, as a notification of intent from applicants to clearinghouses, as an early initial notice that Federal assistance is to be applied for (clearinghouse procedures will govern).

APPLICANT PROCEDURES FOR SECTION I

Applicant will complete all items in Section I. If an item is not applicable, write "NA". If additional space is needed, insert an asterisk "*", and use the remarks section on the back of the form. An explanation follows for each item:

Item	
1.	Mark appropriate box. Pre-application and application guidance is in FMC 74–7 and Federal agency program instructions. Notification of intent guidance is in Circular A–95 and procedures from clearinghouse. Applicant will not use "Report of Federal Action" box.
2a.	Applicant's own control number, if desired.
2b.	Date Section I is prepared.
3a.	Number assigned by State clearinghouse, or if delegated by State, by areawide clearinghouse. All requests to Federal agencies must contain this identifier if the program is covered by Circular A–95 and required by applicable State/areawide clearinghouse procedures. If in doubt, consult your clearinghouse.
3b.	Date applicant notified of clearinghouse identifier.
4a–4h.	Legal name of applicant/recipient, name of primary organizational unit which will undertake the assistance activity, complete address of applicant, and name and telephone number of person who can provide further information about this request.
5.	Employer identification number of applicant as assigned by Internal Revenue Service.
6a.	Use Catalog of Federal Domestic Assistance number assigned to program under which assistance is requested. If more than one program (e.g., joint-funding) write "multiple" and explain in remarks. If unknown, cite Public Law or U.S. Code.
6b.	Program title from Federal Catalog. Abbreviate if necessary.
7.	Brief title and appropriate description of project. For notification of intent, continue in remarks section if necessary to convey proper description.
8.	Mostly self-explanatory. "City" includes town, township or other municipality.
9.	Check the type(s) of assistance requested. The definitions of the terms are:
	A. Basic Grant. An original request for Federal funds. This would not include any contribution provided under a supplemental grant.
	B. Supplemental Grant. A request to increase a basic grant in certain cases where the eligible applicant cannot supply the required matching share of the basic Federal program (e.g., grants awarded by the Appalachian Regional Commission to provide the applicant a matching share).
	C. Loan. Self explanatory.
	D. Insurance. Self explanatory.
	E. Other. Explain on remarks page.
10.	Governmental unit where significant and meaningful impact could be observed. List only largest unit or units affected, such as State, county, or city. If entire unit affected, list it rather than subunits.
11.	Estimated number of persons directly benefiting from project.
12.	Use appropriate code letter. Definitions are:
	A. New. A submittal for the first time for a new project.
	B. Renewal. An extension for an additional funding/budget period for a project having no projected completion date, but for which Federal support must be renewed each year.
	C. Revision. A modification to project nature or scope which may result in funding change (increase or decrease).
	D. Continuation. An extension for an additional funding/budget period for a project the agency initially agreed to fund for a definite number of years.
	E. Augmentation. A requirement for additional funds for a project previously awarded funds in the same funding/budget period. Project nature and scope unchanged.
13.	Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions will be included. If the action is a change in dollar amount of an existing grant (a revision or augmentation), indicate only the amount of the change. For decreases enclose the amount in parentheses. If both basic and supplemental amounts are included, breakout in remarks. For multiple program funding, use totals and show program breakouts in remarks. Item definitions: 13a, amount requested from Federal Government; 13b, amount applicant will contribute; 13c, amount from State, if applicant is not a State; 13d, amount from local government, if applicant is not a local government; 13e, amount from any other sources, explain in remarks.
14a.	Self explanatory.
14b.	The district(s) where most of actual work will be accomplished. If city-wide or State-wide, covering several districts, write "city-wide" or "State-wide."
15.	Complete only for revisions (item 12c), or augmentations (item 12e).

Item	
16.	Approximate date project expected to begin (usually associated with estimated date of availability of funding).
17.	Estimated number of months to complete project after Federal funds are available.
18.	Estimated date preapplication/application will be submitted to Federal agency if this project requires clearinghouse review. If review not required, this date would usually be same as date in item 2b.
19.	Existing Federal identification number if this is not a new request and directly relates to a previous Federal action. Otherwise write "NA".
20.	Indicate Federal agency to which this request is addressed. Street address not required, but do use ZIP.
21.	Check appropriate box as to whether Section IV of form contains remarks and/or additional remarks are attached.

APPLICANT PROCEDURES FOR SECTION II

Applicants will always complete items 23a, 23b, and 23c. If clearinghouse review is required, item 22b must be fully completed. An explanation follows for each item:

Item	
22b.	List clearinghouses to which submitted and show in appropriate blocks the status of their responses. For more than three clearinghouses, continue in remarks section. All written comments submitted by or through clearinghouses must be attached.
23a.	Name and title of authorized representative of legal applicant.
23b.	Self explanatory.
23c.	Self explanatory.
Note:	Applicant completes only Sections I and II. Section III is completed by Federal agencies.

FEDERAL AGENCY PROCEDURES FOR SECTION III

If applicant-supplied information in Sections I and II needs no updating or adjustment to fit the final Federal action, the Federal agency will complete Section III only. An explanation for each item follows:

Item	
24.	Executive department or independent agency having program administration responsibility.
25.	Self explanatory.
26.	Primary organizational unit below department level having direct program management responsibility.
27.	Office directly monitoring the program.
28.	Use to identify non-award actions where Federal grant identifier in item 30 is not applicable or will not suffice.
29.	Complete address of administering office shown in item 26.
30.	Use to identify award actions where different from Federal application identifier in item 28.
31.	Self explanatory. Use remarks section to amplify where appropriate.
32.	Amount to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions will be included. If the action is a change in dollar amount of an existing grant (a revision or augmentation), indicate only the amount of change. For decreases, enclose the amount in parentheses. If both basic and supplemental amounts are included, breakout in remarks. For multiple program funding, use totals and show program breakouts in remarks. Item definitions: 32a, amount awarded by Federal Government; 32b, amount applicant will contribute; 32c, amount from State, if applicant is not a State; 32d, amount from local government if applicant is not a local government; 32e, amount from any other sources, explain in remarks.
33.	Date action was taken on this request.
34.	Date funds will become available.
35.	Name and telephone no. of agency person who can provide more information regarding this assistance.
36.	Date after which funds will no longer be available.
37.	Check appropriate box as to whether Section IV of form contains Federal remarks and/or attachment of additional remarks.
38.	For use with A-95 action notices only. Name and telephone of person who can assure that appropriate A-95 action has been taken—If same as person shown in item 35, write "same". If not applicable, write "NA".

Federal Agency Procedures—special considerations

A. *Treasury Circular 1082 compliance.* Federal agency will assure proper completion of Sections I and III. If Section I is being completed by Federal agency, all applicable items must be filled in. Addresses of State Information Reception Agencies (SCIRA's) are provided by Treasury Department to each agency. This form replaces SF 240, which will no longer be used.

B. *OMB Circular A-95 compliance.* Federal agency will assure proper completion of Sections I, II, and III. This form is required for notifying all reviewing clearinghouses of major actions on all programs reviewed under A-95. Addresses of State and areawide clearinghouses are provided by OMB to each agency. Substantive differences between applicant's request and/or clearinghouse recommendations, and the project as finally awarded will be explained in A-95 notifications to clearinghouses.

C. *Special note.* In most, but not all States, the A-95 State clearinghouse and the (TC 1082) SCIRA are the same office. In such cases, the A-95 award notice to the State clearinghouse will fulfill the TC 1082 award notice requirement to the State SCIRA. Duplicate notification should be avoided.

PART II

PROJECT APPROVAL INFORMATION

Item 1. Does this assistance request require State, local, regional, or other priority rating? ______Yes ______No	Name of Governing Body ______ Priority Rating ______
Item 2. Does this assistance request require State, or local advisory, educational or health clearances? ______Yes ______No	Name of Agency or Board ______ (Attach Documentation)
Item 3. Does this assistance request require clearinghouse review in accordance with OMB Circular A-95? ______Yes ______No	(Attach Comments)
Item 4. Does this assistance request require State, local, regional or other planning approval? ______Yes ______No	Name of Approving Agency ______ Date ______
Item 5. Is the proposed project covered by an approved comprehensive plan? ______Yes ______No	Check one: State ☐ Local ☐ Regional ☐ Location of Plan ______
Item 6. Will the assistance requested serve a Federal installation? ______Yes ______No	Name of Federal Installation ______ Federal Population benefiting from Project ______
Item 7. Will the assistance requested be on Federal land or installation? ______Yes ______No	Name of Federal Installation ______ Location of Federal Land ______ Percent of Project ______
Item 8. Will the assistance requested have an impact or effect on the environment? ______Yes ______No	See instructions for additional information to be provided.
Item 9. Will the assistance requested cause the displacement of individuals, families, businesses, or farms? ______Yes ______No	Number of: Individuals ______ Families ______ Businesses ______ Farms ______
Item 10. Is there other related assistance on this project previous, pending, or anticipated? ______Yes ______No	See instructions for additional information to be provided.

INSTRUCTIONS

PART II

Negative answers will not require an explanation unless the Federal agency requests more information at a later date. Provide supplementary data for all "Yes" answers in the space provided in accordance with the following instructions:

Item 1 — Provide the name of the governing body establishing the priority system and the priority rating assigned to this project.

Item 2 — Provide the name of the agency or board which issued the clearance and attach the documentation of status or approval.

Item 3 — Attach the clearinghouse comments for the application in accordance with the instructions contained in Office of Management and Budget Circular No. A-95. If comments were submitted previously with a preapplication, do not submit them again but any additional comments received from the clearinghouse should be submitted with this application.

Item 4 — Furnish the name of the approving agency and the approval date.

Item 5 — Show whether the approved comprehensive plan is State, local or regional, or if none of these, explain the scope of the plan. Give the location where the approved plan is available for examination and state whether this project is in conformance with the plan.

Item 6 — Show the population residing or working on the Federal installation who will benefit from this project.

Item 7 — Show the percentage of the project work that will be conducted on federally-owned or leased land. Give the name of the Federal installation and its location.

Item 8 — Describe briefly the possible beneficial and harmful impact on the environment of the proposed project. If an adverse environmental impact is anticipated, explain what action will be taken to minimize the impact. Federal agencies will provide separate instructions if additional data is needed.

Item 9 — State the number of individuals, families, businesses, or farms this project will displace. Federal agencies will provide separate instructions if additional data is needed.

Item 10 — Show the Federal Domestic Assistance Catalog number, the program name, the type of assistance, the status and the amount of each project where there is related previous, pending or anticipated assistance. Use additional sheets, if needed.

PART III – BUDGET INFORMATION

SECTION A – BUDGET SUMMARY

Grant Program, Function or Activity (a)	Federal Catalog No. (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1.		$	$	$	$	$
2.						
3.						
4.						
5. TOTALS		$	$	$	$	$

SECTION B – BUDGET CATEGORIES

6. Object Class Categories	– Grant Program, Function or Activity				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	$	$	$	$	$
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges					
j. Indirect Charges					
k. TOTALS	$	$	$	$	$
7. Program Income	$	$	$	$	$

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INSTRUCTIONS

PART III

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately shown for different functions or activities within the program. For some programs, grant or agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may not require a breakdown by function or activity. Sections A, B, C, and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Sections A, B, C, and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary
Lines 1-4, Columns (a) and (b).

For applications pertaining to a *single* Federal grant program (Federal Domestic Assistance Catalog number) and *not requiring* a functional or activity breakdown, enter on Line 1 under Column (a) the catalog program title and the catalog number in Column (b).

For applications pertaining to a *single* program *requiring* budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the catalog number in Column (b). For applications pertaining to *multiple* programs where *none* of the programs *require* a breakdown by function or activity, enter the catalog program title on each line in Column (a) and the respective catalog number on each line in Column (b).

For applications pertaining to *multiple* programs where one or more programs *require* a breakdown by function or activity, prepare a separate sheet for each program requiring the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g).

For new applications, leave Columns (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Columns (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period *only* if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase or decrease of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amount(s) in Column (g) should *not* equal the sum of amounts in Columns (e) and (f)

Line 5 — Show the totals for all columns used.

Section B. Budget Categories

In the column headings (1) through (4), enter the titles of the same programs, functions, and activities shown on Lines 1-4, Column (a), Section A. When additional sheets were prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Lines 6a-h — Show the estimated amount for each direct cost budget (object class) category for each column with program, function or activity heading.

Line 6i — Show the totals of Lines 6a to 6b in each column.

Line 6j — Show the amount of indirect cost. Refer to Office of Management and Budget Circular No. A-87.

Line 6k — Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5. When additional sheets were prepared, the last two sentences apply only to the first page with summary totals.

Line 7 — Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount. Show under the program narrative statement the nature and source of income. The estimated amount of program income may be considered by the Federal grantor agency in determining the total amount of the grant.

SECTION C – NON-FEDERAL RESOURCES

(a) Grant Program	(b) APPLICANT	(c) STATE	(d) OTHER SOURCES	(e) TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTALS	$	$	$	$

SECTION D – FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal					
15. TOTAL	$	$	$	$	$

SECTION E – BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) FIRST	(c) SECOND	(d) THIRD	(e) FOURTH
16.	$	$	$	$
17.				
18.				
19.				
20. TOTALS	$	$	$	$

SECTION F – OTHER BUDGET INFORMATION

(Attach additional Sheets If Necessary)

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

PART IV PROGRAM NARRATIVE (Attach per instruction)

INSTRUCTIONS

PART III
(continued)

Section C. Source of Non-Federal Resources

Line 8-11 – Enter amounts of non-Federal resources that will be used on the grant If in-kind contributions are included, provide a brief explanation on a separate sheet. (See Attachment F, Office of Management and Budget Circular No. A-102.)

Column (a) – Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary

Column (b) – Enter the amount of cash and in-kind contributions to be made by the applicant as shown in Section A. (See also Attachment F Office of Management and Budget Circular No. A-102.)

Column (c) – Enter the State contribution if the applicant is *not* a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) – Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) – Enter totals of Columns (b), (c), and (d).

Line 12 – Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f) Section A.

Section D. Forecasted Cash Needs

Line 13 – Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 – Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 – Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16-19 – Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary For new applications and continuing grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This Section need not be completed for amendments, changes, or supplements to funds for the current year of existing grants.

If more than four lines are needed to list the program titles submit additional schedules as necessary.

Line 20 – Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F – Other Budget Information.

Line 21 – Use this space to explain amounts for individual direct object cost categories that may appear to be out of the ordinary or to explain the details as required by the Federal grantor agency.

Line 22 – Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 – Provide any other explanations required herein or any other comments deemed necessary.

SUPPLEMENT TO PART III, SECTION F
KEY PERSONNEL

NAME AND POSITION TITLE	ANNUAL SALARY RATE (1)	NO. MOS. BUDG. (2)	% TIME (3)	TOTAL AMOUNT REQUIRED (4)
FRINGE BENEFITS (Rate ________)				
	CATEGORY TOTAL			$

PHS SUPPLEMENTARY INSTRUCTIONS

PART III, SECTION F

1. **Personnel**

Enter in Column 1 the annual (12 months) salary rate for each key position referred to in the narrative, which will be filled for all or any part of the year by an incumbent working on the project. This rate may not be more than that paid by the grantee to other employees in comparable positions or, if the grantee has no comparable positions, the rate may not be more than that paid for such services elsewhere in the community.

Enter in Column 2 the number of months the position will be filled by an incumbent working on the project.

Enter in Column 3 the percent of time or effort the incumbent will devote to the project during the number of months shown in Column 2. Enter in Column 4 the total amount required, as computed from the information shown in Columns 1 thru 3. Use the following formula:

$$\text{Annual Salary } (\textit{Col. 1}) \times \frac{\text{No. of Months } (\textit{Col. 2})}{12} \times \text{Percent of Effort } (\textit{Col. 3}) = \text{Total Amount Required } (\textit{Col. 4})$$

EXAMPLES:

PERSONNEL

NAME	ANNUAL SALARY RATE (1)	NO. MOS. BUDG. (2)	% TIME (3)	TOTAL AMOUNT REQUIRED (4)
Full-Time Employee of Institution working 60% time on project.				
John Doe	$24,000	12	60%	$14,400
Calculation	24,000 ×	$\frac{12}{12}$ ×	60%	= $14,400
Part-Time Employee (3 months) to be paid $1,000 a month. Will Work on project 25% of time.				
Richard Roe	$12,000	3	25%	$ 750
Calculation	12,000 ×	$\frac{3}{12}$ ×	25%	= $ 750

2. **Fringe Benefits**

Enter in the parenthesis the fringe benefit rate applicable to employees of the institutions. In Column 4, enter the amount determined by applying the rate to the total of the salaries in Column 4 to which the rate applies.

3. **Option for Salary Detail Submission**

Institutions may request that the salary rates and amounts requested for individuals not be made available to HEW reviewing consultants. To do so, an additional copy of this page must be also submitted, complete in all respects, except that Columns 1 and 4 may be left blank.

INSTRUCTIONS

PART IV
PROGRAM NARRATIVE

Prepare the program narrative statement in accordance with the following instructions for all new grant programs. Requests for continuation or refunding and changes on an approved project should respond to item 5b only. Requests for supplemental assistance should respond to question 5c only.

1. OBJECTIVES AND NEED FOR THIS ASSISTANCE.

Pinpoint any relevant physical, economic, social, financial, institutional, or other problems requiring a solution. Demonstrate the need for assistance and state the principal and subordinate objectives of the project. Supporting documentation or other testimonies from concerned interests other than the applicant may be used. Any relevant data based on planning studies should be included or footnoted.

2. RESULTS OR BENEFITS EXPECTED.

Identify results and benefits to be derived. For example, when applying for a grant to establish a neighborhood health center provide a description of who will occupy the facility, how the facility will be used, and how the facility will benefit the general public.

3. APPROACH.

a. Outline a plan of action pertaining to the scope and detail of how the proposed work will be accomplished for each grant program, function or activity, provided in the budget. Cite factors which might accelerate or decelerate the work and your reason for taking this approach as opposed to others. Describe any unusual features of the project such as design or technological innovations, reductions in cost or time, or extraordinary social and community involvement.

b. Provide for each grant program, function or activity, quantitative monthly or quarterly projections of the accomplishments to be achieved in such terms as the number of jobs created; the number of people served; and the number of patients treated. When accomplishments cannot be quantified by activity or function, list them in chronological order to show the schedule of accomplishments and their target dates.

c. Identify the kinds of data to be collected and maintained and discuss the criteria to be used to evaluate the results and successes of the project. Explain the methodology that will be used to determine if the needs identified and discussed are being met and if the results and benefits identified in item 2 are being achieved.

d. List organizations, cooperators, consultants, or other key individuals who will work on the project along with a short description of the nature of their effort or contribution

4. GEOGRAPHIC LOCATION.

Give a precise location of the project or area to be served by the proposed project. Maps or other graphic aids may be attached.

5. IF APPLICABLE, PROVIDE THE FOLLOWING INFORMATION:

a. For research or demonstration assistance requests, present a biographical sketch of the program director with the following information; name, address, phone number, background, and other qualifying experience for the project. Also, list the name, training and background for other key personnel engaged in the project.

b. Discuss accomplishments to date and list in chronological order a schedule of accomplishments, progress or milestones anticipated with the new funding request. If there have been significant changes in the project objectives, location approach, or time delays, explain and justify. For other requests for changes or amendments, explain the reason for the change(s). If the scope or objectives have changed or an extension of time is necessary, explain the circumstances and justify. If the total budget has been exceeded, or if individual budget items have changed more than the prescribed limits contained in Attachment K to Office of Management and Budget Circular No. A-102, explain and justify the change and its effect on the project.

c. For supplemental assistance requests, explain the reason for the request and justify the need for additional funding.

PART V

ASSURANCES

The Applicant hereby assures and certifies that he will comply with the regulations, policies, guidelines, and requirements including OMB Circulars Nos. A-87, A-95, and A-102, as they relate to the application, acceptance and use of Federal funds for this Federally assisted project. Also the Applicant assures and certifies with respect to the grant that:

1. It possesses legal authority to apply for the grant; that a resolution, motion or similar action has been duly adopted or passed as an official act of the applicant's governing body, authorizing the filing of the application, including all understandings and assurances contained therein, and directing and authorizing the person identified as the official representative of the applicant to act in connection with the application and to provide such additional information as may be required.
2. It will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and in accordance with Title VI of that Act, 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 otherwise subjected to discrimination under any program or activity for which the applicant receives Federal financial assistance and will immediately take any measures necessary to effectuate this agreement.
3. It will comply with Title VI of the Civil Rights Act of 1964 (42 USC 2000d) prohibiting employment discrimination where (1) the primary purpose of a grant is to provide employment or (2) discriminatory employment practices will result in unequal treatment of persons who are or should be benefiting from the grant-aided activity.
4. It will comply with requirements of the provisions of the Uniform Relocation Assistance and Real Property Acquisitions Act of 1970 (P.L. 91-646) which provides for fair and equitable treatment of persons displaced as a result of Federal and federally assisted programs.
5. It will comply with the provisions of the Hatch Act which limit the political activity of employees.
6. It will comply with the minimum wage and maximum hours provisions of the Federal Fair Labor Standards Act, as they apply to hospital and educational institution employees of State and local governments.
7. It will establish safeguards to prohibit employees from using their positions for a purpose that is or gives the appearance of being motivated by a desire for private gain for themselves or others, particularly those with whom they have family, business, or other ties.
8. It will give the grantor agency or the Comptroller General through any authorized representative the access to and the right to examine all records, books, papers, or documents related to the grant.
9. It will comply with all requirements imposed by the Federal grantor agency concerning special requirements of law, program requirements, and other administrative requirements approved in accordance with Office of Management and Budget Circular No. A-102.

PHS SUPPLEMENTARY INSTRUCTIONS

CHECKLIST

NOTE TO APPLICANT: Complete and forward this sheet with your application.

Type of Application

☐ New ☐ Noncompeting Continuation ☐ Competing Extension ☐ Supplemental

CHECKLIST

- ☐ Proper Signatures and Dates (item 23 on face page)
- ☐ Human Subjects Certification (when applicable)
- ☐ Staff and Position Data (biographical sketch(es) with job description when required)
- ☐ State and areawide Clearinghouse Review (as requried by OMB Circular A-95) - Attach comments or evidence of submission to A-95 Clearinghouse(s).
- ☐ Health Systems Agency Review if required by Federal regulations - Attach evidence of submission to Health Systems Agency.
- ☐ Civil Rights Assurance on File with HEW (45 CFR 80)
- ☐ Assurance Concerning the Handicapped on File with HEW (45 CFR 84)
- ☐ Assurance Concerning Sex Discrimination on File with HEW (45 CFR 86)

A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence:

- ☐ (a) A reference to the organization's listing in the Internal Revenue Service's most recent cumulative list of organizations.
- ☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- ☐ (c) A statement from a State taxing body or the State Attorney General certifying that the organization is a nonprofit organization operating within the State and that no part of its net earnings may lawfully inure to the benefit or any private shareholder or individual.
- ☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- ☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date filed must be indicated.

Previously filed with: ______________________________ on ______________ (date)

Name, title, address and telephone number of official in business office to be notified if an award is made.

____

____

____

Name, title, address and telephone number of official responsible for carrying out the proposed project.

____

____

____

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported; or (3) a negative certification.

☆U.S. GOVERNMENT PRINTING OFFICE: 1979 O—295-019

Exhibit 9

OCT 19 1979

Henry A. Foley, Administrator
Health Resources Administration
David S. Tatel, Director
Office for Civil Rights

Deputy Director
Office for Civil Rights
Office of Program Review and Assistance

Guidelines on Underserved Population Groups (Memorandum of September 18, 1979)

I. Background

As you are aware, Bruce Mayor, OCR's Deputy Director for Standards, Policy and Research (OSPR) has commented on the above referenced guidelines. (See attached memoranda of August 4, 1979 and October 2, 1979.) His critique focused on the question of whether HRA's proposed guidelines conflicted with OCR's responsibility to enforce Title VI and Section 504 or would interfere with OCR's ability to place further requirements on HSAs and SHPDAs under the authority of Title VI and Section 504.

My office, however, has a somewhat broader interest in the proposed HRA guidelines. As you may know, OCR's Office of Program Review and Assistance (OPRA) has the responsibility to coordinate and assist in the Department-wide initiative to incorporate civil rights into the program operations of the POCs and to provide technical assistance and support services to the POCs for civil rights policy implementation. As part of the Memorandum of Understanding (MOU) signed by Dr. Richmond on July 16, 1979, and approved by former Secretary Califano on July 27, 1979, the Public Health Service agreed to "[i]ncorporate civil rights concerns into regular program review and audit activities to assure that benefits and services are delivered equitably to eligible minorities, women and handicapped persons" and to "[r]eview, in cooperation with OCR, program regulations, directives and instructions to assure support for the Department's civil rights authorities." One of the specific management objectives approved by Dr. Richmond as an FY 80 activity to implement the civil rights initiative calls for PHS "[t]o integrate Title VI and Section 504 into Health System Agency (HSA) and State Health Planning and Development Agency (SHPDA) programs."

Under our responsibility to incorporate civil rights into the program operations of the POCs, we have set forth below our supplementary comments to OCR's earlier critique. Our comments are designed to address the sufficiency of HRA's proposed guidelines in implementing the civil rights-related requirements of P.L. 93-641 and P.L. 96-79.

The goals of P.L. 93-641 are certainly compatible with, and in many ways similar to, the goals of the civil rights statutes. Specifically, in the 1974 National Health Planning and Resources Development Act, Congress recognized the significant contribution that planning agencies could and must make toward the achievement of "equal access to health care". (§2(a)(1) of P.L. 93-641, as amended.) The 1979 Planning Act reemphasizes that view and further elaborates on it by the addition of project review criteria for new health services addressing "the extent to which proposed services will be accessible to all the residents of the area to be served by such services." (§1532(c)(6)(E) of the Planning Act, as amended.) Similar amendments include "accessibility" as a criterion in appropriateness reviews. (§1513(g)(3) and §1523(a)(6) of the Planning Act, as amended.)

HRA's recently issued regulations (April 7, 1979) have also recognized the importance of access. These Planning Act regulations, as amended, take a significant step in assuring that planning agencies, in both plan development and certificate of need review, recognize the needs of minorities and the handicapped as well as others who have traditionally experienced difficulty in obtaining equal access to health services. Although the proposed guidelines on medically underserved populations, transmitted on September 18, 1979 from Colin C. Rorrie, Jr., Ph.D., Director of the Bureau of Health Planning, are an important step in giving guidance on how planning agencies should address the interests of those traditionally denied access, the guidelines lack the specificity which we feel is necessary to enable planning agencies to achieve this most important objective. The following comments and illustrations are our attempt to amplify the proposed guidelines to assist planning agencies in fulfilling this important segment of their statutory and regulatory obligation.

II. Recommendation for Additional Civil Rights Guidelines Mandated by P.L. 93-641 and P.L. 96-79

A. OCR Comments re: Guidelines for PLAN DEVELOPMENT - (page 3)

The 1979 amendments to the Planning Act, when considered together with certain provisions in the original Planning Act as enacted in 1974, support the need for specific guidelines that address plan development with respect to the medically underserved. The Congressional findings which introduce the 1974 Planning Act begin with the following finding: "The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government" (§2(a)(1) of the 1974 Planning Act, emphasis added). Congress states in §1502 (1) "provision of primary care services for medically underserved populations ..." as the first of the national health priorities which deserve "priority consideration" by Federal, State, and area health planning programs. Further, §1513(a)(2) of the 1974 Planning Act lists "increasing accessibility (including overcoming geographic, architectural, and transportation barriers)..." as a primary responsibility of health systems agencies.

medically underserved persons in the area. Note, however, that projected need may be greater if the medically underserved are at higher risk for particular health problems. Meeting the needs of high risk populations must be considered a top priority in planning, and specific steps to address the needs of high risk populations must be set forth as a distinct plan to ensure provision of appropriate care.

* Section 1513(b)(1) of the Planning Act mandates the types of data that planning agencies must assemble and analyze in the performance of their health planning and resource development functions, including plan development. To adequately address the needs of the medically underserved, planning agencies must assemble and analyze existing data according to race, sex, income, age, handicap status, and method of reimbursement. Today, the vast majority of planning agency patient-origin studies do not include race or method of payment characteristics. The mandatory collection of such data is critical if the health needs and access problems confronted by the medically underserved are to be accurately identified.

* Congress has mandated, through the 1979 amendments to §1513(b)(2) and §1524(c)(2)(A) of the Planning Act, that the Health Systems Plan (HSP) and State health Plan (SHP) "state the extent to which existing health care facilities are in need of modernization, conversion to other uses, or closure and the extent to which new health care facilities need to be constructed or acquired." The collection and analysis of this additional data will serve as an important tool in making those determinations in a manner consistent with the needs of the medically underserved. Further, in making those determinations, planning agencies must consider the accessibility as well as the availability of facilities and services to the medically underserved population. In plan development, currently existing or proposed facilities should be judged by, among other criteria, their current or potential contribution in meeting the needs of the medically underserved, including the accessibility of the facility or service to this population.

* Finally, in compiling information on the status of the area's health care delivery system and the use of that system, the plan should be cognizant of and fully consider the performance of Hill-Burton facilities in meeting their obligations for free and below cost care and community service. Although planning agencies should not determine compliance themselves, noncompliance or a pending investigation should be considered in plan development.

B. OCR's Comments re: Guidelines For Reviews (p. 6)

As mentioned above, the recent amendment to §1532(c) (6)(E) of the Planning Act (criteria for review of proposed health system changes) and the amendment to §1513(g)(3) (appropriateness reviews) places a significant additional responsibility upon planning agencies to assure that new and existing services and facilities are accessible to medically underserved populations. The lengthy and explicit legislative history in both the Senate and the House, set forth below, makes clear the need for specific guidelines to implement the new and important review criteria:

In the 1979 amendments to the Planning Act, Congress amended §1501(b)(1) to require that the Secretary, in issuing national health planning guidelines, include standards reflecting "the unique needs of circumstances and needs of medically underserved populations in isolated rural communities. These guidelines are to be considered by health systems agencies in plan development (§1513(b)(2)). The conference report notes that §1501(b)(1), as amended, conforms to the Senate bill. (H.R. Conference Report No. 96-420, 96th Congress 1st Sess. 56 (1979.) The legislative history makes clear that the Senate intended that the standards developed include consideration of the following circumstances: "geographic and transportation barriers; financial barriers for persons on Medicaid, Medicare, State, or local assistance; patients unable to provide preadmission deposits; and patients unable to pay for services; admission barriers for patients without doctors; communication barriers; and informational, educational or cultural barriers." S. Rep. 96-96, 96th Congress, 1st Sess. 54 (1979).

When these various provisions in the Planning Act, as amended, are considered together, the mandate for clarifying guidelines for plan development for medically underserved populations becomes clear. We feel our analysis below appropriately reflects the Congressional intent and that the HSA plan development guidelines should address these important concerns in the following manner:

* Planning agencies must be given guidance in determining (1) those who are medically underserved and (2) the health needs of the medically underserved. Plans developed by HSAs and SHPDAs must identify and address the unique needs of medically underserved populations and must be population-specific (e.g., they must identify those who compose low-income groups, women, the aged, minorities, and the handicapped in the area and their specific needs for facilities and services).

  In special population planning, planning agencies must consider both current utilization data and projection of needs for the medically underserved. For example, planning agencies may consider current utilization data as one relevant indicator in meeting this goal. However, planning agencies cannot assume that the medically underserved utilize health services and facilities to the full extent of their need. Accordingly, demographic and medical indicators of need (e.g., population projections by age, sex, income and educational levels; mortality by age and selected cause; fetal, neonatal, perinatal and infant deaths; average length of stay; fertility rates; morbidity data), where available, must be broken down by race and analyzed to project the needs of the medically underserved. Specifically, on the basis of such information and other information that a planning agency may consider relevant, the agency must determine with regard to the medically underserved: 1) health status vis-a-vis the rest of the population; 2) appropriate target ratios of population to facilities or services (e.g., beds/thousand); and 3) specific kinds of services and facilities that are most needed by the medically underserved population.

* Projected need for facilities and services by the medically underserved, [illegible] the plan must at least approximate the proportion of

"The denial of access to low-income and minority persons has been a focus of increasing concern to the committee. The extent of this problem has been documented in a report of the Congressional Budget Office and in testimony from the Georgia Legal Services Corp. While health care costs have continued to rise at an alarming rate, there has been a simultaneous recognition that many individuals still do not have access to basic health care. In many communities according to testimony received, women are compelled to agree to sterilization procedures before providers are willing to provide other treatment. In many other communities, such basic services as obstetric and gynecological services are simply unavailable under any circumstances.

Congress established as one of the functions of the health systems agency to increase the accessibility of health services. Certificate of need and section 1122 review are therefore to be conducted on the basis of the *general need in the community* for the health service to be provided. *The person proposing a particular service, however, may by policy or practice exclude significant portions of the consumer community from access to the facility.* The need for the health services *should therefore only be considered in light of the population which may be ultimately served by the facility.*" [S. Rep. No. 96-96, 96th Congress, 1st Sess. 79 (1979), emphasis added.]

"... the committee endorses the Department's efforts to require health planning agencies through their project review authority *to focus on issues of access to facilities* and *to address specifically* the contribution of the project in meeting the needs of minorities, women, and handicapped individuals in the health service area." [Id. at 70, emphasis added.][5]

... the planning agency should consider whether or not health services will be available *to all of the residents of an area in need of such services.* The Committee included this criterion because it received disturbing testimony that the services of numerous health care institutions are not accessible to some racial and lower income groups. The Committee notes that such alleged discrimination or selective admissions is in violation of title VI of the Civil Rights Act for institutions which have received Federal construction support under titles VI or XVI of the Public Health Service Act such policies or actions do not comply with assurances made by the institution that the facility will be available to all persons residing or employed in the areas served by the facility, and potentially do not comply with assurances made by the institution that a reasonable volume of services will be made available to persons who are unable to pay for them. This criterion expresses the Committee's belief that *one of the primary purposes of the planning program is to increase and improve access to health care services.* *It*

> *requires the HSA to be cognizant of and thoroughly consider all circumstances, including those cited above*, *which pose barriers to access to health care services or facilities in the area*. In implementing this criterion, though, the Committee does not intend or expect an HSA to carry out HEW's enforcement or compliance responsibilities under title VI of the Civil Rights Act or titles VI and XVI of the Public Health Service Act." [H.R. Rep. No. 96-190, 96th Congress 1st Sess. 73 (1979) emphasis added.]

If planning agencies are to consider and be cognizant of these access problems in performing their review functions, significant changes in the HRA draft guidelines are necessary. Our suggestion for guidelines sufficient to meet this clear Congressional mandate follow:

- Specific guidance must be given to assure that these new criteria are fully considered in the review process. To assist planning agencies in achieving this goal, examples of accessibility and inaccessibility must be set forth in the guidelines. Relevant inquiries would include the following: does a significant portion of the medically underserved population participate in federally funded third party reimbursement programs such as Medicaid and Medicare? Does the applicant participate in those programs? Do staff physicians with admitting privileges admit Medicare and Medicaid patients? Does the applicant facility offer alternative access routes such as clinic or emergency room physician referral and admission? Was the applicant facility or a portion thereof constructed with Hill-Burton funds? If so, has it complied with its requirements to provide free and below cost care? Has it complied with its community service assurance? (*See* H.R. Rep. No. 96-190, 96th Congress, 1st Session re: the Health Planning and Resource Development Act Amendments of 1979.)

- If an application for a new facility or service or for a reduction in services is made by a facility that is determined under the above criteria to be inaccessible to the medically underserved population in the area, or is likely to be inaccessible in the future (e.g., hospital relocation or reductions), planning agencies must require that the applicant set forth affirmative steps (consistent with §1527(a)(2)(A), as amended) to guarantee accessibility.

- To facilitate adequate planning agency review of the "access criteria" planning agencies must require applicants to submit the following information with the application:

  1. The composition of the population of the applicant's actual or potential service area by race, income, sex, age, handicap, and method of payment. The term "actual service area" must include not only those areas from

which the facility derives the majority of its patients but must include areas from which the facility would derive patients if, in fact, it were accessible to the medically underserved.

2. Current patient data (inpatient, outpatient, and emergency room) by zip code, race, sex, age, handicap, and method of payment. This data must further be broken down into separate service components (i.e., pediatrics, intensive care, etc.) by number of patient days and types of services rendered.

3. Data must be supplied on the linguistic composition of the service area. Where a group of limited English-speaking persons comprises 100 persons or 5 percent of the service area, data on bilingual staff by service (i.e., emergency room, social service) must be supplied.

4. Where data supplied by the applicant reveals a discrepancy between the number of medically underserved in the patient population and the service area, the applicant must submit specific affirmative steps that it intends to take to make its current and proposed facility accessible to the medically underserved population.

* Similar information must be gathered and analyzed in performing appropriateness reviews.

* Planning agencies must additionally determine any adverse impact that the proposed facility or service may have upon the medically underserved and take steps to alleviate such impact prior to giving a favorable recommendation or actual approval.

III. Conclusion

I believe that HRA guidelines incorporating the substance of the comments set forth above are essential to adequately implement the civil rights-related provisions of the Health Planning Act. The HRA guidelines as currently proposed are, in my view, insufficient to enable health planning agencies to fulfill obligations with respect to ensuring access for medically underserved populations. I would appreciate if you would consider these changes. Unless substantial modifications are made in the guidelines, I am inclined to recommend, as the head of OPRA, that OCR non-concur in the issuance of the guidelines.

If you have any questions, please call me at 245-6128.

WILBERT A. CHEATHAM
Wilbert A. Cheatham

OFFICE THE SECRETARY

TO : Henry A. Foley, Administrator
Health Resources Administration

DATE: OCT 2 1979

FROM : Bruce Mayor
Deputy Director
Office of Standards, Policy & Research

SUBJECT: Guidelines on Underserved Population Groups - (Memorandum of Sept. 18, 1979)

We have reviewed the revised <u>Guidelines on Underserved Population Groups</u> sent to me from Colin C. Rorrie, Jr., Ph.D. on September 18, 1979. Our review was limited to issues presented to your staff by Burton M. Taylor and Edward Redman on August 14, 1979 and my memo to you of that date.

Although Dr. Rorrie's covering memo identifies your Guidelines as representing a revision of Civil Rights Guidelines originated by our office, it is our view that they represent general and limited guidance on aspects of P.L. 93-641 as these pertain to the underserved population groups. While these are not unrelated to civil responsibilities under Title VI and Section 504, they do not accomplish the intended purpose of the joint HRA/OCR guidelines as originated by OCR. They are, as captioned, guidelines under P.L. 93-641 and not civil rights guidelines.

As discussed with your staff on August 14th, our comments on your March draft were from the perspective as to whether your guidelines would conflict with our responsibilities to enforce Title VI and Section 504. We did not comment on the sufficiency of the Guidelines to implement P.L. 93-641, or to carry forward your agency's civil rights responsibilities in implementing its health planning programs. The responsibility for providing such guidance rests with our Office of Program Review and Assistance.

Our comment on your revised Guidelines is also limited to the perspective of their possible conflict with our responsibilities and the extent to which the revision is responsive to our earlier comment. While we find certain changes are responsive, not all of our concerns have been met.

1. Although the revised guidelines do include reference to Title VI and Section 504 by indicating that health planning agencies must meet their requirements, we believe that in a footnote, or in the text, the Guidelines should contain an explanatory paragraph to cover Title VI and Section 504 substantially as suggested under comment #1 in our August 14th Memorandum.

2. Although we see in the additional language provided at Section II. B.2.d. on page 4, Section II.B.3.e. on page 5, and Section III.4.c. on page 9 some gain in specificity as suggested under our Comment #2 in our August 14th Memorandum, these do not suffice to provide the specificity we were suggesting. We recognize from the August 20, 1979 Memorandum from Dr. Robinson to you, and the discussions on August 14th, that HRA believed that it could not go further in this regard. Nevertheless, we believe that the guidelines should go further in providing specific guidance on how the general responsibilities of health planning agencies should be met.

3. Your revision has deleted Section III.2. of the March guidelines, as we requested. The further thrust of our Comment #3 in regard to data has not been met. We had urged that reference should be made to the use of the standardized Government racial and ethnic categories. While the Guidelines do, as Dr. Robinson points out, address minimally the matter of patient and demographic information to be furnished by grant applicants, data essential to other health planning processes remains unspecified.

4. We note that the revision of the letter of findings item at Section III.5. on page 8 commits OCR to "provide background materials to support the determination of noncompliance." That portion of the last sentence in Section III. 3. must be deleted. We have already requested Mr. John Poore, Deputy Director of our Office of Management and Administration to develop a system for furnishing letters of findings of non compliance to SHPDAs and HSAs in consultation with your office (memo attached). Otherwise, we note that our comment #4 on the need for further explanation of the letter of findings matter has not been accomplished in the revision from the earlier draft.

The revised draft, in paragraph 2 of the Introduction, states: "Health planning agencies must also meet these requirements and separate guidelines pertaining to these provisions which will be published by the Department's Office for Civil Rights." We request that the underlined portion of this sentence be deleted. The exact mode and format for providing policy interpretations applicable to health planning agencies has not been finally determined.

As indicated above, these and our previous comments are based solely on whether these Guidelines may conflict with OCR policy. We have provided a copy of the Guidelines and this memorandum to Gus Cheatham, Deputy Director of our Office of Program Review and Assistance. His Office will evaluate the Guidelines from the broader perspective of whether the Guidelines as revised fulfill the obligations of health planning agencies under P.L. 93-641 from a civil rights standpoint. Mr. Cheatham's telephone number is 245-6128.

Attachments

1. Memo to John Poore
2. My memo of August 14 with attachments

DEPARTMENT (HEALTH, EDUCATION, AND V FARE

John Poore, Deputy Director for Management
and Administration

Bruce Mayor, Deputy Director, Standards /s/ 2-17-79
Policy and Research

Health Planning Agencies Guidelines

As indicated in the attached material, the Health Resources Administration is going to issue guidelines describing the responsibilities of health planning agencies in implementing Public Law 93-641. As indicated in Section III-4 of the attached draft, the guidelines call for health planning agencies to consider OCR letters of finding of non-compliance to health care provider institutions in carrying out their responsibilities. In order to implement this portion of the guidelines, OCR needs to develop a procedure by which it will furnish copies of pertinent LOFs to health planning agencies.

My staff is working with staff of the Health Resources Administration in connection with those aspects of their proposed guidelines which pertain to civil rights policy. I am requesting that your office assume responsibility for developing the procedure referred to in the previous paragraph.

Dr. William Robinson of the Health Resources Administration, (436-7216), is coordinating this matter. Please communicate directly with him on this and keep us informed of your action.

Thanks for your cooperation.

Attachment

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : Henry A. Foley, Administrator
Health Resources Administration

DATE: 14 AUG 1979

FROM : Bruce Mayor, Deputy Director for /s/ Bruce Mayor
Standards, Policy and Research
Office for Civil Rights

SUBJECT: Guidelines Covering Planning for Underserved Populations Under P.L. 93-641 (Your August 2 memorandum)

David Tatel has requested that I reply to your August 2 memorandum in which you enclose proposed Guidelines Covering Planning for Underserved Populations Under P.L. 93-641 (Guidelines). Because of close relationship between certain portions of the Guidelines and requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, Office for Civil Rights staff had hoped that we could issue joint guidelines under the authority of P.L. 93-641 and the civil rights statutes. While we continue to see advantages to issuing joint guidelines, we do not believe that this approach is necessary. As discussed with Dr. William A. Robinson of your staff, attached are our comments on your Guidelines. Burton M. Taylor and Edward Redman will meet with Dr. Robinson and other members of your staff on August 15 to discuss this matter.

I regret any misunderstanding or lack of responsiveness on our part which may have occurred in the past and hope that you find our comments to be constructive. Should any communications problems arise in the future, please let me know.

Attachment

ATTACHMENT

OCR Comments on Guidelines Covering Planning for Underserved Populations Under P.L. 93-641

(Copy received with Dr. Henry A. Foley's August 2, 1979 memorandum)

1. In light of the close relationship of many portions of the Guidelines to requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, the Guidelines should contain a statement which explains its relationship to these statutes. For example:

   > Health planning agencies subject to these guidelines must also comply with the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, as amended. Title VI requires that recipients of Federal financial assistance offer their benefits and services without discrimination on the basis of race, color, or national origin. Section 504 prohibits discrimination on the basis of handicap in federally assisted programs and activities. The Title VI regulation, Nondiscrimination In Federally Assisted Programs, is codified at 45 CFR Part 80. The Section 504 regulation, Nondiscrimination on the Basis Of Handicap is codified at 45 CFR Part 84. These regulations require that a state agency ensure that its methods of administration do not have the effect of perpetuating discrimination by another recipient which is an agency of the same state. In addition, the Office for Civil Rights which administers these statutes, periodically issues guidelines and policy interpretations that explain particular requirements of the statutes and regulations as they apply to health planning agencies and other institutions for which OCR has compliance responsibility.

2. The Guidelines provide a good statement of the general responsibilities of health planning agencies in identifying and planning for the health care needs of disadvantaged and underserved populations, including minorities, women, handicapped and the elderly; however, it provides little specific guidance as to how these responsibilities should be met. For example, appropriate action to meet the responsibilities to provide services to limited English speaking individuals and handicapped persons are not discussed, nor are procedures identified to ensure that proposed closure or conversion of hospitals do not adversely affect disadvantaged populations. Title VI is relevant to these issues.

Attachment

3. Data requirements should be stated with more specificity. Data should be collected by national origin as well as race, sex and age in conformance with standardized Government racial and ethnic categories. The Office for Civil Rights does not have information referred to in III 2 of the Guidelines. We would expect that the National Center for Health Statistics as well as HRA and HCFA would be able to provide relevant data. OCR will provide any relevant data which it collects in the future. Here too, there is a close connection between these Guidelines and what may be required under Title VI and Section 504.

4. The reference to Office for Civil Rights letters of finding in III 4 should be explained further and a procedure needs to be established by which OCR furnishes these letters to the appropriate agencies on a regular basis.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
OFFICE OF THE ADMINISTRATOR

DATE: AUG 02 1979

TO Director
Office for Civil Rights, OS

OSPR - Bruce Mayor to
call Henry Foley by
COB, Mon., 8/6

FROM Administrator

cy to Tatel, Brown, Cheatham

SUBJECT: Guidelines Covering Planning for Underserved Populations Under P.L. 93-641

Please find enclosed a document entitled "Guidelines Covering Planning for Underserved Populations Under P.L. 93-641." A draft of these Guidelines was initially sent to the Office for Civil Rights on March 15 for review and comment by May 1. Subsequent to the May 1 date, we have requested a response from your office on numerous occasions, the latest contained in a memorandum dated July 6.

We now feel that this matter should proceed without further delay. Since your lack of response would indicate that no serious revisions are required, I am requesting my staff to prepare public release of the HRA Guidelines on or before August 8.

Henry A. Foley
Henry A. Foley, Ph.D.

Enclosure

Note: In checking I found out that I did not have a control on this because it came to CR apparently informally.

Gus Cheatham's office had nothing.
Peter Jacobson said the 7/6 memo came to him from Clay Simpson, and that he had responded by phone and then informed Ed Remdond that we needed to get back with comments. Ed Remdond is preparing critical comments and Peter Jacobson prepared some critical comments.

Pat ghes 8/3

GUIDELINES COVERING PLANNING FOR UNDERSERVED POPULATIONS UNDER P.L. 93-641

I. INTRODUCTION

Over the past two years, the Department has given special emphasis to the concerns of disadvantaged and underserved populations, minorities, women, handicapped and the elderly. This attention has been evident in many of the recent proposed regulations under Titles XV and XVI of the Public Health Service Act.

The purpose of these Guidelines is to give special consideration to the Department's emphasis as it pertains to the activities to be carried out under the National Health Planning and Resources Development Act (P.L. 93-641). These particular Guidelines focus on plan development and project review. In the case of plan development much of the material is taken from the recently issued guidelines on plan development. It is anticipated that there will be additional guidelines in the future covering other topics germane to this overriding concern.

In giving attention to the issue of civil rights and P.L. 93-641, through these guidelines, a special point needs to be made regarding the public forum offered through the health planning agencies established under the PHS Act. Specifically, the health systems agency and the statewide health coordinating council and the public processes they foster offer a unique opportunity to address the special needs of disadvantaged populations. Pursuit of the forum and the taking of positive steps to realize the potential that exists are important for making significant inroads into access concerns in the health area.

In general, it is important to stress the Federal expectation that planning bodies will evidence a consistent record of providing appropriate emphasis in their activities to the needs of underserved population groups.

II. GUIDELINES FOR SPECIAL POPULATION PLAN DEVELOPMENT BY HEALTH PLANNING AGENCIES

A. Plans developed by SHPDAs and HSAs should be population-based to the extent possible. This requires identifying those within the population who are medically underserved, low-income, women, aged, minorities and handicapped, and then giving them special consideration in the development and implementation of plans. Special consideration also should be given to the needs of any people or sub-groups of the population who have unique problems or service needs that are not being met. This section establishes goals for the health planning agencies to attempt to achieve. It is not intended as a second set of guidelines for plan development, but rather complements the Guidelines for the Development of Health Systems Plans and Annual Implementation Plans. For additional information on plan development, the February 12, 1979, edition of the aforementioned document should be the primary source. Some areas in which the HSP/AIP guidelines focus on the special needs of underserved populations may be found on pages 2, 4, 20 and 25.

B. Plan Development

1. Section 1513 of the Act prescribes for each HSA that:

   "The Agency shall assemble and analyze data concerning —
   (A) the status (and its determinants) of the health of the residents of its health service area,
   (B) the status of the health care delivery system in the area and the use of that system by the residents of the area,
   (C) the effect the area's health care delivery system has on the health of the residents of the area,
   (D) the number, type, and location of the area's resources including health services, manpower, and facilities,
   (E) the patterns of utilization of the area's health resources, and
   (F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.
   In carrying out this paragraph, the agency shall, to the maximum extent practicable, use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 316(e)."

   For each of these data areas, the planning agencies should, to the maximum extent possible, assemble and analyze existing data according to race, sex, income, age, and handicap status.

2. The agencies should develop a system for evaluating the needs of the above groups and include corrective measures in the health plan:

   a. All health plans (e.g., AIP, HSP, SHP, SMFP, etc.) should consider and include facts, findings, and recommendations relating to the health care needs of all of the target groups;

b. The agencies should evaluate the existing and projected health care needs of these groups, where they are being met, where not, and ways to improve delivery of services to them;

c. Where high risk can be determined, it should be considered a potential priority in planning. For example, if a minority group has high infant mortality rate, specific steps should be identified in planning to deal with the problem;

d. Where the collected data indicate a discrepancy between need and service utilized, planning should take steps to alleviate this. Use of these health services by target groups should be proportionate to their population and to their medical needs. Where high risk (or special need) has been identified, special plans should be specified to ensure the provision of appropriate care. For instance, since blacks are at high risk for sickle cell anemia, infant mortality, and tuberculosis, their proportionate usage of treatments for these diseases should be high. Also, if treatment for a high risk is not available, plans should reflect the need for such services and propose possible alternative solutions to such deficits.

3. Plans should identify existing health resources and address any disparities in availability and accessibility of each health service for the above groups. Any disparities or disproportionate effects of service delivery should be identified and corrective measures proposed in the plans.

a. Types of care, methods of payments, and types of services should be considered in relation to access for the target groups covered by these provisions.

b. HSAs are expected to establish the unique needs of their sub-populations by the analysis of small geographic areas (such as medically underserved urban or rural areas, mental health catchment areas, etc.) and population groups.

c. Plans should be written with consideration of barriers to equal access, such as physical barriers, communication barriers (i.e., no bilingual communications), discriminatory patterns or practices, continuing racial identifiability, or transportation inaccessibility. Plans should identify accessibility to each service and resource for those in need, e.g., 1) Is adequate public transportation available?

2) Are enough facilities open at hours to accomodate the various groups? 3) Are health care services accessible to mobility impaired persons? 4) Are home health care services available?

d. In areas of a concentrated limited English speaking population, plans should address the need for bilingual communications.

e. If health services offered are not used in proportion to the identified needs of the underserved, plans should suggest outreach efforts that providers could consider employing in order to increase utilization, awareness of services and preventive medicine. The HSA should take steps to reach out and secure the involvement of organizations likely to be affected by the plans, with special emphasis on involving minority organizations and organizations of the handicapped. In addition, plans should include specific guidance on corrective measures.

f. Plans which include proposed closure or conversion of hospitals or other health facilities should give special attention to the potential impact of such actions on access to health care for disadvantaged populations.

III. GUIDELINES FOR REVIEW

Reviews include all reviews conducted by HSAs and SHPDAs under Title XV of the Public Health Service Act: Certificate of Need, Section 1122 of the Social Security Act, Review and Approval of Proposed Uses of Federal Funds, and Appropriateness Review of Existing Institutional Services.

1. The planning agencies are required to conduct their reviews using criteria which they adopt through an open public process. Each agency should, in designing their process, make sure that disadvantaged and underserved groups are aware of the opportunity to help develop criteria and are invited to do so. The PHS Act and regulations establish minimum consideration with must be included in criteria which are adopted. Agencies may adopt additional criteria through the same open public process. The considerations required in adopted certificate of need review criteria are below. Similar considerations are required for the other types of reviews. The following criteria are included in project review considerations: "(3)(i) The need that the population served or to be served has for the services proposed to be offered or expanded, and the extent to which low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups are likely to h[illegible] [illegible]ccess to those services.

(ii) In the case of a reduction or elimination of a service including the relocation of a facility or a service, the need that the population presently served has for the service, the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups to obtain needed health care ....

(4) The availability of less costly or more effective alternative methods of providing the services to be offered, expanded, reduced, relocated, or eliminated ....

(13) The contribution of the proposed new institutional health service in meeting the health related needs of members of medically underserved groups and groups which have traditionally experienced difficulties in obtaining equal access to health services (for example, low income persons, racial and ethnic minorities, women, and handicapped persons); particularly those needs identified in the applicable health systems plan and annual implementation plan deserving of priority."

2. The Office for Civil Rights will attempt to make data available to the health planning agencies as soon as possible on the use of provider's services by race, sex, and age. These data will be sought from sources such as the Hospital Uniform Discharge Data effort. The planning agency, in undertaking reviews, should employ these and other data as they relate to the review criteria above.

3. If an application proposes to serve an area where a significant percentage of the residents that are English speaking is limited, the need for bilingual communications should be evaluated in various services such as emergency rooms and outpatient clinics. As a general rule, five percent of the population is a significant amount, although the figure may sometimes be smaller.

4. If OCR has issued a "letter of findings" to a provider institution of violation of civil rights laws, the health planning agencies should consider these findings in the review of any application from the institution. OCR will provide the health planning agencies with copies of these letters.

5. The planning agencies should require each applicant to supply the following information with its application:

   a. The composition of the population of the applicant's actual service area by race, sex, and age.

The number of patients currently served by its existing services according to the above characteristics. If the data is available, applicants should be required to provide breakdowns by method of payment and by inpatient, and emergency room categories.

MEMORANDUM DEPARTMENT OF HEAL EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO Henry A. Foley, Administrator DATE. 9-12-79
Health Resources Administration
THRU : David S. Tatel, Director
Office for Civil Rights

FROM : Deputy Director
Office for Civil Rights
Office of Program Review and Assistance

SUBJECT: Guidelines on Underserved Population Groups (Memorandum of September 18, 1979)

I. Background

As you are aware, Bruce Mayor, OCR's Deputy Director for Standards, Policy and Research (OSPR) has commented on the above referenced guidelines. (See attached memoranda of August 4, 1979 and October 2, 1979.) His critique focused on the question of whether HRA's proposed guidelines conflicted with OCR's responsibility to enforce Title VI and Section 504 or would interfere with OCR's ability to place further requirements on HSAs and SHPDAs under the authority of Title VI and Section 504.

My office, however, has a somewhat broader interest in the proposed HRA guidelines. As you may know, OCR's Office of Program Review and Assistance (OPRA) has the responsibility to coordinate and assist in the Department-wide initiative to incorporate civil rights into the program operations of the POCs and to provide technical assistance and support services to the POCs for civil rights policy implementation. As part of the Memorandum of Understanding (MOU) signed by Dr. Richmond on July 16, 1979, and approved by former Secretary Califano on July 27, 1979, the Public Health Service agreed to "[i]ncorporate civil rights concerns into regular program review and audit activities to assure that benefits and services are delivered equitably to eligible minorities, women and handicapped persons" and to "[r]eview, in cooperation with OCR, program regulations, directives and instructions to assure support for the Department's civil rights authorities." One of the specific management objectives approved by Dr. Richmond as an FY 80 activity to implement the civil rights initiative calls for PHS "[t]o integrate Title VI and Section 504 into Health System Agency (HSA) and State Health Planning and Development Agency (SHPDA) programs."

Under our responsibility to incorporate civil rights into the program operations of the POCs, we have set forth below our supplementary comments to OCR's earlier critique. Our comments are designed to address the sufficiency of HRA's proposed guidelines in implementing the civil rights-related requirements of P.L. 93-641 and P.L. 96-79.

The goals of P.L. 93-641 are certainly compatible with, and in many ways similar to, the goals of the civil rights statutes. Specifically, in the 1974 National Health Planning and Resources Development Act, Congress recognized the significant contribution that planning agencies could and must make toward the achievement of "equal access to health care". (§2(a)(1) of P.L. 93-641, as amended.) The 1979 Planning Act reemphasizes that view and further elaborates on it by the addition of project review criteria for new health services addressing "the extent to which proposed services will be accessible to all the residents of the area to be served by such services." (§1532(c)(6)(E) of the Planning Act, as amended.) Similar amendments include "accessibility" as a criterion in appropriateness reviews. (§1513(g)(3) and §1523(a)(6) of the Planning Act, as amended.)

HRA's recently issued regulations (April 7, 1979) have also recognized the importance of access. These Planning Act regulations, as amended, take a significant step in assuring that planning agencies, in both plan development and certificate of need review, recognize the needs of minorities and the handicapped as well as others who have traditionally experienced difficulty in obtaining equal access to health services. Although the proposed guidelines on medically underserved populations, transmitted on September 18, 1979 from Colin C. Rorrie, Jr., Ph.D., Director of the Bureau of Health Planning, are an important step in giving guidance on how planning agencies should address the interests of those traditionally denied access, the guidelines lack the specificity which we feel is necessary to enable planning agencies to achieve this most important objective. The following comments and illustrations are our attempt to amplify the proposed guidelines to assist planning agencies in fulfilling this important segment of their statutory and regulatory obligation.

II. Recommendation for Additional Civil Rights Guidelines Mandated by P.L. 93-641 and P.L. 96-79

A. OCR Comments re: Guidelines for PLAN DEVELOPMENT - (page 3)

The 1979 amendments to the Planning Act, when considered together with certain provisions in the original Planning Act as enacted in 1974, support the need for specific guidelines that address plan development with respect to the medically underserved. The Congressional findings which introduce the 1974 Planning Act begin with the following finding: "The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government" (§2(a)(1) of the 1974 Planning Act, emphasis added). Congress states in §1502 (1) "provision of primary care services for medically underserved populations ..." as the first of the national health priorities which deserve "priority consideration" by Federal, State, and area health planning programs. Further, §1513(a)(2) of the 1974 Planning Act lists "increasing accessibility (including overcoming geographic, architectural, and transportation barriers)..." as a primary responsibility of health systems agencies.

In the 1979 amendments to the Planning Act, Congress amended §1501(b)(1) to require that the Secretary, in issuing national health planning guidelines, include standards reflecting "the unique needs of circumstances and needs of medically underserved populations in isolated rural communities." These guidelines are to be considered by health systems agencies in plan development (§1513(b)(2)). The conference report notes that §1501(b)(1), as amended, conforms to the Senate bill. (H.R. Conference Report No. 96-420, 96th Congress 1st Sess. 56 (1979.) The legislative history makes clear that the Senate intended that the standards developed include consideration of the following circumstances: "geographic and transportation barriers; financial barriers for persons on Medicaid, Medicare, State, or local assistance; patients unable to provide preadmission deposits; and patients unable to pay for services; admission barriers for patients without doctors; communication barriers; and informational, educational or cultural barriers." S. Rep. 96-96, 96th Congress, 1st Sess. 54 (1979).

When these various provisions in the Planning Act, as amended, are considered together, the mandate for clarifying guidelines for plan development for medically underserved populations becomes clear. We feel our analysis below appropriately reflects the Congressional intent and that the HRA plan development guidelines should address these important concerns in the following manner:

- * Planning agencies must be given guidance in determining (1) <u>those who are medically underserved</u> and (2) <u>the health needs of the medically underserved</u>. Plans developed by HSAs and SHPDAs must identify and address the unique needs of medically underserved populations and must be population-specific (e.g., they must identify those who compose low-income groups, women, the aged, minorities, and the handicapped in the area and their specific needs for ~~facilities~~ and services) in various settings.

- * In special population planning, planning agencies must consider both current utilization data and projection of needs for the medically underserved. For example, planning agencies may consider current utilization data as one relevant indicator in meeting this goal. However, planning agencies cannot assume that the medically underserved utilize health services and facilities to the full extent of their need. Accordingly, demographic and [illegible] ~~medical~~ indicators of need (e.g., population projections by age, sex, income and educational levels; mortality by age and selected cause; fetal, neonatal, perinatal and infant deaths; average length of stay; fertility rates; morbidity data), where available, must be broken down by race and analyzed to project the needs of the medically underserved. Specifically, on the basis of such information and other information that a planning agency may consider relevant, the agency must determine with regard to the medically underserved: 1) health status vis-a-vis the rest of the population; 2) appropriate target ratio [illegible] population to facilities or services (e.g., beds/ -thousand); and 3) specific kinds of services and ~~facilities~~ settings that are most needed by the medically underserved population. settings

[illegible] each

- * Projected need for facilities and services by the medically underserved, as set forth in the plan, must at least approximate the proportion of medically underserved persons in the area. Note, however, that projected need may be greater if the medically underserved are at higher risk for particular health problems. Meeting the needs of high risk populations must be considered a top priority in planning, and specific steps to address the needs of high risk populations must be set forth as a distinct plan to ensure provision of appropriate care. ?

* Section 1513(b)(1) of the Planning Act mandates the types of data that planning agencies must assemble and analyze in the performance of their health planning and resource development functions, including plan development. To adequately address the needs of the medically underserved, planning agencies must assemble and analyze existing data according to race, sex, income, age, handicap status, and method of reimbursement. Today, the vast majority of planning agency patient-origin studies do not include race or method of payment characteristics. The mandatory collection of such data is critical if the health needs and access problems confronted by the medically underserved are to be accurately identified.

* Congress has mandated, through the 1979 amendments to §1513(b)(2) and §1524(c)(2)(A) of the Planning Act, that the Health Systems Plan (HSP) and State Health Plan (SHP) "state the extent to which existing health care facilities are in need of modernization, conversion to other uses, or closure and the extent to which new health care facilities need to be constructed or acquired." The collection and analysis of this additional data will serve as an important tool in making those determinations in a manner consistent with the needs of the medically underserved. Further, in making those determinations, planning agencies must consider the accessibility as well as the availability of facilities and services to the medically underserved population. In plan development, currently existing or proposed facilities should be judged by, among other criteria, their current or potential contribution in meeting the needs of the medically underserved, including the accessibility of the facility or service to this population.

* Finally, in compiling information on the status of the area's health care delivery system and the use of that system, the plan should be cognizant of and fully consider the performance of Hill-Burton facilities in meeting their obligations for free and below cost care and community service. Although planning agencies should not determine compliance themselves, noncompliance or a pending investigation should be considered in plan development.

B. OCR's Comments re: Guidelines For Reviews (p. 6)

As mentioned above, the recent amendment to §1532(c)(6)(E) of the Planning Act (criteria for review of proposed health system changes) and the amendment to § [illegible] (g)(3) (appropriateness reviews) places a significant additional responsibility upon planning agencies to assure that new and existing services and facilities are accessible to medically underserved populations. The lengthy and explicit legislative history in both the Senate and the House, set forth below, makes clear the need for specific guidelines to implement the new and important review criteria:

"The denial of access to low-income and minority persons has been a focus of increasing concern to the committee. The extent of this problem has been documented in a report of the Congressional Budget Office and in testimony from the Georgia Legal Services Corp. While health care costs have continued to rise at an alarming rate, there has been a simultaneous recognition that many individuals still do not have access to basic health care. In many communities according to testimony received, women are compelled to agree to sterilization procedures before providers are willing to provide other treatment. In many other communities, such basic services as obstetric and gynecological services are simply unavailable under any circumstances.

Congress established as one of the functions of the health systems agency to increase the accessibility of health services. Certificate of need and section 1122 review are therefore to be conducted on the basis of the general need in the community for the health service to be provided. The person proposing a particular service, however, may by policy or practice exclude significant portions of the consumer community from access to the facility. The need for the health services should therefore only be considered in light of the population which may be ultimately served by the facility." [S. Rep. No. 96-96, 96th Congress, 1st Sess. 79 (1979), emphasis added.]

"... the committee endorses the Department's efforts to require health planning agencies through their project review authority to focus on issues of access to facilities and to address specifically the contribution of the project in meeting the needs of minorities, women, and handicapped individuals in the health service area." [Id. at 70, emphasis added.]

"... the planning agency should consider whether or not health services will be available to all of the residents of an area in need of such services. The Committee included this criterion because it received disturbing testimony that the services of numerous health care institutions are not accessible to some racial and lower income groups. The Committee notes that such alleged discrimination or selective admissions is in violation of title VI of the Civil Rights Act for institutions which have received Federal construction support under titles VI or XVI of the Public Health Service Act such policies or actions do not comply with assurances made by the institution that the facility will be available to all persons residing or employed in the areas served by the facility, and potentially do not comply with assurances made by the institution that a reasonable volume of services will be made available to persons who are unable to pay for them. This criterion expresses the Committee's belief that one of the primary purposes of the planning program is to increase and improve access to health care services. It

> requires the HSA to be cognizant of and thoroughly consider all circumstances, including those cited above, which pose barriers to access to health care services or facilities in the area. In implementing this criterion, though, the Committee does not intend or expect an HSA to carry out HEW's enforcement or compliance responsibilities under title VI of the Civil Rights Act or titles VI and XVI of the Public Health Service Act." [H.R. Rep. No. 96-190, 96th Congress 1st Sess. 73 (1979) emphasis added.]

If planning agencies are to consider and be cognizant of these access problems in performing their review functions, significant changes in the HRA draft guidelines are necessary. Our suggestion for guidelines sufficient to meet this clear Congressional mandate follow:

* Specific guidance must be given to assure that these new criteria are fully considered in the review process. To assist planning agencies in achieving this goal, examples of accessibility and inaccessibility must be set forth in the guidelines. Relevant inquiries would include the following: does a significant portion of the medically underserved population participate in federally funded third party reimbursement programs such as Medicaid and Medicare? Does the applicant participate in those programs? Do staff physicians with admitting privileges admit Medicare and Medicaid patients? Does the applicant facility offer alternative access routes such as clinic or emergency room physician referral and admission? Was the applicant facility or a portion thereof constructed with Hill-Burton funds? If so, has it complied with its requirements to provide free and below cost care? Has it complied with its community service assurance? (See H.R. Rep. No. 96-190, 96th Congress, 1st Session re: the Health Planning and Resource Development Act Amendments of 1979.)

* If an application for a new facility or service or for a reduction in services is made by a facility that is determined under the above criteria to be inaccessible to the medically underserved population in the area, or is likely to be inaccessible in the future (e.g., hospital relocation or reductions), planning agencies must require that the applicant set forth affirmative steps (consistent with §1527(a)(2)(A), as amended) to guarantee accessibility.

* To facilitate adequate planning agency review of the "access criteria" planning agencies must require applicants to submit the following information with the application:

    1. The composition of the population of the applicant's actual or potential service area by race, income, sex, age, handicap, and method of payment. The term "actual service area" must include not only those areas from

which the facility derives the majority of its patients but must include areas from which the facility would derive patients if, in fact, it were accessible to the medically underserved.

2. Current patient data (inpatient, outpatient, and emergency room) by zip code, race, sex, age, handicap, and method of payment. This data must further be broken down into separate service components (i.e., pediatrics, intensive care, etc.) by number of patient days and types of services rendered.

3. Data must be supplied on the linguistic composition of the service area. Where a group of limited English-speaking persons comprises 100 persons or 5 percent of the service area, data on bilingual staff by service (i.e., emergency room, social service) must be supplied.

4. Where data supplied by the applicant reveals a discrepancy between the number of medically underserved in the patient population and the service area, the applicant must submit specific affirmative steps that it intends to take to make its current and proposed facility accessible to the medically underserved population. ?

* Similar information must be gathered and analyzed in performing appropriateness reviews.

* Planning agencies must additionally determine any adverse impact that the proposed facility or service may have upon the medically underserved and take steps to alleviate such impact prior to giving a favorable recommendation or actual approval.

III. Conclusion

I believe that HRA guidelines incorporating the substance of the comments set forth above are essential to adequately implement the civil rights-related provisions of the Health Planning Act. The HRA guidelines as currently proposed are, in my view, insufficient to enable health planning agencies to fulfill obligations with respect to ensuring access for medically underserved populations. I would appreciate if you would consider these changes. Unless substantial modifications are made in the guidelines, I am inclined to recommend, as the head of OPRA, that OCR non-concur in the issuance of the guidelines.

If you have any questions, please call me at 245-6128.

Wilbert A. Cheatham

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
THE OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

THE GENERAL COUNSEL

AUG 2 1978

DRAFT

TO: Addressees Below

FROM: Peter Libassi

SUBJECT: Decisions Made at the July 25 Meeting with the Under Secretary

I thought that it might be helpful to circulate a summary of decisions made at the July 25 meeting on the Hill-Burton regulations and on civil rights/health planning issues.

Hill-Burton

1. Nondiscrimination. Prohibit discrimination based on race, color, national origin, sex, handicap, creed, or other ground unrelated to medical need or availability of services. Approved.

2. Admissions limitations. Prohibit administrative policies which have the effect of excluding persons unable to pay or categories of persons residing in the area served. Do not explicitly prohibit admission deposits or private physician referral rules. Approved, with instructions to make clear, with illustrations in the preamble, that these policies must be changed if they have an exclusionary effect.

3. Reasonable volume presumptive compliance. Delete open door option. Approved. Adjust 10% standard to account for inflation. Approved.

4. Reasonable cost v. usual charge. Adopt reasonable cost or 75% of usual charge as standard. Approved in concept, but with instructions to use same method and terminology used by HCFA ("allowable cost").

5. Allocation of uncompensated services. Require a first-come-first-served allocation on a quarterly basis unless an alternative plan is published and submitted to the HSA for review and comment. Indicate in NPRM alternative approaches. Approve the recommended alternative, with instructions to require any alternative plan to follow certain characteristics (to be worked out). Also, disapprove publishing alternative approaches in the regulation.

6. Eligibility for free care. Use a national income standard based on CSA poverty line, but give facilities the option to annualize quarterly income to prevent unfair treatment of the recently unemployed. Approved.

7. Nature of availability. Require provision of individual notice to each prospective patient. Approved. Require prior determination on request, but credit services if determination is made subsequently after a patient request. Approved.

8. Enforcement. Require carrying forward of any ummet obligation since 1972. Waiver for financial need by HRA Administrator. Approve prospectively, but with instructions to prepare a paper on feasibility of applying sanctions retroactively to 1972.

Title VI

1. Early warning. Provide for a pre-construction review system under which OCR gets early warning of proposed construction. Approved.

2. 1122 and certificate of need applications. Require DPA to deny or postpone action where HEW has terminated funds under Title VI or has issued a Notice of Hearing and a deferral. Approved. Require DPA to consider any OCR letter of findings in evaluating applications. Approved.

3. Deferral. After an OCR deferral, HCFA should withhold Medicare/Medicaid capital expenditure related reimbursements

DRAFT

which are claimed for the first time subsequent to the deferral. Approved, subject to legal memo from OGC re: scope of activity.

4. Title VI/Title XV. Failure of DPA to apply minority access criteria under Title XV would violate Title VI, not considered.

Title XV

Not considered.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

OFFICE OF THE
GENERAL COUNSEL

July 21, 1978

MEMORANDUM

TO : The Under Secretary
Through: ES _____

FROM : General Counsel

SUBJECT: Action Under Title XV, PHS Act, to Provide for Equality of Access to Health Services - DECISION MEMORANDUM

We have met with HRA and OCR to discuss means by which Title XV of the Public Health Service Act may serve as a means to increase access to health services by minorities, inner city residents and rural populations to whom those services are not now available. The following is, first, a summary of the actions that have been taken by HRA to address this problem and, second, recommendations for additional actions which I believe should be taken for that purpose.

I. Actions by HRA to Date

The second set of National Guidelines for Health Planning, now in draft form, to be issued under section 1501 state as a goal that

> "Every person should have access to emergency and primary health care services and to appropriate specialized, long-term and rehabilitative services at a reasonable cost,"

and that

> "all health services must be provided on a non-discriminatory basis that assures access to quality health care for minorities and the handicapped."

HSAs are required to give "appropriate consideration" to the national health planning goals in the development of their local health plans. The draft discussion of the goals states in part:

> " ... access to health care cannot be discretionary and special attention must be given to the medically underserved. Local planning agencies and hospitals should become aware of the civil rights issues that affect access and take appropriate remedial actions. State agencies should also take affirmative steps to assure that health care services are available on a non-discriminatory basis."

Each HSA is required to have a governing body a majority of which is comprised of consumers who are "broadly representative" of the various elements of the community. Regulations have been proposed which are designed to assure that all segments of the community (including minorities and the poor) are adequately represented on the governing body. Non-metropolitan residents are required by the statute to have representation "equal to" their proportion of the population.

HRA has issued guidelines to assist HSAs and State Health Planning and Development Agencies (SHPDAs) in developing their plans. No specific provisions are included which deal with minorities or inner city or rural residents.

Each set of regulations dealing with the review of individual services or providers (certificate of need, appropriateness of existing services, review of proposed uses of Federal funds) will require that in performing those reviews, HSAs and SHPDAs must consider (among other criteria) the contributions of the service in "meeting the health related needs of minorities, women, and handicapped individuals" in the area served.

II. Recommended Additional Actions

HRA and OCR agree that it is one of the statutory responsibilities of HSAs and SHPDAs to increase the access of underserved populations to health services. (Sections 1502(1) and 1513(a)(2)). They are also in agreement on the basic policies which should be followed by the Department in assisting HSAs and SHPDAs in carrying out that responsibility.

They disagree in some respects as to the formal means for putting that policy into effect.

To summarize, OCR and HRA are in agreement that in making each planning decision (e.g. certificate of need or appropriateness determinations), HSAs and SHPDAs must consider whether the needs of minorities and the handicapped have been taken into account by the proponent of the expenditure and whether and how the expenditure advances the objective of meeting these needs. Of course, other health planning criteria must also be taken into account, and final decisions will not necessarily satisfy minority needs where other considerations outweigh these needs in a particular case. The Department has already issued NPRMs which incorporate this policy. Final regulations will be issued after consideration of public comments. OCR and OGC will review the regulations and recommend changes if necessary, to assure that they satisfactorily reflect this policy. OCR and HRA are also in agreement that policy guidelines should be issued by HRA which advise HSAs and SHPDAs how their obligations under these requirements may be satisfied.

OCR and HRA are not in agreement on the proper course of action with respect to HSA and state health plans. Presently, the Department has no regulations governing the content of these plans, and OCR believes such regulations should be issued. HRA, on the other hand, would prefer to issue policy guidelines which would advise HSAs and SHPDAs on methods by which minority needs may be considered in the development of health plans, but would not be legally enforceable as would regulations. HRA believes that the best strategy for the Department over the next 12-18 months is to concentrate on specific project review decisions (e.g. certificates of need) and to help HSAs and SHPDAs gradually develop satisfactory overall health plans by building on these individual decisions. HRA believes it can achieve substantial movement by inducing voluntary action through guidelines, and that it would issue mandatory regulations after the 12-18 month period if that proves necessary.

I recommend that HRA's approach be tested. It is noted that HRA will submit the guidelines to OCR and OGC for review - under an agreed-upon time limit of seven days.

It is anticipated that the health plan guidelines issued by HRA will be specific enough, not only to induce voluntary compliance, but also to be of some assistance in private

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

OFFICE OF THE
GENERAL COUNSEL

June 27, 1978

SPECIAL

MEMORANDUM

TO: See Below

FROM: Steven J. Cole Steve Cole

SUBJECT: OCR/HRA/OGC Meeting
Civil Rights; Hill-Burton

Attached is a discussion outline which Mr. Libassi asked me to prepare and distribute to you for the upcoming meeting. The outline covers three separate areas: (1) coordination of Title VI enforcement with health planning regulatory activity (e.g. 1122 or certificate of need reviews); (2) Title XV health planning criteria; and (3) the free care and community service regulations. It did not appear to me that the Title XV issues are generating significant controversy, and therefore they should probably receive the least attention at the meeting.

You will note that the paper includes a specific Title VI proposal, as well as specific recommendations on the free care and community service regulations. These have not yet been reviewed by Mr. Libassi.

DISCUSSION OUTLINE

Civil Rights/Health Planning/Hill Burton Regulations

I. Title VI Obligations

A. Issue: How can we best coordinate civil rights enforcement under Title VI of the Civil Rights Act and section 504 with the health planning process?

B. Objectives:

Health care facilities desiring to expand, relocate or make major capital improvements should be required to assure that such capital expenditures will not create discrimination against racial minorities and the handicapped in access to needed health services, and that they will not perpetuate or expand existing discrimination or make its eradication more difficult. The certificate of need and section 1122 review process provides an excellent opportunity for the Department to review major health care facility expansion, relocation, or acquisition for civil rights considerations at a much earlier stage than was previously possible. At the same time, absent coordination between HRA and OCR, and between OCR and local planning bodies, the health planning process also creates the possibility of duplication of effort and seemingly inconsistent decisions.

The objectives which ought to be satisfied by any coordination scheme include the following:

1. avoid inconsistent decisions;
2. increase the opportunities to obtain civil rights compliance <u>before</u> a major new facility or expansion is underway or completed. This would increase the Department's leverage in negotiations, as well as the facilities' flexibility in modifying plans to suit Title VI and 504 concerns;
3. maximize incentives for OCR to resolve issues promptly and for facilities to comply with civil rights laws voluntarily;

4. allocate OCR and HSA/DPA resources and burdens efficiently and consistent with broader concerns under the Title XV planning process;

5. maximize the availability and sharing of necessary information.

C. Proposal

1. OCR should establish a pre-construction review program under Title VI and section 504 along the following lines:

   - A facility applying for a certificate of need or section 1122 approval, or submitting a letter of intent to plan a construction project as required by section 1532(b)(11) of the PHS act, must notify OCR that such an application or letter of intent has been filed by simultaneously filing with OCR a copy of the entire application or letter (or relevant portions) in the following cases:

     a. constrtuction of a satellite facility

     b. relocation of a facility

     c. capital expenditure greater than $500,000 (or $1,000,000)

     d. establishment of an outpatient clinic.

   - OCR will initiate a civil rights review of the facility and its expansion plans, at OCR's discretion. We might wish to compel a review at the facility's option.

   - OCR Titlé VI review underway: The HSA/DPA review under section 1122 or a certificate of need program would proceed as usual so long as OCR has not found a compliance issue. However, no approval should be granted until OCR notifies the HSA/DPA that the facility is in compliance, or the usual maximum review period has expired (90 days after submission of a certificate of need application, or

60-90 days after an 1122 application). A certificate may be denied and an 1122 application denied, at any time, if Title XV criteria so warrant.

- OCR issues letter of findings: If, prior to HSA/DPA approval, OCR issues a letter of findings with respect to a facility, further action on the application for certificate of need or 1122 approval must be deferred for 90 days to give OCR and the facility an opportunity to negotiate compliance. (OCR must notify the HSA of the findings.) If the Title VI issues are resolved within the 90 days, the HSA/DPA may resume consideration of the application. If OCR makes no determination in the 90 days, the HSA/DPA review may continue, but the findings issued by OCR should be taken into consideration under the 1122 or certificate of need criteria.

- OCR issues notice of hearing/deferral: Consideration of the certificate of need and 1122 application should continue to be deferred. (OCR notifies HSA/DPA of the notice.)

- OCR terminates funds: The certificate of need or 1122 application should be denied. (OCR notifies HSA/DPA of the termination.)

- Title VI non-compliance cured: Facility may reapply for certificate of need or 1122 approval and HSA/DPA may review and determine the application.

2. Routine OCR compliance reviews and investigations o complaints should also be coordinated with planning process. HSA/DPA obligations would parallel the procedures for pre-construction reviews:

   - Investigation pending -- no planning delay beyon usual time limits (but see problem noted below).

   - Letter of findings issued -- planning decision delayed for 90 days. If no OCR decision, plann review proceeds.

- Notice of Hearing/deferral -- planning decision deferred pending resolution.

- Termination -- application for 1122 or certificat of need approval denied.

- Compliance achieved -- new application for 1122 or certificate of need approval may be filed and reviewed.

These procedures raise the following practical problems:

- Under 1122, a facility can give the HSA/DPA as little as 60 days notice prior to obligation of funds. OCR will not be able to complete an initial investigation, issue a letter of findings, proceed to hearing and render a decision in such a short period of time, however, yet deferral of 1122 action beyond 60 days could make subsequent disapproval inoperative. One way to cure this problem would be to require, under Title VI authority, an automatic denial subject to reapplication where funds will be obligated prior to a timely OCR decision.

- The proposal might be burdensome to OCR, since it would require review of some construction projects where there is no likelihood of discrimination (e.g. no minorities in the area). One way to solve this is to adopt the approach likely to be recommended by GAO, namely to have the HSA screen applications (which they will do anyway under Title XV) and refer significant problem cases to OCR for review.

- The present 90 day certificate of need review period may need to be lengthened where OCR needs somewhat more time for its initial investigation. The period will need to be lengthened once a notice of findings is issued.

- If a facility loses its Federal funds under Title VI, this procedure would nonetheless require a certificate of need denial because the certificate of need review uses Federal funds even though the facility does not. Thus, because of a Title XV finding, Title VI would continue to reach facilities not directly subject to Title VI.

D. Implementation Steps

1. OCR Title VI regulations or guidelines establishing pre-construction review program and setting forth HSA/DPA obligations to defer or deny applications, as appropriate, in connection with pending investgations.

2. OCR Title VI regulations or guidelines establishing criteria for judging facility expansion or relocation plans.

3. Development of Title VI assurance form for use with 1122 or certificate of need applications. The form would advise the HSA/DPA that OCR was notified of the application and the status of the OCR review (completed, no problem; pending; letter of findings; hearing notice; termination).

4. Development of appropriate data for 1122, certificate of need applications to coordinate Title XV review needs with Title VI investigation needs.

II. Title XV Health Planning Regulations

A. Issue: How may the Department assure that the special needs of minorities, women, and the handicapped are adequately taken account of in state health planning decisions?

B. Discussion: Title XV of the PHS Act provides a unique opportunity for the Department to influence health planning priorities so that the needs of minorities for quality health care are more adequately addressed, without interjecting the Department into individual decisions. As the Public Health Division of OGC has previously advised, numerous vehicles for promoting better access to care by minorities exist under the Act. They include:

1. Establishment by HEW of national guidelines and goals for the delivery of health care which must be used by federally funded planning agencies in developing health systems and state health plans.

2. Issuance of specific access criteria for use in preparation of health system and state health plans, which in turn are utilized in HSA/DPA regulatory review functions.

3. Issuance of specific access criteria for HSA/DPA reviews of: capital expenditures under certificate of need and 1122 programs; the appropriateness of existing or proposed new institutional services; and the use of certain federal grant funds.

4. Issuance of access criteria for development of state medical facilities plans.

Under these authorities, HEW may refuse to offer, or terminate, federal funding or agreements to the extent the federal criteria are not used. Thus, HEW can ensure that health plans reflect applicable federal access criteria, that HSA/DPA criteria used to perform regulatory reviews reflect federal criteria, that in administering the regulatory programs the state and federal criteria are actually utilized, and that state medical facility plans reflect the criteria. (Individual HSA/DPA review decisions are not subject to federal review or reversal for failure to utilize access criteria, although HEW may deny a Title XVI application for construction or modernization funding if the facility's proposal does not conform to the state medical facilities plan).

C. Proposal

1. NPRMs and final Title XV regulations should be drafted or revised by joint HRA/OCR/OGC/H and CR work groups.

Note: At the present time, published NPRMs are outstanding on (1) the review of federal funds (May 9, 1978); (2) appropriateness reviews (May 16, 1978); and (3) certificate of need reviews (March 17, May 16, 1978). These NPRMs include broad language pertaining to access by women, minorities and the handicapped.

Drafts of the following NPRMs are in various stages of preparation: (1) second set of national guidelines; (2) criteria for state medical facility plans; and (3) section 1122 reviews.

2. GCH recommends possible amendment to final criteria for health system and state health plans. Those regulations should be amended.

3. Guidelines instructing HSAs/DPAs in the use of access criteria in all planning and regulatory functions should be prepared by HRA and OCR.

4. A separate document should be published and made widely available setting forth all applicable criteria and procedures relevant to access by minorities, etc., to health care in connection with the health planning process.

5. HRA/OCR/OGC (H and CR) should develop the data needed to be included in certificate of need and 1122 applications to assist HSAs/DPAs in applying access criteria and to assist OCR in its pre-construction review program.

III. Hill-Burton Regulations

A. Issues: Too numerous to summarize in one sentence. As a general matter, however, it is fair to say that the controversy generated by the OCR and HRA drafts center around charges that current administration of the program by the States and HEW has not provided an adequate framework to expand the availability of free hospital care to poor people beyond that which would otherwise be provided without Hill-Burton and that even within the current framework non-compliance is common place. Public interest groups believe that, except for adoption of uniform, objective eligibility standards, HRA's draft does little to improve the program.

B. Summary: The controversy centers around these areas: (1) anti-discrimination provisions; (2) accessibility of services due to admissions limitations; (3) allocation methods (if any) for distributing limited free care to eligible individuals; (4) scope of the "reasonable volume" burden; (5) eligibility levels; (6) reporting and monitoring procedures; and (7) enforcement and sanctions.

Below I outline the key issues in each area, disclose HRA's and OCR's position to date, if any, and give my recommendation (where I have one). You already have my longer memo which you sent to the Under Secretary, and which discusses some of these issues in more detail.

1. Anti-discrimination

Should the PHS regulations bar discrimination based on race, sex, handicap, or source of payment? HRA is silent. OCR includes such a provision (but refers race and handicap complaints to OCR for enforcement). OCR also includes a performance standard under which a hospital is out of compliance if it does not (within 10%) serve minorities in the proportion to their share of the area population.

I recommend that the OCR anti-discrimination prohibitions be included, with Title VI and 504 referrals to OCR. Some discrimination is not covered by Title VI or 504; some facilities do not presently use Federal funds to subject them to Title VI; data collection and monitoring would be efficient if discrimination-related data is reported to HRA with all other relevant data; and private litigants may be assisted by the statutory right of action to enforce the Hill-Burton requirements. I recommend against OCR's performance standard, although it might be useful if used as a trigger for further investigation.

2. Admissions limitations

Practical barriers to admission include:

- hospital rules limiting admission to persons with a referring private physician;
- requirements for pre-admission deposits or advance co-payments for persons eligible for reduced cost care;
- language or hearing problems inhibiting application for free care;
- lack of hospital assistance to patient in obtaining eligibility for Medicaid or other third party coverage.

HRA's draft does not deal with these issues. OCR's draft would require admission of persons without a referring physician; prohibit pre-admission deposit requirements; require multi-lingual staff and interpretors for the deaf; prohibit collection attempts unless Medicaid and other insurance eligibility counseling and services were provided.

All of these problems are real, but the most critical are the first two, physician referral rules and pre-admission deposits. I recommend, at a minimum, prohibiting pre-admission deposits for persons eligible for free or reduced cost care, and requiring hospitals using a referring physican policy to make other arrangements for persons without a physician (hospital staff; rotation responsibilities for those with staff privileges; clinic referrals, etc).

3. Allocation of free care -- 3%/10% hospitals

There are two overriding issues here -- how should the limited amount of free care be distributed mongst potential eligibles? And what services should be available? Current policy and the HRA draft leave allocation decisions totally to hospital discretion; all that is required is that by the end of the year the hospital's total dollar obligation must be met, and that services for which credit is claimed meet certain regulatory provisions (e.g. a prior determination of eligibility must have been made if credit is claimed). Also, hospitals enjoy complete discretion in determining which services they will make available, i.e., emergency, outpatient or inpatient.

The problems with this approach include the fact that no individual has a right to care at any point in time; that the free care obligation can be exhausted by emergency room treatment; that arbitrary selections amongst eligibles is possible; and that the hospital can "wait and see" whether more desirable patients may come through the door on future days (e.g. higher cost cases; pathologically interesting cases, etc.).

OCR makes the following recommendations with which I generally agree:

- require individual notice of free care entitlement at admission;
- prohibit refusal to admit eligible persons except when free care obligation is already satisfied;
- require a mix of all hospital services to be made available, subject to available beds.

These provisions in effect establish a first-come-first-served allocation scheme. I also think it would be desirable to evaluate compliance on a quarterly basis, so patients are told to come back in 1 or 2 months rather than in 6 or 7 months, and so dumping to public hospitals is spread evenly throughout the year.

Some public interest groups have suggested other remedies which may be worth considering, such as: requiring a minimum amount of free care (as opposed to reduced cost care); placing a dollar limit per patient for Hill-Burton credit (to spread care to as many persons as possible); limiting credit to in-patient cases (on the theory that emergency room care is going to be made available in any case); giving priority to essential medical needs; and allowing dumping to public hositals so that free care is more readily available to those who can't get into public hospitals.

4. Definition of "reasonable volume"

The HRA draft establishes a "presumptive compliance" standard under which a hospital will be found in compliance if it either certifies that it will serve all persons unable to pay who request services, or if it provides services in an amount equal to 3% of patient revenues or 10% of Federal assistance previously received, whichever is less. HRA also proposes to change the definition of "uncompensated service" from the difference between "reasonable costs" (as determined under Medicare) and patient payment, to the difference between the hospital's "usual charge" and patient payment. OCR would require the greater of the 3%/10% levels to be used, would use a "reasonable cost" measurement, and would require the Secretary to set higher compliance levels where local conditions warranted.

There is evidence that the first option, the so-called "open door" option, has resulted in some hospitals providing little or no charity care because of hospital policies, referred to above, under which patients are admitted only upon referral by a private physician. In addition, the 10% option represents a reduction in "real care" in light of inflation since the Federal financial aid base utilized is a fixed item. Finally, in addition to being in conflict with our cost containment objectives, the usual charge basis for measurement will result in a reduction of actual free care under both the 3% and 10% rules since the hospital will get more "credit" for each individual served. ("Reasonable cost" rates are approximately 75% of "usual charges".)

I recommend the following:

- HRA should eliminate the open-door option unless physician referral practices are controlled. The HRA draft includes a "waiver" procedure applicable where "there is insufficient need for such services in the area served," and this waiver procedure appears sufficient to protect those hospitals where actual demand is below the 3% or 10% presumptive compliance levels.

- o The definition of "uncompensated services" should consider the "reasonable cost" rate and not the "usual charge."

- o The 10% option should be raised in an amount which will continue in effect the current dollar levels of care being provided.

- o National eligibility rules should be used, since it is impractical for the Secretary to set 4000 individually determined levels.

5. Eligibility criteria

Both HRA's and OCR's draft would substitute a uniform Federal definition of eligibility for the Federal criteria each State now uses to define its own eligibility standard. Under the two proposals, persons are eligible for free care if their gross income for the year preceeding hospital admission is below the official poverty line, i.e., about $6500 for a family of four. Persons are eligible for reduced care if their income is below twice the poverty line.

These levels may be too low to be of any practical assistance to the working poor, who are generally ineligible for Medicaid. The eligibility levels also exclude many of the recently unemployed, many of whom lose group health insurance coverage because of their unemployment, since eligibility is based on income earned over the preceeding year which is no longer available. Lastly, the standard fails to take into account the likelihood that persons seeking free or reduced care often are uninsured and ineligible for Medicaid, and may have expended considerable amounts during the year for medical care, thus making an inflexible gross income standard an unfair measure of their true ability to pay.

I recommend the following:

- o Moderately increase the eligibility level for free and reduced care; or permit applicants for free or reduced care to subtract from the amount of income taken into account in determining eligibility unreimbursed medical costs which are established by rendered bills; or do both.

- Eligibility should be determined by measuring income (and annualizing it if administratively convenient) over a shorter period of time, perhaps three or six months rather than twelve, in order to minimize the effect of a sudden loss or reduction of income.

6. Reporting; Monitoring

The HRA and OCR drafts sharply diverge with respect to reporting of data to HEW for monitoring purposes. HRA's regulation would require conclusory aggregate data that would not be too helpful; OCR requires detailed breakdowns by type of service, race, etc. However, HRA's data form submission to OMB (which was generally approved subject to issuance of regulations) is very close to OCR's draft, and this may not be a real dispute, although there are some areas where the HRA form could be improved. (For example, the form does not distinguish between emergency and other outpatient care, nor does it separate free care from reduced care.)

I recommend that HRA/OCR/OGC jointly devise an acceptable form and that the regulations be amended to be consistent. This is an issue to which Congress has paid special attention in the title XVI legislation.

With respect to monitoring, HRA's draft provides for compliance reviews at least every five years; OCR provides reviews every two years. I have no recommendation here.

7. Enforcement

With respect to the community service obligation, the only HRA "sanction" for non-compliance would be the establishment of an "affirmative action" plan. No sanction is provided, however, for refusal or failure to develop or follow such a plan. With respect to the free care obligation, the only real HRA-proposed sanctions other than adverse publicity are a request to the Attorney General to sue for specific performance, and the establishment of a 50% add-on to the presumptiv compliance amount for the next fiscal year.

OCR's sanctions go beyond HRA's proposals in that they would also authorize (1) withholding of Title XVI payments (if there are any); (2) denial of depreciation reimbursements under Medicare for subsidized portions of the facility; (3) extension of the free care obligation; (4) a recommendation that the HSA or state agency withhold certificate of need approval, and (5) requiring the HSA and state agency to deny proposed uses of Federal funds under the PHS Act and other statutes. Further, recognizing the likelihood that administrative resolution of complaints will be time consuming, OCR would require the Secretary to issue a private "right to sue" letter if requested, even if prior to the six month statutory exhaustion of remedies requirement.

The proposed 50% add-on sanction may not be very effective. For example, a hospital may be better off by providing 150% of the free care obligation in two years than providing 200% in two years as would be required if it was in compliance. Further, if the hospital cannot afford the 150% penalty level, it may apply for waiver under the same HRA provisions applicable to waivers for presumptive compliance standards in cases of complying facilities.

I recommend that the following enforcement measures be added to HRA's draft:

- The 50% penalty should be changed so that the add-on is at least equal to the amount by which the facility fell short; waivers should not be granted, but where there are financial difficulties the penalty can be amortized over future years; the penalty should not be limited by the running of the 20 year period.

- A dismissal of complaints without prejudice on request should be provided to enable prompt private actions prior to expiration of six months where HEW knows it cannot complete an investigation in the six month statutory period;

- Individuals denied care despite eligibility should be provided care if still needed even if the hospital has met its total compliance obligation and even if the hospital is denied Hill-Burton credit because of its failure to comply with the regulations.
- Capital depreciation on Hill-Burton funded facilities should be withheld until there is full compliance.

Steve Cole
June 26, 1978

DRAFT

TO :Addressees Below

FROM :Peter Libassi
General Counsel

SUBJECT:Decisions Made at the August 4 Meeting with the UnderSecretary

As I did after the July 25th meeting on health/civil rights issues, I have prepared a summary of the decisions made when the Undersecretary completed his consideration of those issues on August 4.

Hill-Burton

Issue: Enforcement. Recommendation: Require carrying forward of any unmet obligation since 1972. Decision: Approved, with instructions as follows:

1. Consistent with a legal memo prepared by OGC, Hill-Burton grantees will have a prospective obligation to provide the full level of free or below-cost care which was required of them since 1972, to the extent that any portion of their obligation was unmet in any year. Since the obligations of "open door" facilities are not quantifiable, those facilities shall not be subject to the carry-over of their obligation.

2. If the grantees is unable to demonstrate to the satisfaction of the Administrator of HRA that the obligation has been met, an arrangement must be established whereby the grantees will be required to fulfill a portion of the unmet obligation each year, over a reasonable period of time, until the full obligation has been satisfied. (This may result in carrying the total obligation beyond the otherwise applicable twenty-year limitation.) The details of the arrangement are subject to negotiation between HRA and the grantee. Possible waivers of the prospective obligation for reasons of financial infeasibility may. also be negotiated with the Administrator of HRA.

3. HRA is to take an active role in enforcing this obligation. However, HRA is not expected to immediately begin reviewing the records of all grantees going back to 1972. It is contemplated that HRA's major enforcement activities will arise in the course of regular compliance reviews and in response to complaints.

4. Grantees will be required to submit assurance reports annually containing data specified by HRA. HRA will analyze the data to determine the "worst 20%"

of the facilities -- those which appear to have the greatest compliance problems -- and will do compliance reviews of that group each year.

5. To the greatest extent possible, HRA should look to existing data collected by the Department, and should consider improving existing data sources. HRA should also work with HCFA to determine whether HCFA can be helpful with compliance reviews. If so, HRA may be able to review more than 20% of the facilities annually.

6. Site-visits should be avoided whenever paper reviews will serve the same purpose.

Title VI

Attached is my legal opinion on the obligations HSAs and SHPDAs have under Title VI and Title XV. The UnderSecretary's decisions, summarized below, are consistent with the legal opinion.

Issue: Obligations of HSAs and SHPDAs. Recommendation: Failure of SHPDA to apply minority access criteria under Title XV would violate Title VI. Decision: Disapproved, with substituted policy approved as follows:

1. Consistent with Title VI and its implementing regulation, OCR will take action to ensure that HSAs and SHPDAs are informed of their obligations under Title VI. Appropriate Title VI requirements should be established by OCR through guidelines or regulations and may exceed the requirements of Title XV.

2. OCR will be responsible for monitoring the compliance of HSAs and SHPDAs with Title VI. If an HSA or SHPDA is found in noncompliance with Title VI, OCR may initiate an enforcement action against the agency to correct the violation, or if that fails, to terminate federal assistance to the noncomplying health planning agency.

3. The obligations of HSAs and SHPDAs under Title VI are separate from their obligations under Title XV, and are enforceable by OCR independent of HRA's enforcement efforts under Title XV.

Title XV

1. Issue: Regulations. Recommendation: Mandatorily require ? through the National Guidelines and through regulations governing the review and approval process (a) that HSAs and SHPDAs, in developing their health systems plan and

annual implementation plan, identify the health needs of minority, handicapped, rural, urban, and low-income population groups, as well as other medically underserved groups, and address these needs in the plan; and (b) that in performing individual project reviews, HSAs and SHPDAs consider the needs of the same underserved population groups for the services being proposed or eliminated, and the likely access members of these groups will have to any new services. Decision: Approved.

2. Issue: Guidelines. Recommendation: HRA, with input from OCR, will issue guidelines and policy statements advising HSAs and SHPDAs on methods of implementing the access-related obligations established by the National Guidelines and review and approval regulations. Decision: Approved.

ATTACHMENT

MEMORANDUM TO THE UNDERSECRETARY

DRAFT

THRU: ES__________________

F. Peter Libassi

Obligations of State and local health planning agencies under Title VI of the Civil Rights and Title XV of the Public Health Service Act

The purpose of this memo is to state my legal opinion on what obligations HSAs and SHPDAs have under Title VI of the Civil Rights Act, and what their related obligations are under Title XV of the Public Health Service Act.

Of primary importance is the fact that HSAs and SHPDAs, as recipients of Federal financial assistance, are subject to Title VI of the Civil Rights Act of 1964 its implementing regulation (45 C.F.R. Part 80). This inescapable legal conclusion should be stated explicitly in the preamble of any regulation governing the duties of health planning agencies. However, having reached this conclusion does not settle all issues.

This brings us to the question of what Title VI duties and obligations we believe should be imposed on HSAs and SHPDAs at this time. As recipients, these agencies must sign an assurance of compliance with Title VI. Further, they should be required to defer and deny approval of certificates of need and applications under Section 1122 of the Social Security Act and Title XV, when OCR has deferred or terminated Federal funds and has so advised the HSA and SHPDA.

However, HSAs and SHPDAs need not be obligated to independently determine whether health care facilities which submit applications for review and approval are in compliance with Title VI. The duty to monitor and enforce compliance by hospitals and nursing homes receiving Federal financial assisance may, consistent with the requirement of Title VI, remain in the hands of OCR.

This leaves the question as to the Title VI duties of HSAs and SHPDAs with respect to their own direct planning and decision-making activities.

Henry Foley and David Tatel agree that consideration of the health needs of minorities and the handicapped is required under both Title VI and Title XV. In my view, the obligations under both statutes are similar, if not identical. However, OCR in its role as the Department's enforcer of Title VI may, consistent with the Title VI regulations, issue guidelines to HSAs and SHPDAs informing them of their Title VI obligations. These obligations will be enforced by OCR, not HRA. If an HSA or SHPDA violates Title VI, OCR has the authority to bring an enforcement action against the agency to correct the violation or, if that fails, to terminate federal funds to the agency.

Under Title XV, health planning agencies have two basic obligations related to access and civil rights. First, in developing their health systems plan and their annual implementation plan, an HSA and SHPDA should be required to identify the health needs of minority, handicapped, rural, urban, and low-income population groups, as well as other medically underserved populations. Any plan which is adopted must address those needs. Second, in performing individual project reviews, HSAs and SHPDAs should be required to consider the needs of the same underserved population groups for services being proposed or eliminated, and the likely access that members of these groups will have to any new services. If an HSA or SHPDA does not comply with these obligations, HRA has the authority to de-fund the agency.

Thus, OCR and HRA have concurrent jurisdiction over the state and local health planning agencies to enforce separate, though similar, statutory obligations. [illegible]

[illegible]

OFFICE OF THE SECRETARY
OFFICE OF THE GENERAL COUNSEL

TO : Steve Cole
Special Assistant
to the General Counsel

DATE: JUN 20 1978

FROM : Assistant General Counsel
for Public Health

SUBJECT: Civil Rights Obligations of Health Planning Agencies -- Meeting of June 14, 1978.

This is to set out our understanding of the consensus reached at our meeting of June 14 with you, Mr. Hamlin, and members of Mr. Hamlin's staff regarding the civil rights obligations of health planning agencies.

Mr. Hamlin stated that under existing regulations implementing Title VI of the Civil Rights Act of 1964, the [redacted] in the form of [redacted] ning and development agencies (SHPDAs) [redacted] not, [redacted], approve applications under the certificate of need program (section 1523 (a)(4)(B), PHS Act) and the capital expenditure review program (section 1122, SSA) where the applicants have been found by [redacted] own Title VI obligations. Specifically, these directives would state that (1) HSAs and SHPDAs must disapprove applications from applicants for whom termination has been ordered by OCR after a hearing, and (2) HSAs and SHPDAs may not approve applications from applicants to whom a "deferral letter" or "letter of findings" has been issued or with respect to whom an investigation of a complaint is pending. Where an 1122 application is involved, applications in category (2) above would have to be disapproved prior to the expiration of the statutory "reasonable notice" period to avoid their automatic approval.

The conclusions expressed by Mr. Hamlin and summarized above are in accord with the "Discussion Outline" which you prepared for the June 14 meeting. Since they represent interpretations of the Civil Rights Act and its implementing regulations and would not rely upon the authority of either Title XV of the PHS Act or section 1122, we defer to Mr. Hamlin's views and have no legal objection to that approach.

Sidney Edelman

Prepared by GH, D.N.YOUNG/jgt 6/20/78, 443-2240

EXHIBIT 10

Work Force Composition By Grade Level, Minority/Nonminority & Sex Fulltime Employment

ORGANIZATION HRA
Summary Sheet

QUARTER ENDING March 31, 1980

PAY PLAN		BLACK		SPANISH SPEAKING		NATIVE AMERICAN		ASIAN		TOTAL MINORITY			TOTAL NONMINORITY			TOTAL		TOTAL EMPLOYEES
General Schedule		M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	
1-4	#	1	44		1		1		2	1	48	49	4	79	83	5	127	132
	%	0.7	33.3		0.7		0.7		1.5	0.7	36.4	37.1	3.0	59.8	62.9	3.8	96.2	100.0
5-8	#	5	74		3		1			5	78	83	15	174	189	20	252	272
	%	1.8	27.2		1.1		0.4			1.8	28.7	30.5	5.5	64.0	69.5	7.3	92.6	100.0
9-12	#	20	60	5	1	1	1	1	3	27	65	92	65	97	162	92	162	254
	%	7.9	23.6	2.0	0.4	0.4	0.4	0.4	1.2	10.6	25.6	36.2	25.6	38.2	63.8	36.2	65.8	100.0
13-15	#	20	18	4	2	1		1	1	26	21	47	167	68	235	193	8	282
	%	7.1	6.4	1.4	0.7	0.3		0.3	0.3	9.2	7.4	16.7	59.2	24.1	83.3	68.4	31.6	100.0
16-18	#												1		1	1		1
	%												100.0		100.0	100.0		100.0
Total General Schedule	#	46	196	9	7	2	3	2	6	59	212	271	252	418	670	311	630	941
	%	4.9	20.8	0.9	0.7	0.2	0.3	0.2	0.6	6.3	22.5	28.8	26.8	44.4	71.2	33.0	66.9	100.0
Commissioned Corps	#	7	4	2	1			1	2	10	7	17	44	17	61	54	24	78
	%	9.0	5.1	2.6	1.3			1.3	2.6	12.8	9.0	21.8	56.4	21.8	78.2	69.2	30.8	100.0
Other Pay Plan	#	10	2							10	2	12	15	5	20	25	7	32
	%	31.2	6.2							31.2	6.2	37.5	46.9	15.6	62.5	78.1	21.9	100.0
Grand Total	#	63	202	11	8	2	3	3	8	79	221	300	311	440	751	390	661	1051
	%	6.0	19.2	1.0	0.8	0.2	0.3	0.3	0.8	7.5	21.0	28.5	29.6	41.9	71.4	37.1	62.9	100.0

HRA-203-1a (7/77)

EXHIBIT 10

Work Force Composition By Grade Level, Minority/Nonminority & Sex Fulltime Employment

ORGANIZATION HRA

QUARTER ENDING March 31, 1980

PAY PLAN		BLACK		SPANISH SPEAKING		NATIVE AMERICAN		ASIAN		TOTAL MINORITY			TOTAL NONMINORITY			TOTAL		TOTAL EMPLOYEES
Total General Schedule	# %	M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	
GS-1																		
GS-2			6						1		7	7	1	12	13	1	19	20
GS-3			13								13	13		20	20		33	33
GS-4		1	25		1		1		1	1	28	29	3	47	50	4	75	79
Sub-Total GS 1-4	# %	1 0.7	44 33.3		1 0.7		1 0.7		2 1.5	1 0.7	48 36.4	49 37.1	4 3.0	79 59.8	83 62.9	5 3.8	127 96.2	13.2 100.0
GS-5			33		2						35	35	2	57	59	2	92	94
GS-6		2	17						1	2	18	20	2	47	49	4	65	69
GS-7		3	21							3	21	24	11	56	67	14	77	91
GS-8			3		1						4	4		14	14		18	18
Sub-Total GS 5-8	# %	5 1.8	74 27.2		3 1.1				1 0.4	5 1.8	78 28.7	83 30.5	15 5.5	174 64.0	189 69.5	20 7.3	252 92.6	272 100.0

HRA-203-1b (7/77)

EXHIBIT 10

Work Force Composition By Grade Level, Minority/Nonminority & Sex Fulltime Employment

ORGANIZATION HRA QUARTER ENDING March 31, 1980

PAY PLAN		BLACK		SPANISH SPEAKING		NATIVE AMERICAN		ASIAN		TOTAL MINORITY			TOTAL NONMINORITY			TOTAL		TOTAL EMPLOYEES
General Schedule		M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	
GS-9		5	13	2				1	2	8	15	23	12	27	39	20	42	62
GS-10														1	1		1	1
GS-11		6	18		1	1	1		1	7	21	28	15	26	41	22	47	69
GS-12		9	29	3						12	29	41	38	43	81	50	72	122
Sub-Total	#	20	60	5	1	1	1	1	3	27	65	92	65	97	162	92	162	254
GS 9-12	%	7.9	23.6	2.0	0.4	0.4	0.4	0.4	1.2	10.6	25.6	36.2	25.6	38.2	63.8	36.2	63.8	100.0
GS-13		9	14	3	1	1				13	15	28	71	47	118	84	62	146
GS-14		5	3	1	1				1	6	5	11	53	16	69	59	21	80
GS-15		6	1					1		7	1	8	43	5	48	50	6	56
Sub-Total	#	20	18	4	2	1		1	1	26	21	47	167	68	235	193	89	282
GS 13-15	%	7.1	6.4	1.4	0.7	0.3		0.3	0.3	9.2	7.4	16.7	59.2	24.1	83.3	68.4	31.6	100.0

HRA-203-1c (7/77)

EXHIBIT 10

Work Force Composition By Grade Level, Minority/Nonminority & Sex Fulltime Employment

ORGANIZATION HRA QUARTER ENDING March 31, 1980

PAY PLAN	BLACK		SPANISH SPEAKING		NATIVE AMERICAN		ASIAN		TOTAL MINORITY			TOTAL NONMINORITY			TOTAL		TOTAL EMPLOYEES
General Schedule	M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	
GS-16												1		1	1		1
GS-17																	
GS-18																	
Sub-Total # GS 16-18 %												1 100.0		1 100.0	1 100.0		1 100.0
Other Pay Plans																	
Exec. Serv. ES-04	2 18.2								2 18.2		2 18,2	7 63.6	2 18.2	9 81.8	9 81.8	2 18.2	11 100.0
St.												2 100.0		2 100.0	2 100.0		2 100.0

HRA-203-1d (7/77)

EXHIBIT 10

Work Force Composition By Grade Level, Minority/Nonminority & Sex Fulltime Employment

ORGANIZATION HRA QUARTER ENDING March 31, 1980

PAY PLAN	BLACK		SPANISH SPEAKING		NATIVE AMERICAN		ASIAN		TOTAL MINORITY			TOTAL NONMINORITY			TOTAL		TOTAL EMPLOYEES
Total Commissioned Officer	M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	
#	7	4	2	1			1	2	10	7	17	44	17	61	54	24	78
%	9.0	5.1	2.6	1.3			1.3	2.6	12.8	9.0	21.8	56.4	21.8	78.2	69.2	30.8	100.0
CO-01																	
CO-02								1		1	1	2		2	2	1	3
CO-03	2		1					1	3	1	4	7	5	12	10	6	16
CO-04	2	3	1						3	4	7	7	3	10	10	7	17
CO-05	2	1							2	1	3	10		10	12	1	13
CO-06	1						1		2		2	18	9	27	20	9	29
CO-07																	
CO-08																	

HRA-203-2 (7/77)

EXHIBIT 10

Work Force Composition By Grade Level, Minority/Nonminority & Sex Fulltime Employment

ORGANIZATION HRA QUARTER ENDING March 31, 1980

PAY PLAN	BLACK		SPANISH SPEAKING		NATIVE AMERICAN		ASIAN		TOTAL MINORITY			TOTAL NONMINORITY			TOTAL		TOTAL EMPLOYEES
Total Other Pay Plans Cont'd	M	F	M	F	M	F	M	F	M	F	T	M	F	T	M	F	
#	10	2							10	2	12	15	5	20	25	7	32
%	31.2	6.2							31.2	6.2	37.5	46.9	15.6	62.5	78.1	21.9	100.0
IPAs												3 50.0	3 50.0	6 100.0	3 50.0	3 50.0	6 100.0
Total Wg Bd	8 61.5	2 15.4							8 61.5	2 15.4	10 76.9	3 23.1		3 23.1	11 84.6	2 15.4	13 100.0
2	1								1		1				1		1
3	2								2		2				2		2
4	1	1							1	1	1				1	1	2
5	1								1		1	2		2	3		3
6	1								1		1				1		1
10	1								1		1				1		1
11		1								1	1	1		1	1	1	2
14	1								1		1				1		1

HRA-203-3 (7/77)

Exhibit 11

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : The Secretary
Through: US________
ES________

DATE: April 7, 1980

FROM : Assistant Secretary for Management and Budget

SUBJECT: Briefing - Meetings on Public Health Service's Proposed Operations Management System (OMS) Initiatives

April 9, 1980 in the Secretary's Conference Room at 3:00 P.M.
Continuation on April 10, 1980 in the Secretary's Conference Room at 10:00 A.M.

I. PURPOSE

To review PHS' proposed plans for 13 of its OMS initiatives, and to reach agreement on which initiatives you and the Under Secretary will monitor.

PARTICIPANTS

The Secretary
The Under Secretary
Dr. Richmond
Mr. Miller
Dr. Lythcott
Dr. Goyan
Dr. Foley
Dr. Martin
Dr. Johnson
Dr. DeLuca
Dr. Pardes
Mr. Trachtenberg
Mr. Veit
Mr. Watson
Dr. Robbins
Mr. Palmer
Mr. Bohen
Mr. Lowe
Mr. Wholey
Mr. Kinder
Ms. Hanft
Dr. Perry
Ms. Stoiber
Mr. Sermier
Ms. Peterson

III. DISCUSSION

The Under Secretary directed PHS to develop sixteen proposals for possible monitoring under OMS. PHS has submitted thirteen proposed plans for your review at this time. PHS will submit proposed initiatives for Grants and Procurement and Affirmative Action by April 30, and its Audit Resolution initiative after ASMB issues final guidance.

Dr. Richmond and PHS staff will discuss the following 13 initiatives:

On Wednesday, April 9.

- Health Maintenance Organizations (Tab A)
- Primary Care (Tab B)
- Adolescent Health/Pregnancy Prevention (Tab C)
- Alcoholism (Tab D)
- Indian Health (Tab E)
- Community Mental Health Centers (Tab F)
- New Drug Applications (Tab G)

On Thursday, April 10.

- Occupational Hazards (Tab H)
- Toxicology (Tab I)
- Immunization (Tab J)
- Health Planning (Tab K)
- Health Facilities Construction Loans (Tab L)
- Medicare Coverage Issues (Tab M)

MB, with PHS, has developed a set of charts which highlight the major indicators for each initiative, key action steps, and resources allocated. For each chart, we have also prepared comments.

In general, we believe that PHS has made a good start towards development of its OMS initiatives.

- The action steps listed in the various operating plans are generally logical in sequence and timing, and are complete.

- Levels of effort generally appear appropriate for those initiatives which the Department has monitored previously. MB has no basis for determining whether the proposed levels of effort for a number of new initiatives are appropriate.

However, there are areas where PHS has agreed to continue working to improve its targets and plans.

- There are some "data" gaps in several initiatives, most of which PHS can fill by May 15.

- Of the six initiatives which could have targets for each individual region, only two currently have such targets. However, PHS intends to have regional targets for virtually all of the remainder by May 15.

- PHS has agreed to revise, add or delete a number of proposed indicators. This will be an evolutionary process as PHS programs work to develop better indicators and implement supporting data systems. PHS and P have agreed to work together to develop more comprehensive sets of program performance indicators for three programs (Indian Health, Mental Health, and Health Planning) by September 30, 1980.

There is a very wide variance in the ability of various PHS programs to report resource expenditures against specific indicators. This is a difficult area and I believe it will require a lengthy period of time to develop the capability throughout the Department to tie financial and work measurement data to operational goals and results. After the first complete round of OMS meetings, I will develop a specific proposal for addressing this problem.

Frederick M. Bohen

Attachments

Tab A - Health Maintenance Organizations
Tab B - Primary Care
Tab C - Adolescent Health/Pregnancy Prevention
Tab D - Alcoholism
Tab E - Indian Health
Tab F - Community Mental Health Centers
Tab G - New Drug Applications
Tab H - Occupational Hazards
Tab I - Toxicology
Tab J - Immunization
Tab K - Health Planning
Tab L - Health Facilities Construction Loans
Tab M - Medicare Coverage Issues

TAB A

HEALTH MAINTENANCE ORGANIZATIONS

Initiative - Health Maintenance Organizations (HMOs)

To control the increase in national health care costs and increase access to HMOs.

INDICATORS

Table 1 - Grants to Develop HMOs

		FY 79	FY 80 Qtrs.				FY 80
		Total	1	2	3	4	Goal
Grants to organizations seeking qualification							
Feasibility	Tgt.			15	20	10	49
	Act.	47	4				
Planning	Tgt.			9	6	22	39
	Act.	31	2				
Initial development	Tgt.			3	9	21	33
	Act.	12	0				
Total Grants	Tgt.			27	35	53	121
	Act.	90	6				
Expansion grants to organizations already qualified	Tgt.			5	9	17	32
	Act.	13	1				

Table 2 - Other Indicators

		FY 79	FY 80 Qtrs.				FY 80
		Total	1	2	3	4	Goal
HMOs qualified annually	Tgt.			8	8	8	30
	Act.	33	6				
Cumulative total	Act.	101	107				
Qualification applications over 120 days old	Tgt.			0	0	0	0
	Act.	2	0				
Average processing time (days)	Tgt.			118	110	110	110
	Act.	120	118				
Compliance site visits	Tgt.			10	5	5	40
	Act.	40	20				
HMO enrollment (millions)	Tgt.						9.7 /a
	Act.	8.8 /a	Date available only annually				

/a Calendar year data (1979 and 1980).

OVERVIEW

The indicators for this initiative focus on grant awards to new and existing HMOs, on PHS actions to process applications for the beneficial designation of "Federally qualified" status, and on compliance site visits. The final indicators tracks total HMO enrollment on a calendar year basis.

Table 1

As part of the national HMO development strategy, OHMO intends to increase the number of expansion grants it awards by 146% over FY 79. PHS believes there is a greater return (in terms of increased enrollment and controlling the increase in health care costs) by helping existing HMOs to expand in comparison to funding for developmental efforts.

Table 2

PHS proposes qualifying three fewer HMOs in FY 80 because PHS reduced significantly its backlog in FY 79 and, thus there are fewer HMOs in the "pipeline" ready for qualification.

PHS' average processing time for qualification applications was 118 days in the first quarter of FY 80. PHS will lower this time by 10 days by instituting a new application form in the third quarter.

PHS is targeting an increase of 10.2% in total HMO enrollment in the United States in calendar year 1980, due primarily to promotional efforts to increase public awareness of the advantages of HMOs.

Initiative - Health Maintenance Organizations (HMOs)

KEY ACTION STEPS

Implement Market Development Group activity to generate feasibility grants in selected communities (June 7, 1980).

Revise the qualification application review system to reduce the average processing time (June 7, 1980).

RESOURCES

		FY 79 Total	FY 80 Qtrs. 1	FY 80 Qtrs. 2	FY 80 Qtrs. 3	FY 80 Qtrs. 4	FY 80 Goal
Obligations ($millions)							
Program	Tgt.			4.5	16.5	25.0	47.8
	Act.	21.0	1.8				
Salaries & Expenses	Tgt.			2.7	2.7	2.7	10.2
	Act.	9.9	2.1				
Staff Years							
Headquarters	Tgt.			29	29	29	115
	Act.	109	28				
Field	Tgt.			18	18	18	72
	Act.	61	18				

KEY ACTION STEPS and RESOURCES

No comments.

TAB B

PRIMARY CARE

Initiative - Primary Care

Increase the Level and quality of primary care health services provided to residents of medically underserved areas.

INDICATORS

Table 1 - Total People Served in Primary Care Sites
(annualized rate in 000s)

		CY 79 [a]	FY 80 Qtrs. 1	2	3	4
People served	Tgt.			4542	4661	4781
	Est.	4616				

Table 2 - Administrative Indicators (% of projects) [b]

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4
Cost per medical encounter between $16 & $24	Tgt.			65	90	100
	Act.	57				
Administrative costs below 16% of total costs [c]	Tgt.			65	90	100
	Act.	55				
Team productivity between 4200 & 6000 encounters per year	Tgt.			65	90	100
	Act.	43				
Complete and timely report submission	Tgt.			65	90	100
	Act.	98				

---

[a] Data on the actual number of people served are only available once a year in mid-March (for the previous calendar year); all other quarters are estimates.

[b] For projects providing services for at least 3.25 years.

[c] Projects with budgets less than $125,000 have a goal of 26%.

OVERVIEW

The indicators in this initiative address the quantity, quality, and cost of primary care services provided by programs of the Bureau of Community Health Services (BCHS). The indicators represent one of the most advanced and comprehensive results-oriented approaches to program management in the entire Department.

BCHS allocates funds to the regions based on grantees' performance and has negotiated performance goals with both the regional offices and individual grantees.

BCHS' current targets for its administrative and clinical indicators monitor the performance of projects which have been providing services for over 3.25 years. By May 15, PHS will establish targets for administrative and clinical indicators to include projects in operation for at least two years.

Complete data for the clinical and administrative indicators are available semi-annually (first and third quarters). BCHS provides estimates for the second and fourth quarters by extrapolating from quarterly data which approximatly 25% of the projects are required to submit.

Table 1

BCHS proposes increasing the annualized rate of the number of people served by 4% between the fourth quarter of FY 79 and the fourth quarter of FY 80.

Table 2

BCHS is one of the few programs that has developed administrative efficiency indicators against which it holds grantees accountable.

To increase the number of projects in compliance with these indicators, BCHS provides technical assistance and conducts audits.

Initiative - Primary Care

Table 3 - Clinical Indicators (% of projects)

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4
Fully immunize 90% of all children under age 18	Tgt.			65	90	100
	Act.	15				
Provide family planning counseling /a	Tgt.			65	90	100
	Act.	43				
Follow-up and diagnosis on positive pap smear reports	Tgt.			65	90	100
	Act.	36				
Hypertension screening	Tgt.			65	90	100
	Act.	56				
Check hemoglobin or hematocrit level	Tgt.			65	90	100
	Act.	36 (children) 40 (women)				
Enroll a predetermined number of women in prenatal programs	Tgt.			65	90	100
	Act.	53				

/a To 90% of adolescents who receive family planning services.

KEY PROCESS STEPS

Conduct 10 program review visits per quarter.

Complete 60 audits to verify data accuracy (September 30, 1980).

RESOURCES

Obligations ($millions)		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Program /a	Tgt.						359.7
	Act.	292.5					
Salaries & Expenses	Tgt.		(Quarterly data not available)				12.2
	Act.	10.7					
Staff Years							
Headquarters	Tgt.						77
	Act.	77					
Field	Tgt.						231
	Act.	231					
Total	Tgt.						308
	Act.	308					

Represents total program allocation for Community Health

Table 3

These indicators cover the minimum set of clinical services which each project must provide.

Resources

PHS has not provided quarterly estimates for obligations and staff years because BCHS' accounting systems currently do not collect these data on a quarterly basis nor can BCHS relate obligations directly to specific program services.

Initiative - Primary Care

INDICATORS

Table 4 - National Health Service Corps

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Volunteers & scholarship recipients matched to sites	Tgt.			182	406	278	1159
	Act.	1038	293				
Primary care professionals in sites	Tgt.						1950
	Act.	1830	1869				

KEY PROCESS STEPS

Negotiate FY 81 NHSC targets with regions (September 30, 1980).

RESOURCES

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Obligations ($millions)							
Program	Tgt.						82.5
	Act.	63					
Salaries & Expenses	Tgt.						10.0
	Act.	7.7					
Staff Years			Quarterly data not available				
Headquarters	Tgt.						51
	Act.	26					
Field	Tgt.						201
	Act.	160					

Table 4

BCHS places professionals in field positions on a continuous basis as a result of its matching program. By May 15, PHS will submit quarterly targets for the number of primary care professionals actually in sites providing medical care.

PHS states that it may revise its goals for the total number of professionals in sites as a result of recent budget adjustments.

Resources

PHS has not provided quarterly estimates for the amount of obligation or staff years because BCHS' accounting system currently does not collect these data on a quarterly basis.

TAB C

ADOLESCENT HEALTH/PREGNANCY PREVENTION

Initiative - Adolescent Health Services and Pregnancy Prevention

To increase the number of adolescents receiving health and family planning services.

INDICATORS

Table 1 - Adolescents Receiving Comprehensive Health Services /a
(annualized rate in 000s)

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4
Total adolescents served	Tgt.			1337	1362	1386
	Act.	1343 /b				

Table 2 - Teenagers Receiving Family Planning Services
(annualized rate in 000s)

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4
Total teenagers served	Tgt.			1548	1579	1607
	Act.	1513 /b				

/a Ages 10-19

/b Comprehensive data on the actual number of adolescents/teenagers served are only available once a year in mid-April (for the previous calendar year); all other quarters are estimates, or calculated from partial semi-annual data.

KEY PROCESS STEPS

Negotiate FY 81 goals with regions/grantees (September 30, 1980).

RESOURCES

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Obligations ($millions)							
Program /c	Tgt.						524.7
	Act.	421.4					
Salaries & Expenses	Tgt.		Data not available quarterly				16.8
	Act.	14.8					
Staff Years							
Headquarters	Tgt.						108
	Act.	108					
Field	Tgt.						317
	Act.	317					

/c Total program allocation for CHCs, migrants and family planning programs.

OVERVIEW

This initiative measures the overall quantity of services delivered to adolescents by the Bureau of Community Health Services' (BCHS) projects. Measures of the quality and efficiency of the services delivered to adolescents are included as part of the indicators in the overall primary care initiative.

Table 1

PHS plans to increase the annualized rate of the number of adolescents receiving comprehensive health services by 3.2% from the fourth quarter of FY 79 to the fourth quarter of FY 80.

Table 2

PHS will increase the number of teenagers who receive family planning services by 6.2% from the fourth quarter of FY 79 to the fourth quarter of FY 80.

Resources

PHS serves adolescents in most of its projects, and has no method for separating the costs of treating adolescents from total program costs. For illustrative purposes, BCHS has included the total costs of all its projects which treat adolescents.

All program costs are grant funds, and PHS feels that these data are not appropriate to break out on a quarterly basis.

Table 3

No Comment.

Table 4

PHS proposes to eliminate measles from the United States by October 1982 because it is one of the most serious childhood diseases (one child of every 10,000 cases dies and one child of every 1000 suffers serious neurological damage). PHS proposes accomplishing this objective not only by maintaining immunization levels but also by breaking the chain of infection (i.e., by increasing surveillance, identifying measles outbreaks during off-peak months (April-October) and immediately taking actions to control the spread of the disease).

Table 5 - Efforts to Ensure Immunizations of New Borns

		FY 79 Total	FY 80 Qtrs.			
			1	2	3	4
Cumulative Number of projects /a with:						
Maternal education programs in targeted hospitals /a	Tgt.	0	30	45	60	63
	Act.					
Immunization recall systems	Tgt.	0	30	45	50	60
	Act.		34			
High risk childhood immunization follow-up systems	Tgt.	0	4	6	10	10
	Act.		4			

/a There are a total of 63 project areas which cover the entire country.

/b 1900 key hospitals serving new mothers who are least likely to have their children complete a basic immunization series.

RESOURCES

		FY 79 Total	FY 80 Qtrs.				FY 80 Goal
			1	2	3	4	
Obligations ($millions)							
Program	Tgt.		16200	3000	5300	0	24500
	Act.						
Salaries & Expenses	Tgt.		257	528	997	440	2222
	Act.						
Staff Years							
Headquarters	Tgt.		11.7	11.8	11.8	11.7	47
	Act.						
Field	Tgt.		20	20	20	20	80
	Act.						

Table 5

PHS believes it is particularly important to immunize children as soon as medically advisable. To accomplish this objective, PHS has established a program to ensure immunization of newborns. The indicators in this table measure projects' implementation of activities PHS believes are necessary to accomplish its objective.

Resources

No comment.

TAB D

ALCOHOLISM

Initiative - Alcoholism

Increase and improve alcoholism treatment services for women, youth and Indians.

INDICATORS

Table 1 - Total Women, Youth, and Indians Served (per quarter)

		FY 80 Qtrs. 1	2	3	4
IHS	Tgt.		16274	16674	17074
	Act.	16278			
NIAAA	Tgt.	Data available April 30.			
	Act.				

Table 2 - NIAAA's Administrative and Clinical Indicators

		FY 80 Qtrs. 1	2	3	4
Treatment to served ratio		PHS will provide targets and baseline data by May 15.			
Individuals completing treatment in programs for women and Indians		PHS will provide targets and baseline data by May 15.			
% of clients contacted after completing treatment	Tgt.		25	35	45
	Act.				
Decrease in client impairment		PHS will provide targets and baseline data by May 15.			
Clients to staff ratio					
Women's programs	Tgt.		11.3	11.4	11.6
	Act.				
Indian programs	Tgt.		11.1	11.2	11.3
	Act.				
Technical assistance and compliance site visits completed	Tgt.			40	40
	Act.	25	44/a		

/a Through February.

OVERVIEW

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) funds community based alcoholism treatment programs for underserved populations (including Indians). NIAAA provides all initial support to Indian alcoholism projects, but after 6 years of funding it transfers projects to the Indian Health Service (IHS).

This initiative represents NIAAA's first effort at holding its grantees accountable for specific, outcome oriented indicators (e.g., increasing the percent of people who successfully complete treatment). By October 1, NIAAA will expand its indicators to improve the quality and efficiency of alcoholism treatment services delivered to all population groups; not just Indians, women, and youth.

IHS also is in the process of developing program indicators and a reporting system, but is approximately one year behind NIAAA. In the interim, IHS proposes only to track the number of Indians receiving alcoholism services. IHS had been using NIAAA's reporting forms to gather data on individual clients, but is phasing that system out. IHS will begin testing its own client-based reporting form in a total of 20 projects in June, July, and August. Using the results of these tests, IHS will establish FY 81 goals for all 88 IHS projects in September 1980.

PHS intends to forward baseline data and "missing" targets by May 15.

Table 1

NIAAA proposes to increase the number of women, youth and Indians served by 10% over FY 79 levels by improving efficiency and taking actions which may lead to decreasing services to adult, non-Indian males. To monitor the potential effects of this initiative on non-Indian males, NIAAA will, by May 15, add an indicator to track the impact on this group.

IHS proposes a 5% increase in Indians served, but IHS has not informed its projects of these goals.

Table 2

PHS' client impairment index weights various behavioral factors (e.g., number of blackouts, lost work days) at intake and 180 days later. PHS is aiming for a 4% improvement in this index. By May 15, PHS will submit an additional indicator which tracks the percentage of clients not drinking after 180 days.

KEY PROCESS STEPS

IHS

- Complete pilot test of new data system in statistically representive sample of projects - 20 of 88 projects (August 1980).
- Report baseline data and indicators to Secretary (September 15, 1980).
- Inform all projects to report regularly under new data system and negotiate FY 81 goals for indicators (September 15, 1980).
- Report projects' progress against goals during 1st quarter FY 81 to the Secretary (February 15, 1980).

NIAAA

- Negotiate targets (with grantees serving all clients) for administrative and clinical indicators and submit them to the Secretary (June 15, 1980).
- Report first quarter performance data to the Secretary (May 1, 1981).

KEY PROCESS STEPS

IHS steps reflect its decision to discontinue using NIAAA's reporting system, implement a new data system, and develop FY 81 indicators and targets by September 30.

Initiative - Alcoholism

RESOURCES

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Obligations ($millions)							
IHS Program	Tgt.		3.1	3.1	3.1	3.1	12.4
	Act.	8.7	1.0				
Salaries & Expenses	Tgt.		.1	.1	.1	.1	.4
	Act.	.4					
NIAAA /a Program	Tgt.		10.4	10.4	10	22	52.8 /b
	Act.	52	10.4				
Salaries & Expenses	Tgt.		.12	.12	.14	.14	.51 /c
	Act.	.5					
Staff Years							
IHS Headquarters	Tgt.		2.2	2.2	2.2	2.1	8.7
	Act.	8.7					
Field	Tgt.		2.0	2.1	2.1	2.1	8.3
	Act.	8.3					
NIAAA Headquarters	Tgt.		2.2	2.2	2.2	2.1	8.7
	Act.	8.7					
Field	Tgt.						0
	Act.						

/a All NIAAA funded alcoholism treatment grants.
/b $52.4 million treatment grant support and $423,000 NAPIS contract.
/c $59,000 total cost per staff member times 8.7 staff.

Resources

No Comments.

TAB E

INDIAN HEALTH

Initiative - Indian Health

Improve the health status of American Indian and Alaskan Native populations.

INDICATORS

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Graduating scholarship recipients providing medical services to Indians /a	Tgt.					100	100
	Act.	30					
IHS hospitals certified by Medicare /b	Tgt.			2	0	2	4
	Act.	44	0	2			
IHS hospitals accredited by JCAH	Tgt.			0	0	1	1
	Act.	32	0				
% women receiving care during 1st two trimesters of pregnancy	Tgt.			90	90	90	90
	Act.		88.5				
% adolescents who receive counseling as part of family planning services	Tgt.			90	90	90	90
	Act.		81				

/a Excludes recipients continuing their education.
/b There are 48 IHS hospitals in total.

KEY PROCESS STEPS

Notify all scholarship recipients of award (June 15, 1980).

RESOURCES

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Total
Obligations ($millions)							
Program	Tgt.						
	Act.						
			Data not available				
Salaries & Expenses	Tgt.						
	Act.						
Staff Years							
Headquarters	Tgt.						
	Act.						
Field	Tgt.						
	Act.						

OVERVIEW

This initiative monitors a number of surrogate indicators for the quality of health care delivered to Indians. PHS intends to expand this initiative over the next few months to include indicators to measure efficiency of services and its activities to increase Indian involvement with service delivery under the Indian Self-Determination Act.

DISCUSSION

PHS proposes to track the number of IHS hospitals which either Medicare certifies or are accredited by JCAH. PHS believes achieving either result is a proxy measure for quality of care because the hospitals must pass strict criteria to be certified/accredited. PHS will coordinate the development of its targets with HCFA's schedule to conduct certification reviews.

In order to develop data related to efficiency, HSA and IHS staff will work with MB finance staff towards the goal of developing, by October 1, 1980, some adaptions to IHS and HEW accounting systems which will break out cost data in finer detail.

PHS also intends to complete a study of various methodologies it uses to measure physician productivity. Initial results are expected in June. PHS hopes to use these results to develop productivity measures and targets for its providers.

By April 28, ASPE and PHS (with assistance from MB) will submit a memorandum to you proposing indicators for monitoring progress with the Indian Self-Determination Act provisions applicable to IHS. The memorandum will include dates by when PHS will obtain baseline data, establish targets, and begin to report on its proposed indicators.

Resources

PHS has not submitted any resource data because the initiative cuts across IHS' budget categories, and IHS' accounting system can not separate out the data related to these targets.

TAB F

COMMUNITY MENTAL HEALTH CENTERS

Initiative - Community Mental Health Centers (CMHCs)

Increase the management capacity and performance levels of the CMHC program (grantees) by developing and implementing selected "core" indicators of performance and standards of performance for those indicators.

INDICATORS

Table 1 - CMHC Performance Indicators

Program Accessibility

Non-white admissions as a % white admissions

Under 18 yrs. of age admissions as a % of 18-64 age group admissions

65 yrs. old & over admissions as a % of the 18-64 age group admissions

Finanical Viability

Fee for service reimbursement dollars as a % of total income

Non-federal public dollars (e.g., state, county dollars) as a % of total income

Operational Efficiency

Average expenditures per discharge

Average number of persons served per full-time equivalent staff member

OVERVIEW

This initiative represents NIMH's first attempt to develop performance-based standards and hold their grantees accountable against those standards. The initiative, at this stage, is entirely developmental. The indicators listed under Table 1 are an initial set of proposed "administrative" indicators. NIMH intends to establish interim standards for these indicators by December 1980 and then launch a program to test and revise the indicators, explore other indicators (including possibly some clinical indicators), establish a reporting system and gain grantee acceptance of a final set of standards. NIMH's current target for completing these actions is November, 1983.

Initiative - Community Mental Health Centers

KEY PROCESS STEPS

Analyze baseline data (May 30, 1980).

Report to Secretary on interim standards and how the CMHCs and NIMH will use the standards to improve management (December 1980).

Obtain OMB clearance of new management form (December 1980).

Award contract to collect data on indicators (January 1981).

Train and educate grantees regarding standards (March 1981).

Submit to the Secretary legislative and regulatory recommendations to implement performance standards (March 1981).

Propose to Secretary additional indicators and proposed evaluation standards (November 1982).

Report to the Secretary regarding the final standards for all indicators (November 1983).

RESOURCES

		FY 80 Qtrs.				FY 80 Goal
		1	2	3	4	
Obligations ($millions)						
Program	Tgt.	87.4	42.6	93.0	67.4	290.4
	Act.					
Salaries & Expenses	Tgt.	.008	.008	.03	.005	.05
	Act.					
Staff Years						
Headquarters	Tgt.	.375	.375	.375	.375	1.5
	Act.					
Field	Tgt.					
	Act.					

Key process steps

Recognizing that this program area is a particularly complex and sensitive area, MB, nevertheless, believes that the Department has now gained enough experience with performance measures to be able to apply that experience to compress the proposed three year implementation schedule for this initiative. MB recommends that you charge PHS (NIMH), working with P and MB, to submit to you, within one month, alternative approaches for accelerating NIMH's currently proposed schedule.

Resources

Obligations represent the appropriation level for the entire CHMC program. However, staff projections only include allocations for part of the initiative. By May 15, PHS will provide complete data on proposed staff allocations.

TAB G

NEW DRUG APPLICATIONS

Initiative - New Drug Applications (NDAs)

To improve the timeliness of the FDA review of drug applications.

INDICATORS - (All targets apply only to NDA's submitted to FDA after October, 1978).

Table 1 - Reduction in Mean Processing Time for NDA Approvals (months)

Drug /a Classification	Baseline FY 76-78		Quarters FY 80 1	Quarters FY 80 3	Quarters FY 81 1
		Tgt.		14.9	14.0
All A's and B's	17.5	Act.			
1C's		Tgt.		19.7	18.6
	20.7	Act.			
All Others		Tgt.		17.2	16.3
	18.1	Act.			

/a A's and B's are NDAs with potential for important or modest therapeutic gains. 1C's are NDAs which have potential for little or no therapeutic gains.

Table 2 - Status of NDA Inventory

		FY 79 Total	FY 80 Qtrs. 1	FY 80 Qtrs. 2	FY 80 Qtrs. 3	FY 80 Qtrs. 4
A's and B's						
NDAs not yet approved beginning of qtr.	Act.					
NDAs received during qtr.	Act.		Data not available			
Approvals	Act.	7				
Returned to manufacturer	Act.					
NDAs not yet approved end of qtr.	Act.					
Average age of NDAs not yet approved (months)	Act.					

OVERVIEW

The Department has come under public and Congressional scrutiny and criticism because of lengthy processing times for New Drug Applications (NDAs). This initiative monitors FDA's efforts to reduce those processing times for NDAs submitted after October 1, 1978. By May 15, FDA will submit indicators which illustrate its efforts to reduce the inventory of NDAs submitted prior to October 1, 1978.

Table 1

FDA made a commitment to Congress to reduce the processing time of the new drug applications classified as likely to result in important and modest therapeutic gains (A's and B's) by 25% (to 13.1 months) by the first quarter of FY 82. If FDA achieves the interim goals established for FY 80 and early FY 81, FDA should achieve its Congressional committment. However, PHS provided no FY 79 baseline data and MB is unable to evaluate the likelihood of achieving the goal. FDA expects much of the decrease in its processing time to come from actions already implemented over the last two years (e.g., publishing standard clinical guidelines, requiring companies to submit standard manufacturing and control information).

FDA proposes to report progress against its processing goals on a semi-annual basis, because of possible distortions stemming from a low volume of quarterly actions (e.g., if only 4 NDAs were acted upon in a given quarter, one extremely lengthy action could give a false impression of performance). MB recommends quarterly reports in this sensitive area, with FDA footnoting extreme individual cases.

Table 2

The inventory presentations in Table 2 will describe FDA's NDA workload for applications received after October 1978. By May 15, PHS will also provide complete data for all drug classifications and report the data on the number of NDAs received prior to October 1, 1978 but not yet acted upon.

Initiative - New Drug Application (NDAs)

Table 2 (continued)

		FY 79 Total	FY 80 Qtrs. 1	2	3	4
1C's						
NDAs not yet approved beginning of qtr.	Act.					
NDAs received during qtr.	Act.					
Approvals	Act.					
Returned to manufacturer	Act.	All data not available				
NDAs not yet approved end of qtr.	Act.					
Average age of NDAs not yet approved	Act.					
All Others						
NDAs not yet approved beginning of qtr.	Act.					
NDAs received during qtr.	Act.					
Approvals	Act.					
Returned to manufacturer	Act.	All data not available				
NDAs not yet approved end of qtr.	Act.					
Average age of NDAs not yet approved	Act.					

Table 2 (continued)

No additional comments.

KEY PROCESS STEPS

Publish 24 clinical guidelines (June 31, 1980).

Publish manufacturing and control guidelines for stability (June 31, 1980).

RESOURCES

		FY 79	FY 80 Qtrs.				FY 80
Obligations ($000)		Total	1	2	3	4	Goal
Program	Tgt.						800
	Act.	796					
Salaries & Expenses	Tgt.						13.6
	Act.	13.4					
Staff Years			Data not available				
Headquarters	Tgt.						391
	Act.	384					
Field	Tgt.						49
	Act.	51					

Key Process Steps

No comment.

Resources

FDA has not submitted complete data because staff who work on NDAs also work on other activities and FDA's financial and work measurement systems cannot break out available data to the level of detail required for this initiative.

TAB H

OCCUPATIONAL HAZARDS

Initiative - Occupational Hazards

Increase the awareness, demand, and impact of the health hazard evaluation/technical assistance (HHE/TA) program.

INDICATORS

Table 1 - HHE/TA Inventory

	FY 79 Total		FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Active requests beginning of qtr.		Act.	206	250			
New HHE/TA requests		Tgt.		80	80	75	323
	230	Act.	88				
HHE/TAs completed with report		Tgt.		40	54	50	177
	132	Act.	33				
HHE/TAs completed without report /a		Act.	11				
Active requests end of qtr.	206	Act.	250				
Processing time /b of HHEs (months)		Tgt.		11.0	10.0	9.0	9.0
	12.4	Act.	11.9				

/a e.g., referred to OSHA, invalid request, or closed with letter.
/b Date HHE received, to date NIOSH completes final report.

Table 2 - Related Indicators

	FY 79 Total		FY 80 Qtrs. 1	2	3	4	FY 80 Goal
HHE/TA requests from small businesses		Tgt.		14	14	14	58
	36	Act.	16				
HHE/TAs initiated on subjects of high public interest or significance		Tgt.		1	1	1	4
	4	Act.	1				
Studies initiated as a result of an HHE/TA		Tgt.			1	2	3
	0	Act.	0	0			

OVERVIEW

The law requires NIOSH to investigate all reports of occupational hazards - a health hazard evaluation (HHE) request. This initiative sets goals to increase the number of HHE requests received and completed, and improve the timeliness of the investigative process. PHS will develop indicators to measure the effect (impact) of HHEs on reported occupational hazards by March 1981 (e.g., number of problems corrected, number of individuals working in a safer environment).

Table 1

PHS believes the number of requests it receives is primarily influenced by the awareness of workers and employers of the services NIOSH offers. Thus in FY 80, NIOSH proposes to stimulate the submission of requests. The goals are a 40% increase in total requests and a 61% increase in small business requests. As one step, NIOSH will meet with leaders of ten major international unions. PHS will attempt to balance the promotion of the HHE program with its capacity to respond to requests.

NIOSH also proposes to increase the number of HHE/TAs it completes in FY 80 by 34% and reduce its average quarterly processing time by 27%. PHS will accomplish this by a 54% increase in staff and improvements in the efficiency of its evaluation process.

Table 2

As a proxy measure for impact, PHS is proposing that you initially track the number of follow on studies initiated as a result of an HHE/TA. NIOSH expects to develop, and report against, a set of more specific impact measures beginning in March, 1981.

Initiative - Occupational Hazards

KEY PROCESS STEPS

Pilot test triage system and report to Secretary the number of HHE/TAs completed by triage designation (June 1980).

Report to Secretary on changes in the HHE process (August 1980).

Publish NPRM (September 1980).

Evaluation of user satisfaction and development of impact indicators for HHE/TA program.

Award Contract (September 1980).

Develop indicators (December 1980).

Provide baseline data and establish targets (March 1981).

RESOURCES

		FY 79	FY 80 Qtrs.				FY 80
Obligations ($million)		Total	1	2	3	4	Goal
Total	Tgt.		1.4	1.4	1.4	1.4	5.6
	Act.						
Staff Years							
Headquarters	Tgt.		27	27	27	28	109
	Act.	71					
Field	Tgt.		6	6	6	7	25
	Act.	16					

KEY PROCESS STEPS

By June 15, PHS will report to you on the number of HHE/TAs it has completed since it implemented a pilot test of its "triage" system in the first quarter in FY 80. The triage system is a method which NIOSH is developing to determine the level of effort it should apply towards each request (e.g., follow-up by a phone call, send a team to the area, refer request to OSHA). This system should improve handling requests in a timely manner and allocating the appropriate amount of resources to each request.

TAB I

TOXICOLOGY

Initiative - Toxicology

Improve the timeliness and increase the amount of scientific information being developed to protect the health of the American public from damage by exposure to toxic environmental chemicals.

INDICATORS

Testing Programs

		FY 79	FY 80 Qtrs.				FY 80
		Total	1	2	3	4	Goal
Carcinogenesis /a testing							
Tests ongoing beginning of qtr.	Tgt.				319	332	N/A
	Act.	308	292	304			
Tests started	Tgt.			15	25	25	80
	Act.	79	15				
Tests completed	Tgt			0	12	12	27
	Act.	95	3				
Tests ongoing end of qtr.	Tgt.			319	332	345	N/A
	Act.	292	304				
Mutagenesis /b testing							
Tests ongoing beginning of qtr.	Tgt.				119	199	N/A
	Act.	0	66	111			
Tests started	Tgt.			53	125	127	350
	Act.	86	45				
Tests completed	Tgt.			45	45	60	150
	Act.	20	0				
Tests ongoing end of qtr.	Tgt.			119	199	266	N/A
	Act.	66	111				

/a Examine chemicals to determine if they cause cancer.
/b Examine effects of chemicals on genetic material.

OVERVIEW

This initiative monitors PHS' toxicology testing program. The current indicators provide data on NIH's testing workload. By May 15, PHS will report to you on possible methods for decreasing the processing time of tests.

DISCUSSION

The number of chemicals which PHS can test is closely related to the program funding levels. PHS provided the following estimates of current testing measures:

Type of Test	Average cost/test ($)	Average elapsed time/test (months)
Carcinogenesis	500,000	64
Mutagenesis	3,000	4

PHS has proposed increasing the number of mutagenesis tests completed by 650% during FY 80. However, PHS may need to revise its targets downward due to budget adjustment.

GAO and others have criticized the Department for the long test times. Thus, by May 15, PHS will examine certain stages (which it can most readily influence) of carcinogenesis testing, determine whether if can establish processing time goals and establish appropriate processing time targets.

Initiative - Toxicology

KEY PROCESS STEPS

Clear 51 protocols (June 1980).

Award 11 Contracts for tests (June 1980).

Publish summaries of test results in Federal Register (twelve in June, twelve in September 1980).

Publish technical reports (thirteen in June, thirteen in September 1980).

Publish annual report on known carcinogens and the extent to which they are regulated (August 1980).

RESOURCES

		FY 79	FY 80 Qtrs.				FY 80
Obligations ($million)		Total	1	2	3	4	Goal
Carcinogenesis							
Contract & Extramural	Tgt.		4.0	4.9	20.8	12.3	42.0
	Act.	24.3					
Intramural	Tgt.		.7	1.2	1.6	1.8	5.3
	Act.	3.2	0				
Mutagenesis							
Contracts	Tgt.	Data not available		.3	.9	1.1	2.4
	Act.		.15				
Intramural	Tgt.			.1	.1	1.1	1.3
	Act.		0				
Staff Years							
Carcinogenesis	Tgt.			10	21	24	95
	Act.	34	40				
Mutagenesis	Tgt.			2.1	2.1	2.1	7.9
	Act.		1.6				

KEY PROCESS STEPS and RESOURCES

No comments.

TAB J

IMMUNIZATION

Initiative - Immunization

Protect the health of the nation's children by immunization.

INDICATORS

Table 1 - Morbidity (Disease) Reduction Targets, All Ages

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Measles:	Tgt.	28100	1700	2500	4000	1200	9400
cases	Act.	15687	1260				
Rubella:	Tgt.	12100	850	2500	4400	850	8600
cases	Act.	12216	862				
Mumps:	Tgt.	11100	3100	4700	4700	1500	14000
cases	Act.	15636	2664				
Polio:	Tgt.					10	10
cases	Act.	12					
Diphtheria:	Tgt.					5	5
cases /a	Act.	2					
Pertussis:	Tgt.					1394	1394
cases	Act.	1394					
Tetanus:	Tgt.					5	5
cases /a	Act.	6					

Table 2 - Immunization Levels for Children Under Age 7

			FY 80 Goal
Measles	Tgt		90
	Act.		
Rubella	Tgt.		90
	Act.		
Mumps	Tgt.		90
	Act.	Reporting system to be developed	
Polio	Tgt.		90
	Act.		
DTP /b	Tgt.		90
	Act.		

/a Children under age 15.
/b Diphtheria, tetanus, and pertussis.

OVERVIEW

This is one of the more complete and comprehensive initiatives (i.e., results oriented with quantifiable objectives and indicators), although there are data gaps. The series of indicators measure various aspects of the program; impact (reduced incidence of morbidity), outcome (level of immunization) and output (number of vaccinations administered). The initiative also monitors two related, high priority efforts; the elimination of measles and immunization of new borns.

Secretarial monitoring of this initiative is important to ensure full cooperation from many different parts of HEW which are involved in accomplishing this initiative.

HEW provides technical assistance, funding, and program guidance to the states who are primarily responsible for administering vaccines. Within HEW, almost all the programs (e.g., community health centers, IHS clinics) which provide direct care also have goals to immunize 90% of the children they serve.

Table 1

This table shows the ultimate impact of immunization -- the reduction of the incidence of disease. PHS developed the FY 80 goals based on previous trends. The FY 80 goals represent reductions ranging between 10% and 35% over FY 79 levels.

Table 2

PHS proposes to reach and/or maintain immunization goals of 90% because this level of protection provides the highest benefit/cost ratios.

PHS proposes that you track the immunization level of children under age 7 because PHS believes their immunization rates are lower than those for school aged children. In surveys done in 1979, levels in this age group ranged from 75 to 85 percent.

Limited data are available to establish the baseline for PHS' goals and there is no comprehensive data system presently in place to collect this information. However, PHS plans to collect these data by the following means: assessing levels annually in Head Start, Day Care, and direct service programs and among all children entering school.

Initiative - Immunization

Table 3 - Doses of Vaccine Administered to Children, Age 0-14 (000s)

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Measles	Tgt.	3745	819	761	838	925	3343
	Act.	4274	854				
Rubella [a]	Tgt.	3303	846	759	853	959	3417
	Act.	3328	781				
Mumps [b]	Tgt.	3195	866	737	815	884	3302
	Act.	3348	745				
Polio	Tgt.	8661	2027	1935	2150	2164	8576
	Act.	9624	2266				
DTP [c]	Tgt.	8737	1929	1887	2030	2282	8126
	Act.	11058	2607				

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[a] Targets for children under age 12 only.
[b] Targets for pre-school children only.
[c] Diphtheria, tetanus and pertussis.

Table 4 - Measles Elimination Effort

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Projects with grants for measles elimination	Tgt.	0	41	52	63	63	63
	Act.						
Active measles surveillance programs	Tgt.	0	41	52	63	63	63
	Act.						
States with measles incidence rates of less than 5 per 100,000 [a]	Tgt.	24				35	35
	Act.						

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[a] For total population.

TAB K

HEALTH PLANNING

Initiative - Health Planning

Limit the approval for the construction of additional hospital beds and the level of approvals for hospital capital expenditures through the HSA/SHPDA Certificate of Need/1122 review processes.

INDICATORS

Table 1 - Hospital Beds Closed, Converted, and Approved

		CY 80 Qtrs.				CY 80
		1	2	3	4	Goal
Beds approved	Act.					
Beds closed or converted	Act.					
Net increase in hospital beds	Tgt.	1233	1233	1233	1233	4932
	Act.					

Table 2.- Capital Expenditure Approvals /a
($ in Billions)

	Jan.-June /b	CY 80 Qtrs.				CY 80
	1979	1	2	3	4	Total
Tgt.		.85	.85	.85	.85	3.4
Act.	2.4					

/a For hospital beds and high cost equipment.
/b Most recent period for which complete data are available.

OVERVIEW

The intent of this initiative is to monitor two important outcome measures of the health planning program (i.e., limiting bed approvals and capital expenditures). However, there are two major limitations to this effort:

.. serious data problems (i.e., PHS estimates it has only received 50% of the required reports necessary to tabulate information on SHPDAs' approvals of new beds and capital expenditures for the period July-December 1979).

.. the Department has not communicated goals for bed approvals or capital expenditures to the SHPDAs and HSAs.

PHS is initiating actions to attempt to increase reporting (see the Key Process Steps) but, due to budget reductions, has only limited staff to assign to this initiative. MB recommends that by May 15, PHS set specific goals to increase SHPDA/HSA conformance with reporting requirements.

P will forward a decision memorandum to you by May 15 concerning establishing expenditure limits. PHS will communicate the goals to SHPDAs and HSAs within eight weeks of your decision.

Table 1 and 2

PHS proposes a goal of limiting the net addition of beds to .5%. This is an ambitious goal as the annual rate of increase has been about 2% a year. However, as mentioned above, HEW has not communicated this goal to the HSAs or SHPDAs.

Other Possible Indicators

PHS will forward targets to you to increase the number of fully designated SHPDA's within eight weeks of your determination regarding whether or not the Department should sponsor legislation to allow States an additional legislative session to comply with the certification of need requirement.

Initiative - Health Planning

KEY PROCESS STEPS

Letter to RHAs requesting that the regions validate whether the number of reviews each State completed equals the number reported to HEW (April 15).

RHAs report findings of investigation and reconcile 90% of differences (June 30).

Complete report determining resources needed to improve data reporting system (April 30).

Complete report which examines reporting incentives (e.g., linking payment of portion of grant award to reporting performance) (June 15).

RESOURCES

		FY 79	FY 80 Qtrs.				FY 80
		Total	1	2	3	4	Goal
Obligations ($millions)							
Program	Tgt.		1.4	1.4	1.4	1.4	5.6[a]
	Act.						
Salaries and Expenses	Tgt.		6.6	6.6	6.6	6.6	26.4
	Act.		7.9	13.1			
Staff Years							
Headquarters	Tgt.		.19	.19	.19	.19	.76
	Act.		.3	.5			
Field	Tgt.		.25	.25	.25	.25	1.0
	Act.		.3	.5			

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[a] Computer processing costs only.

Resources

PHS will revise its program expenditure figures by May 15 to include the total Federal expenditures involved with SHPDA and CON programs.

TAB L

HEALTH FACILITIES CONSTRUCTION LOANS

Initiative - Health Facility Construction Loans

To reduce the likelihood of default on health facility construction loans.

INDICATOR

		FY 79 Total	FY 80 Qtrs. 1	2	3	4
Problem loans to health facilities	Tgt.			170	140	128
	Act.	170	170			

KEY PROCESS STEPS

Implement Loan Early Warning System (June 1980).

Receive annual report on problem loans from regions (September 1980).

Recalculate number of problem loans based on improved definition (September 1980).

RESOURCES

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Obligations ($millions)							
Program	Tgt.		Not Applicable				
	Act.						
Salaries and expenses	Tgt.		125	125	125	125	500
	Act.						
Staff Years							
Headquarters	Tgt.		.9	.9	.9	.9	3.6
	Act.						
Field	Tgt.		2.9	2.9	2.9	2.9	11.6
	Act.						

OVERVIEW

HEW's present loan portfolio consists of 514 loans (totalling over $3.3 billion) for which the government is potentially liable. PHS has developed criteria to measure the financial strength of health facilities and has identified 43% of facilities have loans which are current or potential problems.

PHS will decrease the number of facilities with loans in problem status by providing detailed technical assistance to 42 facilities.

This initiative represents PHS' efforts to assist hospitals with financial difficulties before they are literally at the default stage. PHS has a data limitation since hospitals submit comprehensive financial information only once a year. To offset this problem somewhat, PHS will collect additional data during its site visits to problem hospitals. PHS will establish monthly targets for completing site visits by May 15.

KEY PROCESS STEPS

PHS will refine the definition of "problem" loans to include 18 variables. The current definition has only 6 variables. This action should enable PHS to target its resources more effectively on facilities with problem loans.

RESOURCES

PHS initially allocated 11.6 staff years in the field to provide technical assistance. PHS is reevaluating this committment and, if necessary, will provide revised staffing estimates by May 15.

TAB M

MEDICARE COVERAGE ISSUES

Initiative - Medicare Coverage Issues

Provide support to HCFA by conducting scientific medical evaluations of Medicare reimbursement issues.

INDICATORS

Inventory of Requests

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4	FY 80 Total
Requests pending beginning of qtr.	Act.	60	65	50	48		
New requests	Act.	14	0	4			
Requests completed	Tgt.						
	Act.	9	15	6			
Requests pending end of qtr.	Act.	65	50	48			
Requests over one year old	Act.	46					

KEY PROCESS STEPS

Jointly, PHS and HCFA will submit additional indicators and targets to the Secretary to monitor HEW's overall performance in completing Medicare coverage decisions (May 15, 1980).

RESOURCES

	FY 79 Total		FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Obligations ($000s)							
Program		Tgt.		1	63	66	133
		Act.	3	1			
Salaries & Expenses		Tgt.		40	40	40	152
		Act.	32	32			
Staff Years							
Headquarters		Tgt.		1.4	1.4	1.4	5.4
		Act.	1.2	1.2			
Field		Tgt.	0	0	0	0	0
		Act.					

OVERVIEW

The indicators, as presently stated, attempt to measure the timeliness with which PHS renders decisions on issues relating to the coverage of services under Medicare. Delays in rendering decisions affect both clients and hospitals.

PHS has agreed to work with HCFA to revise these indicators by May 15, and develop a set of indicators which:

- o classifies new requests into categories in terms of priority for action.
- o establishes maximum processing time goals for requests PHS receives after May 15.
- o establishes processing times goals within HCFA (from receipt of request to asking PHS for recommendation, and from receipt of PHS' recommendation to notifying requester).

Resources

PHS has not included the majority of resources it expends on this initiative, (i.e., the staff time that NIH, FDA, and ADAMHA devoted to this effort). PHS states it is unable to provide this information because it has no system to collect the data.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : The Secretary
Through: US_________
ES_________

DATE: May 29, 1980

FROM : Assistant Secretary for Management and Budget

SUBJECT: Briefing - Meeting on Public Health Service's Operations Management System (OMS) Initiatives

June 2, 1980 in the Secretary's Conference Room at 2:30 P.M.

I. PURPOSE

To review and approve 5 new or modified PHS OMS initiatives.

II. PARTICIPANTS

The Secretary
The Under Secretary
Dr. Richmond
Mr. Miller
Ms. Stoiber
Mr. Kelso
Mr. Markowitz
Dr. Johnson
Dr. Klerman
Dr. Pardes
Dr. Dumas
Mr. Sharfstein
Dr. Perry
Ms. Hanft
Mr. Martini
Mr. Bouxsein
Mr. Bohen
Mr. McFee
Mr. Lowe
Mr. Wholey
Dr. Davis
Mr. Sermier
Ms. Townsend
Ms. Peterson

III. DISCUSSION

The 5 initiatives selected for discussion include two new initiatives: (Grants and Procurement, and Affirmative Action) and three that have been substantially altered based on your directions at the April 9 and 10 PHS OMS meetings.

Included at Appendix I are action items resulting from the PHS OMS meeting on April 9 and 10. I, with Dr. Richmond and Mr. Miller, will discuss the status of these action items during the meeting.

Dr. Richmond and PHS staff will discuss the following 5 initiatives:

- Indian Health (Tab A)
- Community Mental Health Centers (Tab B)
- Medicare Coverage Issues (Tab C)
- Grants and Procurement (Tab D)
- Affirmative Action (Tab E)

The material is in the same format as previous meetings, with the addition of the report on the status on previous action items.

Fred Bohen

Frederick M. Bohen

Attachments

TAB A

INDIAN HEALTH

Initiative - Indian Health

PROPOSED NEW INDICATORS

Clinical

.. 90% of patients over age 10 must have had their blood pressure checked on their last visit or within a year of their last visit

.. 90% of patients will be screened for diabetes on their last visit or within a year of their last visit

.. All patients with Pap smears reported as Class III, IV, or V have a documented follow-up and further diagnostic study within six weeks of the test results

Administrative

.. Cost per inpatient day

.. Cost per outpatient visit

Self-Determination

.. Percent of tribes receiving information within 45 days after request

.. Percent of tribes receiving training within x number of days after request

.. Percent of tribes receiving technical assistance within x number of days after request

KEY PROCESS STEPS

Inform Area offices and Service units of their individual goals for all clinical, administrative, and Self-Determination indicators (July 30, 1980).

Collect and analyze baseline data, and propose targets to the Secretary for all clinical, administrative, and Self-Determination indicators (September 30, 1980).

Report IHS' performance (for October - December 1980) to the Secretary for all clinical, administrative, and Self-Determination indicators (February 20, 1980).

Overview

In response to your request for additional indicators, PHS developed the list of new indicators on the opposite page.

Clinical Indicators

IHS has no baseline data regarding the percent of service units which meet these standards. IHS will collect baseline data and submit targets (for the percent of service units which will achieve the standards) to you by September 30. IHS will hold its area offices and service units accountable for these indicators for the first time on October 1, 1980. IHS states that the information on all six of its clinical indicators (i.e., three new indicators and three original indicators listed on page A-4) will be statistically valid and reliable at the lowest organizational unit (service unit). It will report quarterly all the clinical indicators except hypertension and diabetes. For these indicators PHS will report data on all centers semi-annually and data for "problem" service units quarterly. MB and PHS will work together to develop the criteria for determining when a project must report quarterly.

Administrative Indicators

IHS will calculate its administrative indicators on the basis of obligations, not expenditures. The targets, when established in September, will aim at minimizing any increase in costs. IHS is proposing to use the indicators to compare facilities/services units and to seek ways to decrease the operating costs of the units in the upper ranges.

Self-Determination Indicators

The proposed indicators reflect IHS's approach to Self-Determination. Specifically, IHS feels it is not responsible for encouraging tribal units to manage or operate health services and facilities but rather IHS informs the tribes of their rights and opportunities and assists them in accomplishing their objectives.

PHS proposes to track response time to tribal requests for information, training, and technical assistance as indicators of its efficiency and responsiveness to tribal requests. After IHS collects baseline data, by September, it will state what percent of tribal requests will be responded to in what timeframes. For example: responding to 60% of all training requests within 20 days; 90% of all requests within 40 days, 100% of all training requests within 50 days.

PHS will also report semi-annually, on an informational basis, the number and percent of tribes which: a) develop tribal health plans; b) develop health budgets for the service units; c) decide to explore tribal management of health progams; d) develop health management capabilities; e) operate health programs (i.e., by type and number of admissions/contacts); and f) participate in none of the above.

In FY 79, tribes operated three hospitals (which had 1800 admissions) and 182 clinics (which had 533,000 outpatient visits). Additionally, 90% of tribes (252 tribes) had, at a minimum, developed tribal health plans. PHS will provide its first report for items a-f by June 30, 1980.

Initiative - Indian Health

PREVIOUS INDICATORS

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Graduating scholarship recipients providing medical services to Indians /a	Tgt.					100	100
	Act.	30					
IHS hospitals certified by Medicare /b	Tgt.			1	0	2	4
	Act.	44	1	1			
IHS hospitals accredited by JCAH	Tgt.			0	0	1	1
	Act.	32	0	0			
% women receiving care during 1st two trimesters of pregnancy	Tgt.			90	90	90	90
	Act.		88.5	88			
% adolescents who receive counseling as part of family planning services	Tgt.			90	90	90	90
	Act.		81	73			
% children under 27 mths. immunized /c	Tgt.		90	90	90	90	90
	Act.		84	85			

/a Excludes recipients continuing their education.
/b There are 48 IHS hospitals in total.
/c Against diptheria, tetanus, pertussis, polio, measles, mumps, and rubella.

KEY PROCESS STEPS

Notify all scholarship recipients of award (June 15, 1980).

RESOURCES

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Total
Obligations ($millions)							
Program	Tgt.						
	Act.						
Salaries & Expenses	Tgt.						
	Act.						
Staff Years							
Headquarters	Tgt.						
	Act.						
Field	Tgt.						
	Act.						

PHS will provide data by June 30.

Discussion

The charts on the opposite page illustrate the indicators you approved at the last meeting. Second quarter results are as follows:

- In the second quarter of FY 80, the percent of adolescents who received counseling as part of family planning services declined to 73%. By June 15, PHS will forward a memorandum discussing the reasons for the shortfall and the necessary corrective actions;
- In the second quarter of FY 80, 88% of women received care during their first two trimesters of pregnancy; and
- IHS has not achieved its goal of fully immunizing 90% of all children under 27 months of age. Specifically, the shortfalls were in immunizing children for measles, mumps, and rubella. By June 15, PHS will forward a memorandum discussing the reasons for the shortfalls and the necessary corrective actions.

Resources

IHS will provide complete resource estimates by June 30. IHS requires this time period to collect and analyze resource data on the delivery of clinical services. However, PHS reports that they will spend $21.8 million on Self-Determination and $3.6 million on the scholarship program in FY 80.

TAB B

COMMUNITY MENTAL HEALTH CENTERS

Initiative - Community Mental Health Centers (CMHCs)

Increase the management capacity and performance levels of the CMHC program (grantees).

INDICATORS

Table 1 - CMHC Short-term Performance Indicators

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Expending Access							
# of CMHCs in operation	Tgt.				736	740	740
	Act.	701	707	713			
% population with access to CMHC	Tgt.				51	52	52
	Act.	50	50	51			
Pre-grant TA to areas without a CMHC	Tgt.				60	75	220
	Act.	180	40	45			
Initial operations grant applications reviewed	Tgt.				13	22	47
	Act.	43	0	12			
# of Centers Monitored							
On-site /a Audits	Tgt.				59	59	152
	Act.	208	17	17			
Document Reviews/b	Tgt.				146	147	461
	Act.	413	84	84			
Survivability							
TA to CMHCs in their 7th and 8th year	Tgt.				40	59	137
	Act.	125	15	23			
# of CMHCs meeting audit reporting requirements	Tgt.					/c	
	Act.						507

/a These audits are three day on-site reviews of all aspects of a Center's operation. They are conducted by a team of 5-6 persons who use an OMB approved monitoring instrument and procedures.

/b These are comprehensive reviews of documents including the Center's continuation application, grants management reports, previous site visit reports, and health planning agencies recommendations.

/c PHS will provide fourth quarter targets by July 15.

OVERVIEW

As you requested, PHS has developed indicators of the actions NIMH is taking to manage the CMHC program in FY 80. These indicators address the three major operational priorities of the program; 1) expanding access to the program; 2) improving daily center operations; and 3) improving the survivability of CMHCs after Federal funding is terminated.

Within NIMH these management efforts compete for resources with two other priority activities: 1) developing of long-term performance indicators; and 2) preparing for enactment of the Mental Health Systems Act. PHS has taken into consideration estimated resource requirements for these two activities in developing targets for its short-term indicators (Table 1).

Table 1

These indicators are aimed at increasing the percent of the population which has access to CMHCs, monitoring CMHCs' performance against process measures, and ensuring that CMHCs which no longer receive Federal funding continue to provide services.

One of PHS' goals is to expand the CMHC program so that the entire U.S. population has access to mental health services. PHS has developed indicators to measure the increase in the number of CMHCs and the percent of the U.S. population with access to CMHC services. PHS calculates the percent by using the population in the catchment areas for both CMHCs currently receiving Federal support (547) and those CMHCs (249) which are operating without Federal funds.

To increase the number of CMHCs, NIMH is providing technical assistance to communities without centers and is processing applications requesting funds for a center. NIMH believes these indicators are good proxy measures of NIMH's effort to increase the number of centers.

To monitor CMHC operations, PHS staff conduct on-site audits and document reviews. The proposed indicators measure the staff's level of effort to ensure that centers are in compliance with operating and organizational requirements. During FY 80, because of resource and staff contraints, PHS is proposing conducting 27% fewer on-site audits and conducting 10% more document reviews (which are less resource intensive).

In addition to increasing CMHC coverage and monitoring the operations of centers, PHS seeks to ensure that CMHCs will have the capability to continue to operate after eight years of Federal support is terminated. This effort has been successful in helping to prevent total termination of operation, with only one CMHC ceasing all provision of services. However, NIMH does not have data regarding the extent of reduction in services when Federal funds are terminated.

To measure activities in this area, PHS proposes to track: 1) the provision of technical assistance to grantees in either their seventh or eighth year of funding; and 2) the number of CMHCs meeting financial audit reporting requirements. PHS' proposed long term indicators for financial viability will improve its ability to identify centers with financial problems and to provide assistance.

Table 2 - CMHC Long-term Performance Indicators

Program Accessibility

Non-white admissions as a % of white admissions

Under 18 years of age admissions as a % of 18-64 age group admissions.

65 years old and over admissions as a % of the 18-64 age group admissions.

Financial Viability

Fee for service reimbursement dollars as a % of total income.

Non-federal public dollars (e.g., state, county dollars) as a % of total income.

Operational Efficiency

Average expenditures per discharge.

Average number of persons served per full-time equivalent staff member.

KEY PROCESS STEPS

Analyze baseline data (June, 1980).

Report to Secretary on: revisions to indicators and how the CMHCs and NIMH will use the standards to improve management (July and November 1980).

Obtain OMB clearance of new management form (October 1980).

Train and educate grantees regarding standards (October 1980).

Award contract to collect data on indicators (November 1980).

Report to Secretary interim goals (November 1980).

Inform grantees of their targets (November 1980).

Submit to the Secretary legislative and regulatory recommendations to implement performance standards (March 1981).

Propose to Secretary additional indicators, proposed evaluation standards, and report 1980 data (May, 1981).

Report CMHCs performance (for Jan.-June 1981) against targets (September 1981).

Table 2

As discussed with you at the last meeting, this initiative represents NIMH's first attempt to develop performance-based standards and to hold its grantees accountable against those standards. However, PHS has now considerably revised (i.e., shortened) and clarified its schedule for implementing those indicators.

As the schedule of key process steps on page B-4 indicates, PHS is reviewing the indicators with regional and CMHC personnel and will submit goals to you by November. PHS will report 1980 data in May 1981, and provide its first report of CMHCs performance against their goals in September 1981. MB believes this is a reasonable schedule and recommends that you accept it.

Key Process Steps

No additional comments.

Initiative - Community Mental Health Centers

RESOURCES

		FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Obligations ($millions)						
Program	Tgt.	87.4	42.6	93.0	67.4	290.4
	Act.					
Salaries & Expenses	Tgt.	1.9	1.9	1.9	1.9	7.7
	Act.					
Staff Years						
Headquarters	Tgt.	8.5	8.5	8.5	8.5	34
	Act.					
Field	Tgt.	44	44	44	44	176
	Act.					

Resources

Obligations and staff years represent the appropriations level for the entire CMHC program. PHS will provide actual data by July 15.

TAB C

MEDICARE COVERAGE ISSUES

C-2

Initiative - Medicare Coverage Issues

Conduct scientific medical evaluations of Medicare coverage issues.

INDICATORS

Table 1 - Inventory of Requests for HHS

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4	FY 80 Total
Total Requests Pending Beginning of Qtr.	Act.	71	68	62	67		
*New Requests	Act.	6	5	12			
**Requests Completed	Act.	9	11	7			
Requests Pending End of Qtr.	Act.	68	62	67			

Table 2 - HCFA's Inventory of Requests from Receipt to Forwarding to PHS

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4	FY 80 Total
Requests Pending Beginning of Qtr.	Act.	3	2	7	10		
*New Requests	Act.	6	5	12			
****Requests Forward to PHS	Act.	7	0	9			
Requests Pending End of Qtr.	Act.	2	7	10	15		

Table 3 - PHS' Inventory of Requests

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4	FY 80 Total
Requests pending beginning of qtr.	Act.	64	65	50	53		
****New requests	Act.	7	0	9	1/a		
***Requests completed	Tgt.						30
	Act.	6	15	6	3/a		
Requests pending end of qtr.	Act.	65	50	53	51/a		
Requests over one year old	Tgt.					32	
	Act.	46	34	28	30/a		

/a As of May 20.

OVERVIEW

This initiative monitors HCFA's and PHS's progress in rendering decisions on important issues relating to the coverage of services under Medicare. Delays in rendering decisions affect both clients and hospitals.

This initiative tracks only those issues which are important enough to require PHS to make a medical determination. Responsibility for reaching a decision is shared by HCFA and PHS. HCFA initially receives the requests in its regional offices; headquarters reviews the request and determines whether PHS needs to make a determination on the issue. Within PHS, the National Center for Health Care Technology initially reviews the issue and then, as appropriate, includes several other agencies (e.g., FDA, ADAMHA, NIH) in the review process. After PHS makes a recommendation, HCFA reviews the decision and publishes a notice regarding the Department's policy. Tables 2, 3, and 4 monitor workloads distributed among each of these stages.

Table 1

This table provides summary information regarding the total inventory of requests in the Department. For example, in the beginning of the second quarter there were 62 requests which the Department had not yet made a decision on, the Department received 12 requests, and completed 7. Thus there were 67 outstanding requests at the end of quarter.

Table 2

This table reflects how many requests HCFA has pending, the number which it has forwarded to PHS, and the number of requests over six months old.

Table 3

PHS proposes establishing a goal to decrease the number of requests which are over 1 year old from 46 to 32. PHS has already exceeded its fourth quarter target, and MB recommends that PHS consider revising this goal. Currently, 59% of pending requests are over one year old. PHS has indicated that for a large number of their requests, the complexity of the issue involved and not its procedures result in lengthy processing times.

Table 4 - HCFA's Inventory of Requests which have been returned from P

		4th Qtr. FY 79	FY 80 Qtrs. 1	2	3	4	FY 80 Total
Requests Pending Beginning of Qtr.	Act.	4	1	5	4		
***Requests from PHS	Act.	6	15	6			
**Requests Completed	Act.	9	11	7			
Requests Pending end of Qtr.	Act.	1	5	4			

Table 5 - Average Processing Time for Requests Completed During Qtr.

		FY 80 Qtrs. 1	2	3	4
HCFA					
From receipt to sending to PHS (%)					
0-50 days	Tgt. Act.			30	30
51-125 days	Tgt. Act.			60	60
over 125 days	Tgt. Act.			10	10
From PHS to issuing decision (%)					
0-105 days	Tgt. Act.			30	30
106-170 days	Tgt. Act.			60	60
over 170 days	Tgt. Act.			10	10
PHS					
Requests which PHS received after May 15 (months)	Tgt. Act.			12.0	12.0

Table 4

This table reflects the inventory at the final stage of requests (i.e., the decision level). At this stage, HCFA has received PHS' recommendation requesting coverage and must determine whether HCFA agrees with the decision and where coverage is appropriate, publish the Department's decision.

Table 5

This table monitors processing times for requests at various stages in the Department's process.

In the last month HCFA has reorganized and upgraded its procedures for reviewing coverage requests. Given the time and resources necessary to obtain baseline data (which was not readily available), HCFA developed these third and fourth quarter goals on the basis of discussions with staff. The staff state that these goals are ambitious as they believe the time frames are significantly shorter than in the past. HCFA proposes maintaining these goals throughout the remainder of FY 80 until it gains experience with the new procedures. MB concurs.

Presently, the HCFA goals only include the processing time for HCFA's central office; they do not include the time regional offices take to process requests and mail them to headquarters. HCFA states that by September 1, it will review the indicator and determine whether it will include a regional component or initiate basic changes in the procedures (i.e., have requests sent directly to headquarters).

PHS has established a processing time goal of 12 months for requests it receives after May 15. This will be a substantial improvement, as the cumulative average processing time for requests completed through May 15 was 20 months.

KEY PROCESS STEPS

PHS and HCFA will negotiate target dates for completing action for all high priority cases received prior to May 15 and will negotiate target dates for all requests received after May 15 (June 10, 1980).

HCFA will review its portion of this initiative to determine whether it should include a regional component in its review procedure (September 1, 1980).

RESOURCES

PHS

		FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Obligations ($000s)						
Program	Tgt.		1	63	66	133
	Act.	3	1			
Salaries & Expenses	Tgt.		40	40	40	152
	Act.	32	32			
Staff Years						
Headquarters	Tgt.		1.4	1.4	1.4	5.4
	Act.	1.2	1.2			
Field	Tgt.					0
	Act.	0				

HCFA

Obligations ($000s)		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Salaries & Expenses	Tgt.				36	36	144
	Act.	36	36	36			
Staff Years							
Headquarters	Tgt.				10	12	10
	Act.	8	9	10			
Field	Tgt.						
	Act.		HCFA will submit field resource data by July 15, 1980.				

Key Process Steps

HCFA and PHS have not yet negotiated target dates for completing action on high priority cases received prior to May 15 and for all issues received since May 15, but will do so by June 10.

Resources

PHS has not included the majority of resources it expends on this initiative, (i.e., the staff time that NIH, FDA, and ADAMHA devoted to this effort). PHS states it is unable to provide this information because it has no system to collect the data.

TAB D

GRANTS AND PROCUREMENT

Initiative - Grants and Procurement

Improve the management of obligations and award schedules for contracts and grants.

INDICATORS

Table 1 - Contracts and Grants Award Schedule

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Contracts/a							
Dollars Awarded ($millions)	Tgt.			195	315	265	882.8/b
	Act.	962	154.5	148.3			
Award $ as % of FY 80 total/d	Tgt.			21.0	35.7	30.0	100
	Act.	/c	17.5	16.8			
Grants							
Dollars Awarded ($millions)	Tgt.		547	915	1404	1256	4137/b
	Act.	3914	702	825			
Grant $ as % of FY 80 total/d	Tgt.		13	22	34	30	100
	Act.	/c	17	20			

Table 2 - Other Contract Indicators

		FY 79 Total	FY 80 Qtrs. 1	2	3	4	FY 80 Goal
Competitive /a Procurements Cumulative (% of contract $s)	Tgt.			33	38	47	47
	Act.	47	29	37.3			
Awards to Disadvantaged Businesses ($millions)							
Minority Businesses	Tgt.			7.5	11.4	11.5	43.9
	Act.	29	13.6	10.8			
Small Businesses	Tgt.			65.0	85.	65.	282.0
	Act.	281	67.2	66.1			
Women-owned Businesses	Tgt.			1.0	1.4	1.0	3.5
	Act.	0	.1	1.0			
Labor Surplus Areas	Tgt.			2.0	3.0	2.0	36.0
	Act.	70	29.7				

/a Only for contracts/procurements over $10,000.

/b Total calculated using actuals to date plus targets for remaining quarters.

/c Not applicable.

/d Percentages calculated using target for the most recent estimate of FY 80 total dollars awarded.

OVERVIEW

The Department has established a limit that a POC may not obligate more than 30% of its total FY 80 procurement obligations in the fourth quarter; and no more than 12% in each month of the fourth quarter.

PHS has established a system to implement and enforce this requirement. When third quarter obligations are completed, PHS will establish strict limits for fourth quarter obligations to ensure meeting the 30% cap. PHS is now collecting data on total procurement obligations and will use this complete information in determining the dollar amount necessary to meet the 30% cap. MB is conducting a review of PHS' obligation control points to ensure that adequate control procedures are in place. In FY 79, PHS awarded 32% of its contract obligations in the fourth quarter.

Table 1

This data represents a significant part of the obligations subject to the fourth quarter limitation described above. Based on the data presented, PHS awarded 34% of its contractural obligations in the first half of FY 80. This is slightly less (38% vs. 34%) than originally planned.

PHS has forwarded its FY 81 plan for contract award schedules. MB is currently analyzing this submission and will provide comments at the next PHS OMS conference.

Table 2

PHS' cumulative competitive procurement rate over the first half of FY 80 is 37.3%. However, PHS' performance improves significantly if it excludes procurements where competition is precluded (e.g., Buy Indian Act purchases, Cooperative Health Statistics System awards, long term clinical trials). Segregating out these non-discretionary procurements, PHS competitively awarded 53.8% of its funds (on a cumulative basis) through the second quarter.

PHS' proposed awards to small and disadvantaged businesses are consistent with Secretarially established goals. PHS has increased awards to disadvantaged businesses during the first six months of FY 80 to $24 million as compared with $5.8 million during the same period in FY 79.

The significant reduction between FY 79 and FY 80 in awards to labor surplus areas (LSAs) is due to the Conte amendment which restricts the Department from targeting contracts to LSAs when these contracts would not substantially affect employment levels. However, because of a large number of Indian Health Services construction awards in LSAs, PHS' awards in labor surplus areas for the first quarter exceed the Department's entire FY 80 goal of $23 million.

TAB E

AFFIRMATIVE ACTION

Initiative - Affirmative Action

Improve the employment and promotion opportunities of minorities, women, and the handicapped. E-2

INDICATORS

	% of Pop. in GS grade band- FY 79		3rd&4th Qtr. Dept-wide Targets/1	Accessions (Hires) 3rd & 4th Qtr. Tgts.	Accessions (Hires) % Increase From FY 79/2	Promotions 3rd & 4th Qtr. Tgts.	Promotions % of Pop. Promoted/2	Total Employment Opportunity Tgts. FY 80 3	Total Employment Opportunity Tgts. FY 80 4
HISPANICS									
GS 13-15									
Dept.		Tgt.	8.4						
PHS		Tgt.		8.4	18.3	4.0	26	5.0	5.0
	1.7	Act.							
GS 9-12									
Dept.		Tgt.	8.4					3.7	3.7
PHS		Tgt.		8.4	36.0	2.0	25		
	1.5	Act.							
GS 1-8									
Dept.		Tgt.	9.6						
PHS		Tgt.		6.0	71.0	2.0	25	3.9	3.9
	1.4	Act.							
ASIANS									
GS 1-8									
Dept.		Tgt.	2.8						
PHS		Tgt.		2.8	52.0	1.3	25	2.0	2.0
	.8	Act.							
AMERICAN INDIANS/ALASKAN NATIVES									
GS 13-15									
Dept.		Tgt.	.7						
PHS		Tgt.		.7	41.7	.34	25	.4	.4
	1.6	Act.							
GS 9-12									
Dept.		Tgt.	.7						
PHS		Tgt.		.7	31.6	.2	26	.34	.34
	5.8	Act.							
GS 1-8									
Dept.		Tgt.	.4						
PHS		Tgt.		.4	56.0	.3	25	.3	.3
		Act.							

/1 Based on new hires only.
/2 Annual rate.

OVERVIEW

ASPER and MB believe that PHS has established acceptable total employment opportunity (i.e., hiring plus promotions) goals for this inititative. With only one exception, PHS has set hiring goals identical with the Department's goals.

PHS has established employment opportunity targets for only those grade bands and minority categories where its employment representation is below the equivalent national civilian labor force percentages.

DISCUSSION

There are differences between the PHS targets for total employment opportunities and the Departmental goals (e.g., 5.0% vs. 8.4% for Hispanics in grades 13-15). The Departmental goals were determined based on estimates of the number of years it would take the Department to reach parity, through hiring, for a particular minority underepresented in a particular grade band. PHS has developed goals which include both hires and promotions. As a consequence of including promotions, the combined target representing total employment opportunities usally becomes lower than the hiring rate target alone. This is particularly true in grade bands where current minority representation is very low. As an underepresented minority becomes more numerous, the promotion opportunities for that group will increase, and the combined targets should approach the Departmental targets. PHS projects that achieving its hiring and promotion targets will enable it to meet the Departmental timeframes for reaching parity in various grade bands. (NOTE: PHS believes that promotion of more than 26% of any group in any grade band in one year is not feasible. This is more than double PHS' current promotion rate for some grade bands. Setting higher promotion goals would generally be inconsistent with personnel policy for reasons of merit as well as its effect on grade inflation).

PHS states it would have difficulty achieving its hiring goals in some categories if PHS experiences more hiring opportunities than expected, because PHS believes there is an upper limit on the absolute number of certain minorities that it could recruit. This is especially true for Hispanics since: 1) the civilian labor force rate for Hispanics in the geographic areas where most openings will occur is considerably lower than the national rate (2.8% vs. 4.2%); and 2) the job classifications in which most of the opportunities will occur are in patient care fields which have historically low minority representation.

The only PHS hiring goal which is not identical to the Department-wide goal is for Hispanics in the GS 1-8 grade range. PHS believes it would be extremely difficult to locate a large enough number of Hispanics in this grade band to achieve a 9.6% hiring rate. PHS also points out that achieving its proposed 6.0% rate will result in an increase of 71% in the current population from FY 79 levels.

For FY 81, ASPER will calculate the Department-wide targets to include the effect of promotions.

Initiative - Affirmative Action

Improve the employment and promotion opportunities of minorities, women, and the handicapped.

INDICATORS

	% of Pop. in GS grade band-FY 79		3rd&4th Qtr. Dept-wide Targets/1	Accessions (Hires) 3rd & 4th Qtr. Tgts.	Accessions (Hires) % Increase From FY 79/2	Promotions 3rd & 4th Qtr. Tgts.	Promotions % of Pop. Promoted/2	Total Employment Opportunity Tgts. FY 80 3	Total Employment Opportunity Tgts. FY 80 4
BLACKS									
GS 13-15									
Dept.		Tgt.	10.1						
PHS		Tgt.		10.1	5.4	14.6	25	13.5	13.5
	7.2	Act.							
WOMEN									
GS 13-15									
Dept.		Tgt.	41.7						
PHS		Tgt.		41.7	8.0	33.1	20	35.2	35.2
	20.3	Act.							
HANDICAPPED									
GS 13-15									
Dept.		Tgt.	4.0						
PHS		Tgt.		4.0	26.8	1.1	25	1.8	1.8
	.005	Act.							
GS 9-12									
Dept.		Tgt.	4.0						
PHS		Tgt.		4.0	61.0	.6	25	1.5	1.5
	.004	Act.							
GS 1-8									
Dept.		Tgt.	4.0						
PHS		Tgt.		4.0	88.0	1.1	25	2.5	2.5
	.7	Act.							

/1 Based on new hires only.
/2 Annual rate.

Table 1 (continued)

No additonal comments.

STATUS OF ACTION ITEMS

Appendix I

STATUS OF ACTION ITEMS FROM PHS OMS MEETING HELD ON APRIL 9 & 10

HMO

Action Item #1

By April 30, PHS will submit to the Secretary an objective to increase the number of CHCs converted to HMOs.

Status:

PHS submitted its proposal on May 12. Through FY 82, PHS proposes: 1) converting 8 existing pre-paid community health centers (CHCs) to qualified HMO's; 2) completing feasibility studies at 18 pre-paid and fee-for-service CHCs; 3) completing HMO planning grant activity at 18 pre-paid and fee-for-service CHCs; and 4) completing HMO initial development activity at 8 existing fee-for-service CHCs. At the next OMS meeting in July we will include this initiative for your review. MB recommends that you provisionally approve these targets, pending a complete review by you or the Under Secretary at the next PHS OMS meeting in July.

CMHC

Action Item #2

By April 30, PHS will submit to the Secretary a memorandum which describes the CMHC program and outlines the major actions NIMH is taking to improve CMHC's program performance in FY 80. These actions will be stated in such a way that NIMH could include them as OMS indicators or supporting process steps.

Status:

PHS submitted a background memorandum on May 12 and a list of indicators on May 27. ES is in the process of circulating the memorandum and expects to forward it to you shortly. Dr. Richmond and PHS staff will discuss the proposed indicators and targets. Highlights are at Tab B.

FDA

Action Item #3

By May 30, FDA will submit a report to the Secretary on the actions it will take to classify NDAs (for purposes of monitoring processing times) for at least two segments: 1) from receipt of an application to the time an applicaton is complete; and 2) from the point an application is complete until FDA approves/disapproves the application.

Status:

PHS submitted a memorandum on May 30. FDA recommended that it not track NDAs by these categories. MB and ASPE agree with PHS' rationale that it would not be meaningful to classify NDAs as initially requested. At the PHS OMS meeting in July, we will schedule a discussion of this issue.

NIAAA

Action Item #4

By April 30, PHS will report to the Secretary on the feasibility and utility of adding accidents as a variable in calculating its impairment index for Indians.

Status:

PHS submitted its response on May 12. NIAAA is adding accidents to its reporting form and will begin to use this revised form by October 1, 1980.

IHS/NIAAA

Action Item #5

By June 15, PHS (with assistance from MB) will report to the Secretary on the degree to which it is useful and/or practical to ensure that all Indian alcoholism projects have similar management systems and use identical data reporting forms.

Status:

Item not yet due. PHS and MB staff are meeting regularly to resolve issues. PHS expects to submit the report on time.

IHS

Action Item #6

By April 30, PHS will forward to the Secretary a complete list of performance indicators (including BCHS's indicators which could be adopted) which IHS could report to the Secretary on a quarterly or semi-annual basis, and will specify for which of these indicators IHS has negotiated goals with area offices/clinics/tribes. PHS should also indicate which specific indicators and targets from this list they propose for Secretarial tracking.

Status:

PHS submitted its response on May 12. IHS proposed 8 additional indicators which are discussed in the briefing material (pages A-2 and A-3).

Action Item #7

By April 30, IHS will provide estimates of resources it intends to expend in FY 80 related to its OMS initiative.

Status:

PHS submitted a partial response on May 12. PHS has requested an extension until June 30 to obtain and analyze data regarding obligations and personnel expenditures for clinical services. MB supports the request for an extension, given the effort IHS will have to expend to extract the relevant data from existing personnel and financial accounting systems.

NIOSH

Action Item #8

By April 30, NIOSH will report to the Secretary whether it can achieve its OMS goals with its present staff and resources. If not, PHS will revise the targets accordingly.

Status:

Submitted May 12. NIOSH lowered its goal for the number of health hazard evaluations it would complete by 15% (from 177 to 150) to account for the hiring freeze and budget reductions. OMB believes this revision is reasonable. At the July PHS OMS meeting, PHS will discuss this issue in more detail.

Action Item #9

By October 15, PHS will propose to the Secretary impact indicators for health hazards evaluations and the dates by which it proposes to establish a data system to measure impact, report baseline data, and establish quarterly targets.

Status:

Action Item not yet due.

Action Item #10

By April 25, OGC will forward a memorandum to CDC describing its opinion on whether NIOSH may establish cooperative agreements with private entities to have them conduct substantial portions of health hazards evaluations.

Status:

Submitted April 25. It is OGC's opinion that NIOSH may use cooperative agreements, on a demonstration basis, to conduct health hazard evaluations.

Toxicology

Action Item #11

By April 30, PHS will submit to the Secretary three sets of goals for testing of toxic chemicals based on three different resource assumptions (i.e., if the hiring freeze extends for 3 months, 6 months, or continues indefinitely).

Status:

PHS submitted a memorandum on May 15 regarding the impact of the freeze on the National Toxicology Program (NTP). A six month freeze or indefinite freeze would reduce by half the number of new carcinogenic tests which PHS could begin in FY 80, FY 81, and FY 82 (i.e., from 80 tests to 40 per year). The freeze would also affect the development and validation of short term tests for carcinogenicity and NTP's ability to respond to such issues as Agent Orange, and the Love Canal. This issue will be discussed fully at the July meeting.

HRA

Action Item #12

By June 15, PHS will report to the Secretary on the steps it has taken, including tying reporting requirements to funding, to ensure States report all information regarding capital expenditure approvals and bed approvals within a fixed timeframe.

Status:

Action Item not yet due. PHS expects to meet due date.

Action Item #13

By May 1, PHS will forward a memorandum to the Secretary describing the effects on other PHS programs (CHCs, CMHCs) if, for various reasons including funding reductions, SHPDAs do not reach full designation by the date required in legislation. PHS should include options for addressing this potential problem.

Status:

PHS submitted a memorandum on May 7. ES is circulating the memorandum and expects to forward it to you by May 30, 1980.

OHCTR

Action Item #14

By May 15, PHS will submit a report: 1) with semi-annual targets for the number of coverage requests it will complete (but will report quarterly); 2) classifying, with HCFA, all coverage requests (received after May 15) into categories of priority for action; and 3) establishing processing time targets for completing the less complex requests received after May 15.

Status:

PHS and HCFA have satisfied most of these requirements, as described in Tab C. However, PHS and HCFA will require an extension until June 10, to establish target completion dates for high priority requests and those requests it receives after May 15.

Other

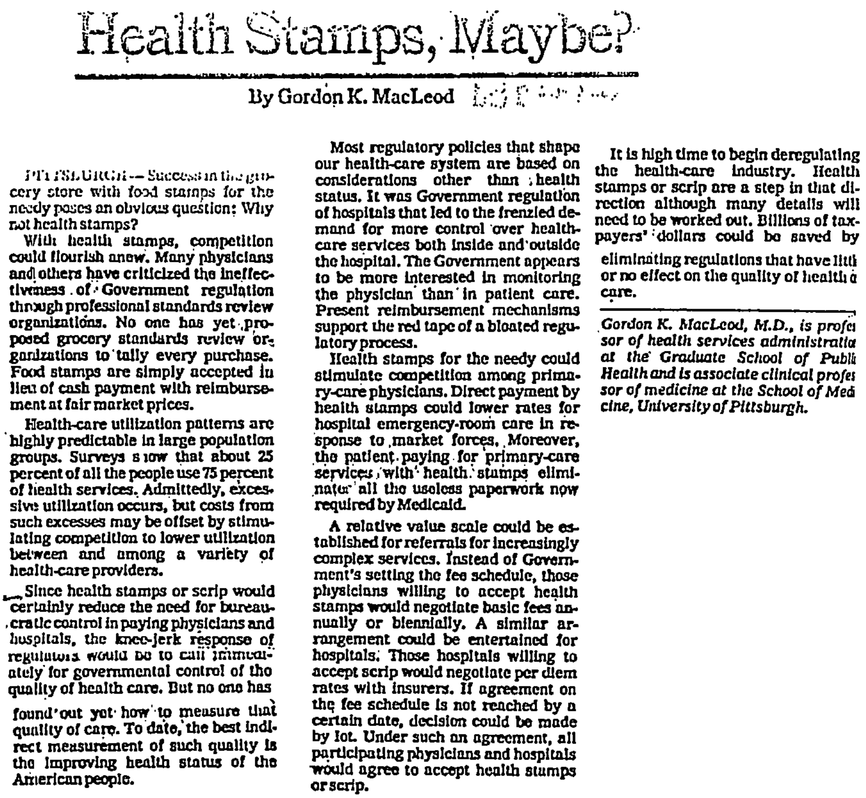
Action Item #15

By May 15, ASPER, after meeting with the Under Secretary and MB, will forward to the Secretary an information memorandum on the precise ways that OMS targets will be reflected in HHS performance appraisals.

Status:

On May 22, you signed a memorandum to all senior departmental officials which described the necessary linkages between OMS and the performance appraisal process. Related to this effort, Mr. Miller and Mr. Bohen personally reviewed the performance plans of 25 senior managers throughout PHS to determine whether their plans contain objectives and standards which correspond to their OMS initiatives. They will be prepared to discuss the results of this review at the

Exhibit 12



Health Stamps, Maybe?

By Gordon K. MacLeod

PITTSBURGH — Success in the grocery store with food stamps for the needy poses an obvious question: Why not health stamps?

With health stamps, competition could flourish anew. Many physicians and others have criticized the ineffectiveness of Government regulation through professional standards review organizations. No one has yet proposed grocery standards review organizations to tally every purchase. Food stamps are simply accepted in lieu of cash payment with reimbursement at fair market prices.

Health-care utilization patterns are highly predictable in large population groups. Surveys show that about 25 percent of all the people use 75 percent of health services. Admittedly, excessive utilization occurs, but costs from such excesses may be offset by stimulating competition to lower utilization between and among a variety of health-care providers.

Since health stamps or scrip would certainly reduce the need for bureaucratic control in paying physicians and hospitals, the knee-jerk response of regulators would be to call immediately for governmental control of the quality of health care. But no one has found out yet how to measure that quality of care. To date, the best indirect measurement of such quality is the improving health status of the American people.

Most regulatory policies that shape our health-care system are based on considerations other than health status. It was Government regulation of hospitals that led to the frenzied demand for more control over health-care services both inside and outside the hospital. The Government appears to be more interested in monitoring the physician than in patient care. Present reimbursement mechanisms support the red tape of a bloated regulatory process.

Health stamps for the needy could stimulate competition among primary-care physicians. Direct payment by health stamps could lower rates for hospital emergency-room care in response to market forces. Moreover, the patient paying for primary-care services with health stamps eliminates all the useless paperwork now required by Medicaid.

A relative value scale could be established for referrals for increasingly complex services. Instead of Government's setting the fee schedule, those physicians willing to accept health stamps would negotiate basic fees annually or biennially. A similar arrangement could be entertained for hospitals. Those hospitals willing to accept scrip would negotiate per diem rates with insurers. If agreement on the fee schedule is not reached by a certain date, decision could be made by lot. Under such an agreement, all participating physicians and hospitals would agree to accept health stamps or scrip.

It is high time to begin deregulating the health-care industry. Health stamps or scrip are a step in that direction although many details will need to be worked out. Billions of taxpayers' dollars could be saved by eliminating regulations that have litt or no effect on the quality of health c care.

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Health stamps or script would reduce the need for bureaucratic control in paying physicians and hospitals; stimulate competition among primary-care physicians; lower the rates for hospital emergency-room care and also eliminate useless paperwork now required by medicaid. Additionally, health stamps would be a step in the direction of eliminating regulations that have little or no effect on the quality of health care, thereby saving billions of tax payers' dollars.

EXECUTIVE SUMMARY

Consumer Choice Health Plan (CCHP): An Approach to National Health Insurance (NHI) Based on Regulated Competition in the Private Sector.

I. MAIN IDEAS

1. Controllable Subsidies Based on Need. Government would help people enroll in and pay for a private health benefits plan (insurance, HMO, etc.) with tax credits or vouchers whose amounts are based on actuarial category and, for the poor, financial need, and which are usable only for premiums in qualified health plans. A typical tax credit for a middle income family of four might be $800; a typical voucher for a poor family might be $1,350. Government would seek to phase out its open-ended commitment to third-party reimbursement insurance that is now a main cause of inflation.

2. Competing Alternatives and Informed Choice. Rules would assure that all people have a choice among competing alternatives (which few have today); that they have good information on which to base their choice; that competition emphasizes scope of benefits, quality of services and total cost (as opposed to today's emphasis on preferred risk selection, minimizing only administrative cost, etc.).

3. Equity and Incentives for Economy. CCHP is aimed at correcting today's cost increasing incentives. It takes money now used to subsidize people's choice of more costly systems of care (i.e. the unlimited exclusion of employer contributions from taxable income, and Medicare and Medicaid's cost-reimbursement), and uses it to raise the floor for the least well covered. It gives consumers an incentive to seek out systems that provide care economically by letting them keep the savings. Although Government would assure that people have enough money to enroll in a good plan, beyond the subsidy level the economically self-sufficient would be using their own (net after-tax) money, which should motivate them to seek value for it.

4. Based on Functioning Programs. CCHP is modeled after the Federal Employees Health Benefits Program (FEHBP) now serving 10.5 million people, and similar non-Federal programs; it extends to the whole population and to all qualifying health plans its proven principles of competition, multiple choice, private underwriting and management, and periodic government-supervised open enrollment.

II. SPECIFIC COMPONENTS

A. Financing

1. Tax credit. The present exclusion of employer and deductibility of employee contributions to health insurance and deductibility of medical expenses from taxable income (now costing about $10.1 billion including

payroll taxes) would be replaced by a tax credit based on actuarial category (e.g. non-aged family of four). That is, the present open-ended tax subsidy of roughly 30% of health insurance costs up to any level would be replaced by a 100% subsidy up to a predetermined level with no subsidy above that.

2. <u>Vouchers for Medicaid</u>. Medicaid would be replaced by a system of vouchers for premium payments to qualified health benefits plans, integrated with reformed welfare, and reaching 100% of actuarial cost of basic benefits in the case of the poor.

3. <u>Freedom of Choice in Medicare</u>. The Medicare law would be changed to permit each beneficiary to have his Adjusted Average Per Capita Cost paid to the qualified health plan of his choice as a fixed prospective periodic payment. (Conventional Medicare would be retained for those who choose it. A voucher would supplement Medicare for poor beneficiaries.)

B. <u>Pro-Competitive Regulatory Framework</u>

1. <u>Open Enrollment</u>, through an annual government-managed open-season, would enhance competition and assure everybody access to all qualified plans in their area.

2. <u>Community Rating</u>, i.e., premiums equal for all persons in the same actuarial category enrolled for the same benefits in the same area would preclude prohibitive rates for poor risks and would spread health care costs over the total population.

3. <u>Rating by Market Area</u> would "internalize" costs of health services by NHI market area to give local regulators incentives for cost control and eliminate anti-competitive cross-subsidies. (Today, because the cost of operating unneeded health facilities is paid mostly from outside their area, while the jobs are inside their area, local regulators have little incentive to close them.)

4. <u>Low Option</u>. Qualified plans must offer a "low option" limited to the basic benefits defined in the NHI law (to prevent plans from limiting membership to the well-to-do by offering only plans with costly supplemental benefits).

5. <u>Maximu</u> [illegible] use cost-
sharing bu [illegible] ily) out-of-
pocket out [illegible] full protection
against ca [illegible] bankruptcies."

6. <u>Health</u> [illegible] ry member would
serve seve [illegible] minate questions
of payment [illegible]

7. Information Disclosure would help consumers judge the merits of alternative plans and help assure public confidence. Data would include patterns of utilization, availability of services, and total per capita cost including premiums and out-of-pocket costs.

8. Grievance Procedures would be required to provide a forum for resolving disputes.

9. Compatibility with Economic Controls. Physician fee and hospital cost controls could be implemented through CCHP by making compliance a condition for a plan to be qualified. However, the experience with economic regulation generally has been that it protects producers from competition and raises rather than lowers costs to consumers.

C. Other

1. Flexibility in Benefits. CCHP principles could be adapted to any benefit package and eligibility definition under consideration for NHI.

2. Flexibility in Administration. CCHP could be administered entirely by the Federal Government or jointly with the States.

3. Reliance on Existing Resources for Financing and Administration. CCHP would provide a continuing substantial role in health financing for employers and health and welfare funds.

III. GOALS

A. Short Term

1. Equity in the Use of Public Funds. Today Medicare and the tax-subsidies pay more for people with more income and who are better insured; CCHP would pay more to people in greater medical and financial need.

2. Motivate Efficiency by Changing Financial Incentives.

3. Competition and Informed Choice. Each consumer would have a choice from among competing alternatives and more and better information to help him make a wise choice.

4. Continuity of Coverage. Assure each person continuity of coverage in the same health plan regardless of job status. (Today loss of job generally means loss of health coverage and change of job means change of coverage.)

B. Long Term

1. Improve Access to Care. Access (financial, geographic, social) for every American to comprehensive health care services of good quality,

willingly provided, and with a freedom of choice that respects each person's preferences.

2. Delivery System Reform. Transformation of the health care delivery system into competing organized systems that reward providers for offering high quality but cost-effective care. Confidence that this would happen is based on the demonstrated economic superiority of the leading prototype HMO's and other efficient organized systems of health care delivery. What is needed is for the government to correct the anti-HMO biases in the tax laws, Medicare law, HMO Act, and other laws and programs, and systematically create the conditions for a fair market test among competing alternatives.

3. Personal Choice in Use of Resources. CCHP would let spending for personal health care services be set in the marketplace on the basis of individual priorities rather than being set in a political process.

IV. COSTS

The long term effects on total health services spending of CCHP or any other NHI plan are impossible to estimate. However, there is much reason to believe that CCHP's incentives approach would restrain long-term cost growth more effectively than any other approach to NHI. As for short-term costs to the Federal Budget, CCHP is flexible and could be implemented at various levels of subsidy. A "full" version of CCHP with tax credits of 60% of Actuarial Cost for the non-poor, rising to to 100% for the poor, would have a net cost to the Federal Budget at FY 1978 prices of about $22.4 billion, not counting any changes in Medicare. This compares to roughly $50 billion for a universal government-run, third-party reimbursement system ("Kennedy-Mills") or $90 billion for Health Security. (The gross cost of the tax credits and vouchers would be roughly $46.2 billion, offset by $23.8 billion in saved "tax expenditures," replaced Federal Medicaid, and other programs.)

V. PHASING IN CCHP

CCHP is a flexible concept, not an "all or none" proposal. It can be phased in. For example, a version with a tax credit equal to 30% of actuarial cost (AC) for the non-poor, raised on a sliding scale to 100% of AC at the income-guarantee level ($4,200 for a family of four) would have a net cost in FY 1978 prices of $3.1 billion. The credit could be raised, e.g., 2.5 percentage points per year over 12 years, until the tax credit reached 60%, at an annual increase in outlay of about $1.6 billion.

D R A F T
September 22, 1977

MEMORANDUM FOR SECRETARY CALIFANO

FROM: ALAIN ENTHOVEN

SUBJECT: NATIONAL HEALTH INSURANCE (NHI)*

> "...We must have a comprehensive program of national health insurance.... The coverage must be universal and mandatory....freedom of choice in the selection of a physician and treatment center... will always be maintained.... We must phase in the program as rapidly as revenues permit, helping first those who most need help, and achieving a comprehensive program well-defined in the end.... We must encourage... alternative delivery systems such as health maintenance organizations and rural group practices. ...I support organized approaches to delivery of services. ... Incentives for reforms in the health care delivery system and for increased productivity must be developed. ...Incentives for the reorganization of the delivery of health care must be built into the payment mechanism. ...It is not required that the government run the entire health care program in our country--I would not favor that."
>
> Jimmy Carter
> April and October, 1976

I. GOALS

This memorandum outlines what I believe is the best strategy to move us toward the goal of access (financial, geographic, and social) for every American to comprehensive health care services of good quality, willingly provided, and with freedom of choice that respects each person's preferences. Our society also has other pressing needs: helping the poor, rebuilding cities, energy conservation, environmental protection, and investment incentives to create jobs. So the care we seek must be cost-effective.

To achieve our health care goals at a cost in balance with other goals, we need to reorganize the delivery system. The Government cannot do that directly. People would resist such changes involuntarily imposed. But Government can change the underlying economic incentives so that consumers and

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*To reconcile the need for a concise overall statement with the need for documentation and detailed explanation of many points, I have made liberal use of appendices which are referred to in the text by numerical superscripts. I suggest you read the Memorandum first without consulting the appendices, and then return to the appendices on any particular points on which you have questions.

providers of care can benefit from seeking out and joining cost-effective organized systems (e.g., Health Maintenance Organizations and the like). The delivery system would then be forced to reorganize itself in response to a market of consumers who are seeking out and choosing what is in their own best interest. Because the distinctive idea of this NHI proposal is to let consumer preferences guide the reorganization of the system, I have called it "Consumer Choice Health Plan (CCHP)."

II. INFLATION AND INEQUITY TODAY

1. Main Problems. Real (i.e., net of general inflation) per capita spending on health care increased 79 per cent from 1965 to 1976; on hospital care it increased 110 per cent. As a per cent of GNP, health care went from 5.9 to 8.6 per cent. There are good reasons for much of this: the growth in public and private insurance coverage brought access to many who previously did not have it, especially the aged and the poor; advances in technology increased the power of medicine to prolong life and enhance its quality; the population aged; the health care system took on new assignments (e.g., in mental health, alcohol and drug abuse); the pay of health care workers was brought up to the level of other industries; rising incomes and expectations increased consumer demand for health care services. Our present concern with the growth in spending should not mislead us into thinking it is all bad.

But, especially in recent years, the increase has far exceeded what could be justified on these grounds. Hospital charges and physician fees rose faster than the CPI. Health workers' pay overshot equality with other industries.[1] There is great inefficiency, e.g., duplication of costly underutilized facilities. Wide variations in the per capita consumption of various costly health services (e.g., hospitalization and surgery) among similar populations, without any apparent difference in medical need or health outcome, suggest that there is much spending that yields no significant benefit in terms of health.[1] People might be just as healthy with half as much hospitalization.

While the nation is spending more, some people are enjoying the benefits less. Gaps in coverage leave some unprotected from heavy financial burdens, others protected only after medical costs have made them poor. Public funds (including tax subsidies) do more for the well-protected well-to-do than for the working poor who need help more. Also there is uneven geographic distribution, leaving many rural and inner-city residents poorly served while there are too many doctors in some well-to-do areas.

2. Causes of Inflation and Inequity. The main cause of the unjustified and unnecessary increase in costs is the complex of perverse incentives inherent in the tax-supported system of fee-for-service for doctors, cost-reimbursement for hospitals, and third-party intermediaries to protect consumers. Fee-for-service rewards the doctor for providing more and more costly services whether or not more is necessary or beneficial to the patient. Cost-reimbursement rewards the hospital with more revenue for generating more costs. Indeed, a hospital administrator who seriously pursued cost cutting, e.g. by instituting tighter controls on surgery and laboratory use and avoiding buying costly diagnostic equipment by referring patients to other hospitals, would be

punished by a loss in revenue (Medicare and Medicaid would cut him dollar for dollar), and a loss in physician staff and, therefore, patients. Third-party reimbursement leaves the consumer with, at most, a weak financial incentive to question the need for or value of services or to seek out a less costly provider or style of care.

These incentives are reinforced by the demands and expectations of anxious patients, the prestige associated with costly technological care, the malpractice induced need for "defensive medicine," and the government-inspired proliferation of health manpower--especially physicians. Thus, the financing system rewards cost-increasing behavior and provides no incentive for economy. At the same time, it is inequitable. Medicare and Medicaid are among the worst offenders.

(a) Medicare pays more on behalf of the people who choose more costly systems of care. For example, in 1970, Medicare paid $202 per capita on behalf of beneficiaries cared for by cost-effective Group Health Cooperative of Puget Sound, but paid $356, or 76 per cent more, on behalf of similar beneficiaries in the same area who got their care from the fee-for-service sector. Medicare pays more to doctors who charge more and more to hospitals that cost more. At the same time, Medicare pays more on behalf of rich than poor (because they live in better-served areas and can more easily afford the coinsurance), white than black, well-served than underserved.

(b) Medicaid, which also relies almost entirely on third-party, fee-for-service and cost-reimbursement, is particularly vulnerable to fraud and abuse. Its beneficiaries are particularly unlikely to be able to judge the need for or value of services provided to them, and are less motivated to weigh the value against the cost because they are not spending their own money. As President Carter said last year, "Medicaid has become a national scandal. It is being bilked of millions of dollars by charlatans."

(c) Tax-subsidized private insurance, with no limit on tax-free employer contributions, subsidizes employee decisions to select more costly health care systems, and encourages employee pressure for rich employer-paid benefits. (Most of the roughly $10.1 billion FY 1978 "tax expenditures"--including payroll taxes-- is about a 30% subsidy of health insurance.[21]) This tax system also provides more subsidy for better paid and covered than for poorly paid and covered people.

These incentives also help to defeat regulation and local efforts at cost containment. Why should a Health Systems Agency or a Board of County Supervisors defy local pressures and force the closing of an unneeded hospital, with loss of jobs, when most of the extra costs of keeping it open are paid from outside their area?

Thus, the increase in health care spending is a serious problem, but not because more spending is bad in itself. Indeed, if the spending were all on necessary, cost-effective care yielding significant benefits for the quality of people's lives (and much of it is), we would be celebrating it. Rather, it is a problem because:

(a) The financing system does not inspire confidence that resources are being used wisely, and examples of waste abound; and

(b) Medical care costs are straining public finances at every level of government, and are forcing cutbacks in services to the needy. Public sector spending rose from $9.5 billion, or 25 per cent of the total, in 1965 to $59 billion, or 42 per cent of the total, in 1976. More than half of this is in open-ended, third-party reimbursement programs in which government spending is not controllable. Medicare outlays are increasing 47 per cent from FY 1976 to FY 1978.

3. Lack of Competition and Choice. There are competitive elements in the health care industry. For example, insurance companies compete with each other, and with self-insurance, for group contracts, by offering lower administrative costs. But there is very little competition to produce services more efficiently or offer a less costly style of care, and pass the savings on to consumers. Most workers are offered a single health insurance plan by their employer or Health and Welfare Fund (HWF), usually a third-party reimbursement plan. (The Health Maintenance Organization Act was intended to open up employee groups to HMOs by mandating dual choice, but the qualification process has been bogged down in HEW, and many employers are holding back on offering HMOs until they are qualified.)[18]

The Medicare law has a complex provision for paying HMOs, but it is based on retrospective cost-finding, includes an implicit tax on HMOs, and has not been put into operation. So Medicare beneficiaries are stuck with a third-party, cost-reimbursement system; they cannot choose a more efficient system and realize the savings for themselves.

While the fee-for-service, third-party reimbursement system offers the patient a free choice among doctors and hospitals in his community, it does not offer him the alternative of keeping much of the savings he would generate by choosing effective but less costly care. The premiums and charges he must pay reflect the cost-generating behavior of doctors and hospitals in his community and the experience of his insured group. His choice of doctors and hospitals is generally limited to those who work within the framework of the cost-increasing incentives. If he would prefer, for example, a system that used half as much hospitalization per capita, in exchange for more home care or better access to ambulatory care, at an equal per capita cost, the third-party, fee-for-service system would not be able to offer it to him.

4. Other Market Imperfections. In addition to these barriers to desirable competition, consumers today generally have poor information about health care alternatives. They must rely on physicians, who often have a financial interest in more costly care, for information on benefits of proposed treatments. There is great uncertainty about these benefits in many cases. There are many restrictive laws and practices.

Geographic and specialty maldistribution of physicians are exacerbated by third-party, fee-for-service financing, which creates an open-ended demand for subspecialty care in well-to-do areas, and little incentive to offer primary care in inner city or rural areas.

5. The Physicians' Role. Physicians receive only about 20 per cent of the health care dollar, but they control or influence most of the rest. Even though it may not appear so on an organization chart, physicians are the primary decision-makers in our health care system. But the present structure of the industry imposes very little responsibility on them for the economic consequences of their health care decisions. Their education and professional attitudes combine with the financial incentives and other factors such as the malpractice threat, to minimize concern over cost and to foster cost-increasing behavior. If the managers of a system are not concerned with cost-effectiveness, the system will not be cost-effective.

6. Discontinuities in Coverage. Most private health insurance is provided as an employment-related fringe benefit--a system that works reasonably well for a large portion of our economically self-sufficient population with job stability (except that, as noted above, the limit on employer health plan offerings is a key barrier to competition and consumer choice). However, the employment health insurance linkage is not compatible with an effective universal system because: people lose their coverage when they lose their jobs; job changes commonly require health coverage changes, with breaks in continuity of coverage and care and nonproductive administrative costs; it is very difficult to arrange good coverage for persons in marginal industries or with seasonal, intermittent, or otherwise unstable employment; employer-employee financing is regressive; without mandated coverage the low-paid who often need the most protection gets the least; and with mandated coverage, in addition to great administrative problems for workers with unstable employment, the economic burden would fall heaviest on the lowest paid and provide a strong disincentive for employing marginal workers.

In a society that agrees that everyone should have financiel access to a decent level of health care, it makes no sense to have a system in which many people lose their coverage when they lose their jobs, while many others lose their Medicaid eligibility when they get even a poorly paid job. Cycling in and out of Medicaid eligibility with income changes produces hardship and work disincentives for the poor, and heavy non-productive administrative burdens for States, counties, and providers. As incomes fluctuate, contributions, not eligibility, should vary with ability to pay. Everyone's health care coverage should be continuous.

7. Regulation Won't Make Things Better.[2] In recent years, the main line of Government policy has been to attack the problems created by inappropriate incentives with various forms of regulation, e.g. planning controls on hospital capacity, controls on hospital prices and spending, controls on hospital utilization, and controls on physician fees. The weight of evidence, based on experience in many other industries, as well as in health care, supports the view that such regulation is likely to raise costs and retard beneficial innovation.

A great deal of regulation of health services is inevitable. And in some fields, regulation is used to maintain competition, e.g. the Securities and Exchange Commission. Indeed, a key part of CCHP is pro-competitive regulation.

The issue, then is not regulation in general; it is the specific types of regulation and their likely consequences. The point here is that direct controls on costs, in opposition to the basic financial incentives, are not likely to make things better.

In the long run, price regulation amounts to cost-reimbursement and has the same incentives. Regulation tends to protect regulated firms whenever competition or technological change threatens established positions within the industry. Regulators often see the purpose of the price structure as providing a mechanism for subsidizing some groups at the expense of others, rather than as a mechanism for offering incentives to buyers and sellers to make economical choices. The main reason hospitals favor regulation is that it would function as a cartel to protect them from buyers who want to cut costs; they know that the approved rates will be based on their costs.

Medical care has many characteristics that make it a particularly unsuitable candidate for successful economic regulation. Basic to the problem is the subtle, elusive, and indeed almost indefinable nature of the product. In the health care sector to date, the only economic regulation that has been thoroughly tested is regulation of hospital capacity. And it is clear that certificate-of-need regulation has not helped control the problem of overbedding. A fixed legislated limit on total capital spending by hospitals might offer a temporary illusion of effectiveness, but it is vulnerable to a number of countermeasures such as "unbundling."

Physician fee controls have been advocated, and were tried in the Nixon Administration. In judging their likely value as a cost control device, one should be aware that the "doctor visit" is highly compressible. And the need for doctor visits is impossible to test objectively except in extreme cases.

Overall controls on hospital spending face similar prospects: circumvention, unbundling, exceptions. The Administration proposal has already been emasculated by the wage pass through, despite the fact that hospital workers now earn more than their counterparts doing similar jobs in other sectors.[1] But even if it were ultimately successful at controlling total hospital spending at the stated growth rate, there would be no force in the system to assure efficiency or equity in the allocation or production of services. At best, we would have frozen the hospital industry in its present wasteful and inequitable pattern.

If you are interested in motivating efficiency and equity, you must address the fundamental financial incentives in the system.

8. <u>NHI Is Already Here</u>. We have a sort of NHI system, with separate programs for the aged, poor, employed middle class, veterans, military dependents, etc. So the issue is not "whether NHI ". It is "what kind of NHI." I do not accept the view that we cannot afford NHI now, and that we must wait for it until we get costs under control. On the contrary, we are already paying for NHI, but we are not getting the benefit because we have an inefficient inequitable system that results from historical accident and interest group pressure. Some groups remain unprotected; prompt action is needed to assure universal coverage. But an equally urgent reason for NHI

today is the need to find good ways to reorganize the system and build in incentives for equity and cost-effectiveness.

III. CONSUMER CHOICE HEALTH PLAN (CCHP)

A. Main Ideas

1. Reform Through Incentives. To achieve good quality comprehensive care for all, at a cost we can afford, we must change the fundamental structure of the health care financing and delivery system. Instead of today's fragmented system dominated by cost-increasing incentives, we need a health care economy made up predominantly, though not exclusively, of competing organized systems. In such systems, groups of physicians would accept responsibility for providing comprehensive health care services to defined populations, largely for a prospective per capita payment, or some other form of payment that rewards economy in the use of health care resources.

Today we cannot see very clearly what such an economy would look like. We should seek to find our way there by a fair market test among competing alternatives in which systems that do a better job for a lower cost survive and grow. Many types of systems might succeed in such a competition, including not only Prepaid Group Practices (PGP) and Individual Practice Associations (IPA), the two "official" types of HMO, but also "Health Care Alliances" as proposed by Ellwood and McClure and "Variable Cost Insurance" as proposed by Newhouse and Taylor in which premiums reflect the cost-control behavior of providers. There would be a substantial role for pure insurance and for traditional fee-for-service practice. CCHP seeks to accomplish this transformation by voluntary changes in a competitive market.

2. Informed Choice Among Competing Alternatives. CCHP is designed to assure that all people have a choice among competing alternatives, that they have good information on which to base their choice, and that competition emphasizes quality of benefits and total cost (as opposed to today's emphasis on preferred risk selection, minimizing only administrative cost, etc.). CCHP would resemble the Federal Employees Health Benefits Program (FEHBP) and other conceptually similar plans. It would extend to the whole population and to all qualifying health plans its proven principles of competition, multiple choice, private underwriting and management of health plans, periodic government-supervised open enrollment and equal rates for all similar enrollees selecting the same plan and benefits.

3. Equity and Incentives for Economizing Choices. CCHP seeks to correct inequities and cost-increasing incentives in the tax laws and Medicare. The present exclusion of employer and deduction of employee premium contributions would be replaced by a refundable tax credit based on actuarial category. Medicaid would be replaced by a system of vouchers for premium payments, integrated with reformed welfare, and reaching 100 per cent of Actuarial Cost for basic benefits in the case of the poor. Medicare would be changed to give each beneficiary the freedom to have his Adjusted Average Per Capita

Cost (AAPCC) paid to the qualified plan of his choice as a fixed prospective periodic payment. Thus, CCHP takes money now used to subsidize people's choice of more costly systems of care, and uses it to raise the floor under the least well covered. It gives people an incentive to seek out systems that provide care economically by letting them keep the savings. While Government assures that people have enough money to join a good plan, at the margin people are using their own (net after-tax) money, which should motivate them to seek value for it. These changes would permit continuity of coverage regardless of job status.

4. Incremental Changes. CCHP is not an immediate radical replacement of the present financing system with a whole new one. Rather, it is a set of incremental "mid-course corrections" in the present financing and regulatory system, each one of which is comparatively simple and familiar taken by itself, but whose cumulative impact is intended to alter the system radically, but gradually and voluntarily, in the long run. CCHP corrects the faulty incentives produced by present government programs, and seeks to correct known market imperfections. CCHP preserves flexibility. If these changes do not produce the desired results, after experience has been gained, more corrections can be made. CCHP recognizes that there is no "final solution" to health care financing problems, as experience in countries with NHI clearly demonstrates. CCHP is not necessarily incompatible with some proposed regulation such as health planning, hospital cost controls, and physician fee controls. On the contrary, CCHP would increase the effectiveness of the Health Systems Agencies by giving them incentives to control costs they now lack. And competing private plans with the right incentives might enforce a fee schedule far more effectively than a government agency could.

B. The Financing System

1. Actuarial Categories and Costs.[3] The flow of funds in CCHP is based on Actuarial Cost (AC), i.e. the average total costs of covered benefits (insured and out-of-pocket) in the base year, updated each year by a suitable index, for persons in each actuarial category. For persons not covered by Medicare, the actuarial categories might be the simple and familiar three-part structure of "individual, individual plus one dependent, and individual plus two or more dependents." However, in a competitive situation, this might give health plans too strong an incentive to attempt to select preferred risks by design of benefit packages (e.g., good maternity benefits to attract healthy young families), location of facilities, or emphasis in specialty mix (strength in pediatrics, weakness in gerontology and cardiology). Carried to a logical extreme, such a system could lead to poor care for high-risk persons (though open enrollment--described below--would always assure the right of high-risk persons to join any qualified health plan). So experience might show that a more complex set of actuarial categories is desirable. For example, the three-part structure might be supplemented by special categories for persons aged 45-54 and 55-64. In the limit, one might go to a structure based on individual age (e.g. in 10-year steps) and sex, though I doubt this would be necessary.

Actuarial Cost would also reflect location, because there are large regional differentials in health care costs. The appropriate geographic unit would probably be the State. However, regional differences in real per capita subsidies based on AC would be phased out over a decade.

The appropriate index for updating AC would probably be the "all services" component of the Consumer Price Index (CPI).

Assume, for the sake of illustration, that the AC for a "typical" family of four is $1,350 per year. (This happens to reflect the approximate average per capita cost for hospital and physician services for children and working-age persons in FY 1978.)[21]

In CCHP, premiums would be set by each health plan for each actuarial category and benefit package, based on its own costs and its own judgment as to what it can charge in a competitive market. Thus, persons in more costly actuarial categories would pay higher premiums. This is desirable because we want competing plans to be motivated to serve them. This is made socially acceptable by giving such people higher subsidies through the following mechanisms.

2. Tax Credit. The present exclusion of employer and health and welfare fund (HWF) contributions from taxable income, and the deductibility of individual premium payments would be replaced by a refundable tax credit equal to some predetermined percentage (call it "X%") of the family's AC. (The deductibility of direct medical expenses would be limited to those in excess of 10% of Adjusted Gross Income.) Employers and HWF's would continue contributing to employee health insurance under existing agreements, but they would report such contributions as a part of total pay on W-2 forms. The tax credit is allowed only if spent on premiums for a qualified health plan. To the ordinary employee, then, CCHP would appear initially as a quite simple change in the way his compensation is taxed.

The appropriate level of "X" requires a policy judgment that balances a number of factors. Too low a level (e.g. below 30%) would leave too weak an incentive for plans to qualify. Too high a level (e.g. above 70%) would set the subsidy at a level above that needed for a truly efficient plan, and would weaken incentives for economy. Within this range, a lower "X" targets a higher percentage of the available funds on the poor through the voucher system. A level around 30% would make the tax credit approximately offset the tax increase caused by repeal of the exclusion of employer contributions for most employed middle-income people--thus helping to minimize political opposition. (Those whose marginal tax-rate times employer contribution exceeded the tax credit would lose.) A greater "X" means more cost to the Federal budget, more income redistribution and less of the total to be in means-tested vouchers. A greater "X" would reduce the incentive for the non-poor to buy high deductible "catastrophic" insurance, and would reduce the potential for people to manipulate the system to their advantage, taking a minimum cost catastrophic plan when they expect to be healthy, then switching to a full-benefit plan when they anticipate elective surgery or pregnancy. In my judgment, an "X"around 60 per cent, approximating the

FEHBP contribution level, would make the system work best. However, CCHP could start with a tax credit equal to 30%, at a comparatively low cost (see below), with higher levels phased in as revenues permit. In what follows, I will assume a 50% tax credit for illustration.

3. Vouchers for the Poor[5] The poor need more subsidy to assure their access to an acceptable plan. CCHP would provide them with a voucher usable only as a premium contribution to the qualified plan of their choice. It should be administered through the reformed cash-assistance system and designed according to the same principles. The voucher's value would be means-tested on the same basis as cash income supplements. The exact choice of formula requires analysis and judgments similar to those that went into welfare reform. Here is one example; others are discussed in Appendix 5. Reformed welfare guarantees a family of four a minimum cash income of $4,200; the income supplement is reduced 50 cents for each dollar of earned income until it reaches zero at a family income of $8,400. Related to this, one could set the voucher at $1,350 for a family with a total income, including cash assistance, of $4,200, and phase it down to $625--the tax credit level for non-poor families--at a "benefit reduction rate" of 15 cents for every dollar of income. In this particular case, the voucher would reach $625 at a total family income of $8,367. (This would raise the total Federal "benefit reduction rate" to 59%, a possibility that was anticipated in the analyses leading to welfare reform.)

The voucher system can be integrated with the tax system and the unemployment insurance system.[6]

4. Medicare would be retained for the aged, disabled, and victims of end-stage renal disease (ESRD). Eligibility would be expanded to all legal residents aged 65 and over for Part A (institutional services) and Part B (physicians' services). The benefits should be expanded to conform to the benefits for the rest of the population. The 150-day limit on hospital days should be removed--in effect providing catastrophic coverage. Better still, an annual limit on out-of-pocket expenses on covered benefits by any individual should be enacted.

The most important change needed in Medicare is a "freedom of choice provision" that would permit any beneficiary to direct that the "Adjusted Average Per Capita Cost" (AAPCC) to the Medicare program for people in his actuarial category be paid to the qualified plan of his choice in the form of a fixed prospective periodic payment. If done properly, this would end the Medicare subsidy to those who choose a more costly system of care, and would permit beneficiaries to reap the benefit of their economizing choices in the form of reduced cost-sharing or better benefits. (The technical and political problems of doing this are discussed in Appendix 8).

In addition, about 7.7 million aged, blind, and disabled receive Medicaid supplements to assist with costs not covered by Medicare. CCHP would replace this part of Medicaid, as far as acute care is concerned, with a voucher, comparable to the voucher for the non-aged poor, for premiums for a policy to supplement Medicare. In FY 1978, the average per capita hospital and physician costs for the aged not covered by Medicare will be about $385. This would be an appropriate level for the voucher.

C. Pro-Competitive Regulatory Framework

In order to qualify to receive tax credits, vouchers, or Medicare payments, a health plan would have to operate by the following rules for a fair and socially desirable competition based on quality and cost-effectiveness.

1. Open Enrollment.[9] Each plan would participate in a periodic government-run open enrollment in which it must accept all enrollees who choose it, without regard to age, sex, race, religion, national origin, or, with possible minor exceptions, prior health conditions. Each September, for example, every family would receive an informative booklet published by the administrative agency. During October, each head of household would make an election for the coming year, through his employer, welfare office, or local office of the administrative agency. This would greatly enhance competition by giving each person a choice from among competing plans, and it would assure that every person could enroll in a qualified plan.

2. Community Rating. A qualified plan must charge the same premium to all persons in the same actuarial category enrolled for the same benefits in the same area. (Nominal differentials might be allowed to reflect differences in costs of collecting premiums from different sized groups.)

Open enrollment and community rating are essential features of CCHP.

3. Rating by Market Area. Qualified plans must set community rates by market area (such as Health Service Areas or groups of contiguous HSAs). This is to prevent anti-competitive cross subsidies from one area to another, and to "internalize" the costs of health services by Health Service Area so that a decision by a Health Systems Agency to permit construction of a new health facility will be fully reflected in the premiums paid by citizens in that area, thus giving the HSA a more balanced set of incentives to control costs.

4. Low Option. Qualified plans must offer a "low option" limited to the basic benefits defined in the NHI law. This is to prevent plans from limiting membership to the well-to-do by offering only plans with costly supplemental benefits.

5. Maximum on Out-of-Pocket Costs. Qualified plans must publish a clearly stated maximum on individual (or family) out-of-pocket outlays over a one or two-year period (e.g., $1,500 in one year, $2,500 in any two consecutive years). Beyond that amount, the plan must pay all costs for covered benefits. This would help assure that plans do not compete by offering "thin" benefits that would leave the seriously ill uninsured and a burden on the public sector. It is appropriate to limit consumer choices in this respect because, in the case of non-poor families, society's primary objective is to protect everyone in case of serious illness. (I would leave the amount to be set by each plan. It is likely to become an important competitive variable. But it could be set by regulation.)

6. Health Plan Identification/Credit Card. Every qualified plan would issue each member a card which would inform providers of each person's coverage and which would serve as a credit card for covered services for eligible providers. This would virtually eliminate questions of payment at the provider's office, and it would put the burden of credit and collection on the financial intermediary, the agency best equipped to handle it. Revolving credit at regulated interest rates would ease the cash flow problem for persons facing large out-of-pocket payments. The intermediary's computer could figure out the copayments and deductibles--a great convenience for the consumer. And the credit card would allow the intermediary to capture total cost information--allowing it to report total per capita cost for covered benefits as discussed below. Special measures would be required to assure the ability of health plans to collect debts and to finance the large float.[10]

7. Information Disclosure is an essential part of CCHP to help consumers judge the merits of alternative plans and to help assure public confidence in the plans. Uniform financial disclosure would be required, comparable to what the SEC requires of public companies. Data on patterns of utilization, availability and accessibility would be required, as is required of HMOs in the HMO Act. Data should also be developed and published on qualifications of providers and on indicators of quality of care and consumer satisfaction such as rates of medical injuries, complaints, etc. To aid consumer choice, each plan would be required to publish total per capita costs, including premiums and out-of-pocket costs. The administrative agency would have authority to review and approve (for accuracy and balance) promotional materials, including presentations to be included in the booklet available to all eligibles at "open season"--as the Civil Service Commission does for the FEHBP. The administrative agency would also have authority to review and approve "endorsed options" and contract language such that all options offered would either conform to a standard contract or be able to be described by a standard contract and a manageable number of additions and exclusions. This would force plans to publish their terms in a format that is understandable to consumers and that facilitates direct comparison among plans without the consumer having to master and compare a lot of fine print.

8. CCHP and Direct Controls. CCHP is not necessarily incompatible with some proposed regulation such as health planning, hospital cost controls, and physician fee controls. Compliance with controls can be made a condition for a plan to be qualified. CCHP would increase the effectiveness of the Health Systems Agencies by giving them incentives they now lack to control costs. Moreover, the present structure of physician fees has perverse incentives. A system of controls on the fee-for-service sector might improve this situation and also encourage physicians to join cost-effective organized systems. Competing private plans with incentives to control total costs would probably be able to enforce such controls more effectively than could a government agency. Controls on the fee-for-service sector from which cost-effective organized systems were exempted might encourage the restructuring of the delivery system. However, experience with regulation in health care and elsewhere suggests that the regulatory process usually protects established provider interests from competition. So the purposes of CCHP could be defeated by conventional regulation. The burden of proof must be placed on the proponents of controls to show that the controls will not have their usual effect of retarding cost-reducing innovation.[20]

9. Other. In CCHP, as in any NHI system, there would be requirements for grievance procedures, and safeguards for civil rights and against fraud and conflict of interest. Also, some changes in selected State laws would be useful.[12]

D. Benefits and Eligibility.

Any NHI plan must include definitions of covered benefits and eligible persons. The choices are largely political judgments. However, there are economic considerations. For example, the use of prescription drugs is strongly influenced by physicians, and it would be desirable for health plans to be at risk for prescription drugs to give physicians an incentive to prescribe carefully. The principles of CCHP can be applied to any of a broad range of benefit packages and eligibility criteria, including coverage of essentially every legal resident of the United States. The philosophy of CCHP suggests that, beyond the essentials, what is included in health benefits plans should be determined by consumer desires expressed in the marketplace, rather than by provider interests.

E. Federal-State Roles in Financing and Administration.

CCHP is compatible with many possible ways of splitting Federal and State financing responsibilities. The choice must be considered in the context of Federal-State burden sharing in general--of which acute medical care financing is only one piece--and it must rest largely on political judgments. One illustrative possibility is as follows. First, about 35% of Medicaid pays for long-term care. About 58% pays for acute medical care and prescription drugs and sundries. In Fiscal 1976, the Federal Government paid 55% of Medicaid. The Federal Government might pay 100% of the cost of the health insurance premium vouchers, i.e. the replacement of the acute care paid for by Medicaid, in return for which the States might take on an increased share of the financing of long-term care, supplementary payments to low-income families in high-cost areas where the vouchers do not pay for adequate health care coverage, and assistance with such benefits as dentistry and the part of mental health not financed through NHI. Because States are potentially important factors in health facilities planning and cost controls, the Federal Government should not pay more on behalf of States that have higher real per capita health care costs in such a way as to weaken their incentive to control costs.

CCHP could be administered entirely by the Federal Government or jointly by the Federal Government and the States under Federal standards. Some of the merits of each are discussed in Appendix 13.

F. Role of Employers, Unions, and Labor-Management Health and Welfare Funds (HWF).

Employers, unions, and HWFs would continue to play a significant, though modified, role in CCHP. They would continue to serve as the main vehicles for collecting the funds for workers' health insurance premiums. There would be no sudden change with enactment of CCHP; merely a change in the way employees are taxed on a fringe benefit. Because additional health benefits would no longer receive preferred tax treatment, one can expect that in the future employees would demand more of their compensation in wages, less in health benefits. If we wish to curb the growth in health spending, that is a desirable result. Open enrollment in all qualified health plans might reduce what little bargaining power employers and HWFs have with respect to providers; it would increase the role of individual choice by consumers. HWF and employer bargaining power would be based on advice, not on their power to limit the choices of their workers. So far, employers and HWFs have not been very successful in bargaining with providers for cost control.

In addition to their key role in aggregating funds for the efficient purchase of health benefits, employers and unions would have two very important roles to play in CCHP. The first would be to organize the provision of information, advice, and voluntary evaluation for their workers. Under CCHP, there might be more than a dozen qualified health plans in operation in some areas. Busy workers would need help in knowing on which few they should focus attention, and the relative merits of each as discovered, in large part, by the experience of their coworkers. Unions and employers could organize committees, hire experts, take surveys of member satisfaction, and publish "consumer reports" to help their workers find their way through the market. Such private voluntary agencies are in a much better position to provide information that depends on value judgments than are government agencies. Government agencies are usually hamstrung by legal requirements of proof and objectivity and by well-focused pressures from providers.

The second role would be direct action to help reorganize the health care delivery system. Under CCHP, it would be even more advantageous for an employer and for union members to have lower health care costs in their area than is the case today. Thus, employers and unions could contribute to the goals of CCHP and serve their own interests at the same time by taking the initiative to organize cost-effective systems of care.

G. Special Categories: DOD (CHAMPUS), Veterans, Indians, Migrants, Derelicts, Underworld, Illegal Aliens, Non-Enrollers, etc.

Special measures can be designed for the special problems of each of these categories within the context of CCHP. CCHP will not, of itself, solve these problems, but it does provide a framework that helps.[7]

H. Delivery System Reform[14]

CCHP creates a framework of financial incentives that is favorable to the growth of cost-effective organized systems. But it does not, in itself, create those systems. If such systems are to come into being, many local efforts to organize them will be required. Public policies to encourage such efforts should be the subject of separate legislation.

I would not recommend more special grants and subsidies for HMOs because (a) experience with the HMO Act shows that they come at an extremely high political price, and (b) given a truly fair market test, those demonstrating the economic superiority of the best HMOs will prosper without help (though getting started is another matter). The HMO Act promised grants and loans, on the basis of which many costly restrictions were justified. The costly restrictions were enacted; the financial help actually delivered fell far below the amounts originally authorized. Advocates of more "help for HMOs" should remember what happened last time. I am much more impressed by the economic superiority of the best prepaid group practice plans than by unenforceable promises of generous public subsidies for HMOs. Experience suggests thatthe soundest public policy would be firm adherence to the principle of a fair market test among competing alternatives.

An antitrust strategy specifically designed for the peculiar economics of the health care industry is needed. Ordinary antitrust theory, developed for other industries, does not fit very well in health care. It is easy to imagine some non-competitive outcomes in CCHP. For example, a county medical society might form an IPA and use it as a price-fixing arrangement, and keep out would-be competing physicians through control of hospital privileges. Or a market might continue to be dominated by multiple third-party plans, all paying the same providers the same fees and costs. Continuing research, policy analysis, and possibly more legislation would be needed.

I. Presidential Leadership.

The effectiveness of CCHP could be enhanced considerably by strong Presidential leadership on at least two points. First, the average American needs to be reminded that, ultimately, he will pay the costs of health care, and the costs will be lower and the quality better if many Americans will get involved personally in the cost-effectiveness of their own health plan. Existing laws and financing patterns have created the illusion for most people that health care is being paid for by somebody else. And much NHI rhetoric that is strong on the benefits and quiet about the revenue sources serves to foster that illusion. Second, Presidential encouragement of local voluntary actions to start cost-effective organized systems could be of great value.

J. Costs and the Federal Budget

1. The Estimating Problem. Before considering estimates of the costs of NHI, consider the inherent limitations in the estimating methods. Costs are estimated by multiplying recent prices of services by recent utilization rates by the size of the covered population. To that is added an estimate of "induced demand," i.e. the short-term increase in demand attributable to improved coverage. The calculation uses assumptions about elasticity of demand--a measure of utilization increase when price to the consumer is reduced by insurance. There is no firmly based estimate of demand elasticity for health services. But assumptions are made by actuaries that experts agree are reasonable.

But the methods totally lack any scientific way of forecasting the long-term effect of the incentives on unit costs, utilization, and standards of care. Hence, the estimators are forced to make assumptions with very little but judgment to go on. The history of programs like Medicare has been one of consistent large underestimation in the long run. For example, in 1965, the 1975 costs of hospital insurance were projected at $4.3 billion; the actual was about $11.7. Deflate this for the 71 per cent increase in general price levels and you still get about a 60 per cent overrun. Comparing cost estimates as a per cent of taxable payroll allows for inflation. In 1965, the 1971 costs were projected at .95 per cent of taxable payroll; the actual turned out to be 1.30 per cent or 37 per cent higher. There was a similar history in the renal dialysis program. But the problem is potentially far more serious in NHI because the size and impact of the program are larger.

Compounding the effects of a lack of reliable estimating methods are the incentives and optimism of proponents of social insurance programs, similar to the causes of understatement in costs of weapon systems. Few, if any, people may be seriously interested in realistic estimates at the time of program inception. What reward is there for realism?

The best you can do is to start with the judgment of reputable actuaries whose concern for professional reputation gives them an incentive to be accurate. But the assignments given to them may include the directed use of assumptions--such as that hospital cost controls will be effective--chosen by advocates of certain NHI approaches to make the costs of their proposals appear acceptable. Because many assumptions must be made to produce a NHI cost estimate, some important assumptions may not be called to your attention in the summary document.

The key factor in long-run costs is the effect of the incentives in the NHI system on unit costs, utilization, and standards of medical care. A key factor in costs to the Government is whether the system makes them "controllable" or open-ended and uncontrollable. A key feature of CCHP is that, with the exception of the costs of those Medicare beneficiaries who remain with conventional Medicare, CCHP's costs to the Federal Government are "controllable" and can be estimated with far greater reliability than the costs of an open-ended third-party reimbursement system. On the cost issue, these are the points on which you should focus your judgment.

2. CCHP Cost Estimate. With respect to the costs of CCHP to the Budget of the Federal Government, Appendix 21 contains detailed illustrative calculations of what the impact on the FY 1978 budget would have been had CCHP been in effect.[21] In each case, the calculations assume:

a. Actuarial Cost (AC) is $200 for a person under 19, $475 for a person 19-64, and therefore $1,350 for a "family of four." (That compares, for example, to annual dues of $1,284 in 1978 for a family in Washington D.C. to join Georgetown University Community Health Plan.)

b. AC for a Medicare beneficiary will be $1,150, all but $385 of which, on average, will be paid by Medicare. Therefore, a 100% of AC voucher for a poor Medicare beneficiary is $385.

c. Offset against the cost of the tax credits and vouchers are the "Federal Income Tax Expenditures of $8.7 billion, Federal Medicaid of $11.8 billion, "Social Security Tax Expenditures" of $1.4 billion, and other programs of $1.9 billion, for a total of $23.8 billion.

d. No changes in the net cost of Medicare.

If the tax credit for the non-poor were 30% of AC (i.e. $405 for a family of four), and the voucher for the poor were 100% of AC at the income guarantee level (e.g. $4,200 for a family of four), reduced 20 cents for each dollar of family income (including cash assistance) above that, the gross cost of the tax credit/vouchers would be $26.9 billion; the net cost to the Federal budget $3.1 billion.

If the tax credit for the non-poor were 50% of AC, and the voucher for the poor were 100% of AC at or below the cash assistance breakeven level (i.e. $8,400 for a family of four), reduced 25 cents for every dollar of income above the breakeven, the gross cost of the tax credit/vouchers would be $44.6 billion; the net cost to the Federal budget would be $20.8 billion, This would be an extremely generous voucher program; 33% of the population would be receiving voucher payments.

A "full" CCHP program might include a 65% of AC tax credit for the non-poor (i.e. $878 for a family of four), a voucher bringing the total to 100% of AC at the income guarantee level, reduced 10 cents for every dollar of family income above that. The gross cost would be $49.8 billion; the net cost, $26 billion.

As for how to pay for CCHP, I assume that the Administration, which has promised a NHI proposal, is considering this problem in the context of its overall tax reform proposals. Obviously CCHP can cost much less than alternative NHI proposals (see below).

From a fiscal point of view, CCHP would make the Government's contribution to personal health services a "controllable" expenditure that could be set at a level in balance with other priorities, instead of today's open-ended commitments through the third-party intermediary system. Moreover, in CCHP, those who want more health services have the option of using their own net-after-tax income to buy them, which would result in less pressure on the Congress than would be the case, e.g. under Health Security.

Most important, by establishing strong incentives for cost effectiveness, CCHP promises in the long run to be less costly for any given level of coverage.

IV. WHY CCHP? SOME ISSUES

1. Will the desired reorganization of health services take place fast enough?

Reorganization of health services will take a long time--a very long time by political standards--a decade or more, even under the most favorable conditions, before half the population is served by some kind of organized system with incentives for economy. The Medical Profession is very resistant to organizational change. There are powerful vested interests throughout the health services industry, institutions with long traditions and deep roots in their communities. Many people will change their health plans and providers only reluctantly and slowly. There are no easy routes to health services reorganization. It will take a great deal of effort by many people in many localities.

Direct regulatory approaches to reorganizing health services promise fast results--but all the evidence shows that the promises are false. Health security and universal third-party insurance would freeze the system in its present patterns. (See Section VI below). A judgment in favor of the CCHP approach must be based, in part, on a realistic appraisal of the alternatives.

The main reason for optimism about the prospects for a reorganization, given a fair market test among competing alternatives, is that the economic advantage of organized systems can be large. A recent review of the many comparison studies over the past 25 years concluded, "The evidence indicates that the total costs (premium and out-of-pocket) for HMO enrollees are 10-40 per cent lower than for comparable people with health insurance." A Social Security Administration comparison of Medicare reimbursements for beneficiaries served by six group practice prepayment plans and a matched sample served by fee-for-service in 1970 found the former cost 73% of the latter. The point is not that <u>all</u> HMOs cost a lot less; in any industry there will be more and less efficient producers. The point is that substantial number of HMOs have shown that the savings can be large. Moreover, these HMOs have achieved large savings even in the absence of real competition from similar organizations.

The creation of organized systems of care would not have to take the many years of institution and facilities building characteristic of the leading Prepaid Group Practice (PGP) plans. If there were a market, simpler organizations, based on existing institutions, facilities, and practice styles, might be developed fairly quickly on the Individual Practice Association (IPA) model, the Health Care Alliance (HCA), or other broadened definition of HMO. In an IPA, the physicians agree to provide comprehensive benefits, largely for a fixed prospective periodic payment, under the following arrangements. First, they agree among themselves on a fee schedule. When they render a service to a member of the plan, they bill the plan, not the member. Second, they accept peer review of the appropriateness of services. Third, they agree to accept a pro rata reduction in fees if the money runs low. Fourth, they team up with an insurance company that offers a hospital insurance policy. The premium for that policy reflects the hospitalization experience of the members of that plan, which is, of course, controlled by the doctors in the IPA. So if the total premium for physician and hospital services is determined by the market, the less the hospitalization, the lower the insurance premium, and the more is left over for the doctors. HCAs have similar characteristics.

IPAs, like other HMOs, have not grown rapidly in the past for reasons explained below. Moreover, there is evidence that IPAs have been less effective than PGPs at control of hospital utilization. I believe the reason for this has been a lack of competitive necessity. If they had to develop good utilization controls to survive, I believe they would do so.

IPAs like this could be operative within a fairly short period of time. They can start with physicians already established in fee-for-service solo practice, with existing doctor-patient relationships, existing facilities, and without the need for large front-end investments. I believe that, to survive in the long run, they would have to strengthen internal controls, carefully balance specialty mix, etc. But these changes could come gradually.

In CCHP, physicians would be under strong economic pressure to sign up with or form qualified plans. This will be intensified by the coming doctor surplus.

Thus, I do not believe that one should estimate future HMO membership in a CCHP world by applying some plausible compound growth rate to present HMO membership. Rather, there is reason to expect that many new organizations would be formed quickly.

2. <u>If HMOs are superior, why haven't they grown faster?</u> The main answer is the strong and pervasive anti-HMO bias in the policies of the Federal Government (detailed in Appendix 18) and the consequent lack of incentives for consumers and providers to join HMOs under existing financial arrangements. The tax laws, the Medicare law, the Planning laws, and the HMO Act all have important anti-HMO biases. And the anti-HMO bias in State laws is notorious. Most people do not have a choice between an HMO and a third-party, fee-for-service plan, or if they do, the tax laws, Medicare, and employer financing arrangements do not let them keep the savings. HMOs have done very well in competitive multiple-choice situations. For example, Kaiser-Permanente of Northern California serves 37% of the Federal employees, 43% of the State of California employees, and 37% of the University of California employees in its service area. And, despite the obstacles, HMOs' growth rates in areas where they are established is impressive. From 1960 to 1976, Kaiser's California membership increased from 720,000 to 2,617,000, a compound annual growth rate of 8.4%, despite the fact that in many years, they had to limit new enrollments because of the time and cost required to plan, build, and staff new facilities.

3. Is health care financing more appropriately organized as a Government monopoly, or through private markets?[17]

Much of the case for NHI rests on "private market failure." And there is no doubt that the private market for health insurance, as presently constituted and shaped by numerous government policies, does a poor job of allocating resources. The main idea of CCHP is that the private market needs to be restructured, and that a reconstituted private market can do a better job than a government monopoly of health insurance.

Consideration of private market failure needs to be balanced by an appreciation of some of the characteristic limitations of government. The following generalizations, while obviously not true in every case, summarize important insights that must be considered in deciding whether NHI should be based mainly on private markets or on a government monopoly. They are stated here baldly and without applicable qualifications to save time. The point of what follows is not to imply that government is "bad" compared to private enterprise, or that government people are better or worse than private enterprise people. Rather, the point is that government has certain limitations that are deep rooted, if not inherent. Government is good at some things such as taking money from taxpayers and paying it to social security beneficiaries, and maintaining competition in many industries; it performs badly at other things. The problem of public policy design is to define the appropriate role for government to achieve desirable social purposes most effectively.

a. Government responds to well-focused producer interests; competitive markets respond to broad consumer interests. People specialize in production, diversify in consumption. They are therefore much more likely to pressure their representatives on their producer interests than on consumer interests.

b. "The rule of 'Do no direct harm' is a powerful force in shaping the nature of social intervention. We put few obstacles in the way of a market-generated shift of industry to the South... but we find it extraordinarily difficult to close a military base or a post office." (Schultze) Thus, a government-run or regulated system must be very rigid.

c. When every dollar in the system is a Federal dollar, what every dollar is spent on becomes a Federal case. Abortion illustrates the point.

d. Equality of treatment by Government tends to mean uniformity. The uniform product is often a bargained compromise that pleases no one.

e. Government generally does a poor job providing services to individuals.

f. The Government performs poorly as a cost-effective purchaser. Think of the Rayburn Building, the South Portal Building, Medicaid, and the C-5A. If a government agency gets tough with suppliers, the suppliers can bring pressure to bear to get the rules changed. Government purchasers are surrounded by many complex procedural rules; they cannot use nearly as much judgment as their private sector counterparts. The Government seems addicted to cost-reimbursement despite its notorious record for generating cost overruns. Cost-reimbursement protects providers.

g. The Government has a much harder time than the private sector in attracting and retaining the best operating management talent on a career basis. Government attracts many of the best people--usually for two to four-year tours. But building an effective, economical operating organization usually takes years of dedicated effort; it cannot be done on revolving two or four-year stands.

h. The political system is extremely risk averse. This makes it very difficult to innovate in a government-regulated environment.

The financing of individual health care services does not need to be a monopoly. There is no technical or economic factor that must make it a "natural monopoly" like a public utility. Nor is personal health care a "public good" like defense or police protection. The benefits of individual health care services are enjoyed primarily by the individual and his family, and he should be allowed a large measure of choice concerning it. The important public purposes of universal access to good quality care can be pursued most effectively in a decentralized private system guided by an appropriate structure of incentives and pro-competitive regulation.

4. The "Consumer Choice" Issue. Proposals to rely on consumer choice to guide the health services system are invariably subjected to the attack that "consumers are incapable of making intelligent choices in health care matters." So it seems worthwhile to make clear exactly what is being assumed. Admittedly, the element of ignorance and uncertainty in health care is very large; that is true for physicians and civil servants as well as ordinary consumers. CCHP does not assume that the ordinary consumer is a good judge of what is in his own best interest. Consumers may be ignorant, biased, and vulnerable to deception. CCHP merely assumes that, when it comes to choosing a health plan, the ordinary consumer is the best judge of it. The theory of optimum allocation of resources through decentralized markets does not assume that every consumer is perfectly informed and economically rational. Markets can be policed by a minority of well-informed rational consumers. And we are seeking merely a good and workable solution, not a theoretical optimum. CCHP provides consumers with substantially better information than they get now and much stronger incentives to use it. If there were a demand for it, much could be done to organize better consumer information. In any case, the key factor is the incentive CCHP gives to providers, i.e. provider systems will get their money from satisfied consumers rather than from the Government. In CCHP, above the tax credit/voucher level, consumers would be working with their own money, not somebody else's.

Critics of the consumer choice position usually are not very explicit about whom they consider to be better qualified than the average American to choose his health plan for him. In reality, the alternative to a consumer choice system is a provider-dominated system.

Presumably every NHI scheme under consideration would allow each consumer choice of physician and free choice as to whether or not to accept recommended medical treatment--decisions that could be aided by technical knowledge. What distinguishes CCHP from the others is that it seeks to give the consumer a choice from among alternative systems for organizing and financing care, and to allow him to benefit from his economizing choices. The issue then is whether consumers can be trusted to choose wisely when it comes to picking a health plan--some of which cost less than others.

Part of the "consumer choice" issue is resistance to the idea of letting the poor, because of their poverty, choose a less costly health plan that might not meet their medical needs. There is appearance of a conflict here with the principle of CCHP that people must be allowed to benefit from their economizing choices. (There is, of course, an issue as to how much the poor should be forced to accept their share of society's assistance in the form of costly medical technology of doubtful value, as opposed to leaving them free to spend the resources on other things like food and housing known to be good for health.) The problem can be resolved in CCHP by setting the premium vouchers (usable only for health insurance) at a high enough level to assure access to a plan with adequate benefits--always letting plans that do a better job attract members by offering less cost sharing or more benefits.

5. Equity Issues[19]. CCHP uses the most effective way to redistribute income, i.e. directly. It takes money from the well-to-do and pays it to lower-income people in the form of tax credits and vouchers. By this method, the amount of redistribution is clearly visible, and one can be sure the money reaches its intended target. CCHP can thus be used to bring about whatever income redistribution for medical purchases our political process will support. I suspect the reason some will criticize CCHP on equity grounds is because they think that the amount of redistribution Congress will be willing to vote is less than their own personal preferences. So they seek indirect methods of redistribution that may be supported on other grounds. A major trouble with this approach is that third-party insurance systems are an exceedingly ineffective way to redistribute income. Medicare pays more on behalf of rich than poor. In a bureaucratic system, such as would be created under Health Security, individuals and organized groups who are forceful and skillful at getting their way come out ahead.

The equity of CCHP ought to be compared with where we are today and where we are likely to go as a society. It is useless to compare it to some hypothetical egalitarian ideal that has never been attained in any society and is surely not supported by the American people today.

6. Is a multiple-choice system feasible? The feasibility of a competitive model for NHI has been demonstrated by the Federal Employees Health Benefits Program (FEHBP) and numerous other choice-of-plan systems. The FEHBP was authorized in 1959. It now provides health benefits for 10.5 million people. A 1964 report on the FEHBP noted, "The program finally authorized by Congress permits a wide range of choice of plans by all employees and was, in effect, a negotiated compromise among many divergent and highly organized interests. It was the only approach which at any time during the legislative process gained acceptance by all of the principals:

the American Medical Association, Blue Cross-Blue Shield, insurance companies employee unions, group and individual practice prepayment plans, and the Federal Government as the employer. Although there can be no doubt that the 'single plan' approach would have been most desirable from the standpoint of administrative simplicity, now that we have learned to live with the administrative problems which stem from multiple choice, it becomes equally clear that the wide choice of plans has produced a program which is more effective in meeting the needs of Federal employees and their dependents. ...It was anticipated by many that serious administrative problems would develop that would require continual legislation of a perfecting and remedial nature. This has not been the case."

The California State Public Employees' System has been in operation for almost as long as the FEHBP. It provides benefits for about 175,000 people. It has proved so successful that non-State public employee groups are now joining it. And it has been a significant factor in the growth of HMOs in California.

7. Some Other Problem Areas

a. Underserved rural areas. CCHP would not "solve" the problem of underserved areas, but it should help. It would provide assured medical purchasing power to people in rural areas, many of whom have low incomes, and by ending the open-ended tax subsidy in the well-served areas, it will put some financial pressure on physicians to relocate. The best way to provide good care in rural areas is through organized systems that can provide outreach, e.g. through physician extenders, and that can provide financial and professional support to physicians working in such areas. For example, Kaiser-Permanente operates remote outposts in Hawaii, including a single-physician clinic on the northern shore of Oahu. Though far from the main Medical Center, this doctor can easily consult with his specialist partners by telephone, and can refer patients if necessary.

b. Malpractice. CCHP will not "solve" the problem of malpractice. But the growth of competing organized systems should help. An important part of the malpractice problem is the frequency of medical injury and the lack of quality control of physicians operating in solo practice. Good physicians in the fee-for-service sector complain of their inability to stop the bad ones from practicing because of the complex legal procedures involved. In an organized system, on the other hand, the physician group has direct professional and financial incentives to control the quality of its membership. Perhaps even more important than the ability to expel the bad actors is the ability of physicians in the Prepaid Group Practice setting to limit the activities of a physician who has passed the peak of his proficiency to tasks that remain within his competence, without threatening his livelihood. In such a system, quality control need not be an "all or none" determination of whether or not a physician should be allowed to practice. It can be a careful delineation of which tasks he is and is not currently qualified to perform. In such a setting, there is no financial incentive for a physician to practice beyond his level of competency.

c. The "HMO underservice" issue. Some allege that HMOs achieve financial success by underserving their members. The established HMOs like Kaiser-Permanente and Group Health of Puget Sound, etc., have for many years served such educated middle class groups as Federal and State employees, university faculties and other teachers. If there were a significant amount of underservice, one would think that the word would get around and that these people would switch at the next open season. I have been unable to find any documented case of a pattern of underservice among such HMOs. On the contrary, the main selling point of such organizations is usually improved accessibility. A recent study compared patterns of ambulatory use in five health care delivery systems in Washington D.C. and found "...(1) for preventive use, rates are lowest in OPD/ERs (outpatient department/emergency rooms) and highest in the prepaid group (Group Health Association, a Prepaid Group Practice), with both being significantly different from solo practice; (2) for initiation of care, rates are significantly and consistently highest in the prepaid group, ...; (3) for follow-up care, rates are highest in fee-for-service groups and moderate in the prepaid group. ... it is clear that services are more equitably distributed in the prepaid system than in the fee-for-service systems, for every use measure." The allegations of underservice arose in the case of the Medicaid Prepaid Health Plans, mainly in Southern California. There, a State government was trying to cut short-run costs in a hurry, and accepted unrealistically low bids for Medicaid contracts, and enrollment practices that interfered with free choice. The underservice problem arose from the State government's politically motivated purchasing policies, not from the nature of HMOs. If you assure that every family has the purchasing power to buy membership in a good plan, and a free choice among competing plans, organizations that make a practice of underserving members will not last long.

This is not to imply that the financial incentives in the existing HMOs are perfect or that their performance is without shortcomings. We simply do not know what are the "right" financial incentives; there is no logical or empirical basis for such a determination. CCHP proposes to find out what are good incentives through experience in a competitive market. And good incentives do not guarantee good performance. Medical care is full of judgment and uncertainty; mistakes are made in any setting, including HMOs. HMOs may have replaced financial barriers with institutional barriers to care. The most effective pressure to perform to satisfy consumers is competition.

V. PHASING AND PART-WAY STEPS

Section III described the complete CCHP proposal. To have maximum impact, the whole plan should be adopted. But CCHP is not an "all or none" proposal. It can be viewed as a menu of individual proposals, many of which would improve the market, even if adopted alone or in groups. Or it can be seen as a direction--a strategy to be implemented as political and economic realities permit. It can be phased in.

1. Phasing the Tax-Credit Voucher. As indicated above, a version of CCHP with a tax credit equal to 30% of Actuarial Cost for the non-poor, and a voucher equal to 100% of AC at the income guarantee level ($4,200 for a family of four) and a 20% "benefit reduction rate" would have a net FY 1978 cost of $3.1 billion. The breakeven income for the voucher would be $8,925 for a family of four, and about 24% of the population would receive vouchers. Alternatively, CCHP with a 60% tax credit, and a voucher with a 12% benefit reduction rate would have a net FY 1978 cost of $22.4 billion.

CCHP might be started with a 30% tax credit for the non-poor, with the breakeven point at which the voucher is phased out held constant at $8,925 in 1978 prices, and with an increase of 2.5 percentage points per year in the basic tax credit over 12 years, until the tax credit for the non-poor reached 60% of AC. Thus, the net budgetary outlay would be increased an average of about $1.6 billion per year. (A table illustrating this is shown at the end of Appendix 5.)

The attractive and unique feature of this approach is that it enables the Government to address the basic financial incentives in the whole system at a net budgetary outlay of several billions in the first year.

2. Cap the Exclusion of Employer Contributions. If the above phasing is not acceptable, at a minimum, the Administration should propose to cap the exclusion of employer contributions from taxable income at a level high enough so that few suffer a loss today, but low enough that in the future many people will start paying the extra costs of health insurance out of their own net-after-tax incomes. A level of about $1,500 per year for the sum of employer contributions and premium deductibility would seem about right. Such caps exist in the tax laws now (e.g. on group life insurance).

3. Amend Section 1876 of Medicare. The freedom of choice provision in Medicare described above should be enacted whether or not other parts of CCHP are proposed. A similar principle should be applied to Medicaid.

4. Dual Choice. Section 1310 of the Public Health Service Act ("the HMO Act") requires any employer of 25 or more who is subject to the minimum wage requirement under the Fair Labor Standards Act to include in his employee health benefits plan the option of joining one group practice HMO and one IPA HMO if such are available in the area where 25 or more of his employees reside. This requirement might be broadened, all at once, or in steps. In the interest of enhancing competition, employers might be required to add one plan a year up to a maximum of five or six. To this should be added the right of any employee to "carry his health plan membership with him" as he changes job but maintains the same residence.

5. Premium Rating by States. The market would be improved if the FEHBP asked its carriers to adopt a system of premium rating by States. The carriers have the information needed to do this, and could do so at a nominal cost. A similar practice would be in the interest of any multi-division or multi-plant company that wanted to know its costs accurately by location. Some carriers offer this as a service to some multi-

plant companies now. So it is not clear why this even needs to be required. I recommend that the Federal Government show the way by modifying the FEHBP.

6. Allow Others to Join the FEHBP. The California law authorizing the health benefits part of the Public Employees Retirement System allows local government agencies to participate in the State employees system by contract. Would it not make sense to allow other Federal, State, and local government agencies to buy into the FEHBP? (This assumes the premium rating by State outlined above is enacted.) To begin with, some of the seven million civilian CHAMPUS eligibles might be included, e.g. in areas where military facilities are not available. (To include all of them would require resolution of some complex problems of coordination with the military direct care system and the health plans offered by the civilian employers of some of the beneficiaries.)

7. Should CCHP be tried first in one or a few States? The answer depends on the purposes of the trials and how they are done. I do not believe that the long-term efficacy of CCHP in motivating delivery system reform can be tested in an "experiment," Experiments may be quite useful in producing information on individual responses to cost-sharing formulas, income subsidies, and the like. But people are not likely to make the kind of effort and long-term commitment required to build institutions for an experiment. However, it could be very useful to use one or a few States as pilot models to test and evaluate rules and procedures in the context of a national decision to follow a CCHP strategy.

Some aspects of CCHP, such as changes in the Federal Income Tax law, would be hard to try on a State basis. Others, such as "freedom of choice" for Medicare beneficiaries should not be turned on and off. These changes would need to be made nationally at the outset and can be justified on their own merits. Many parts of CCHP have been in practice for years on a limited basis. Multiple-choice has been demonstrated in the FEHBP, in the California Public Employees' plan, Medicaid in Oregon, and elsewhere. Congress was sufficiently persuaded of the merits of open enrollment and community rating that it imposed them on HMOs. CCHP merely extends these principles to all qualified health plans. Operational test and evaluation would probably be wise. But those proposing it should specify what questions the test will answer and how.

VI. ALTERNATIVES TO CCHP

There are two broad alternatives to CCHP, each of which can be designed to cover the same people and benefits. The stated goals of their proponents are the same, i.e. access for every American to comprehensive health care services of good quality. The essential differences are in their financial and organizational structures, in the incentives they provide and in the way resources would be allocated.

1. Universal third-party insurance is the most familiar approach, i.e. a program that sees to it that, by one means or another, everybody is insured. This would generalize the financing principle that dominates our health care economy today. There are many variations on the theme, i.e. different mixes of public and private insurance and different schedules of copayments and deductibles. Most of the perennial NHI bills are in this group, including "Kennedy-Mills," "Long-Ribicoff," "CHIP" and proposals by the industry groups (AMA, AHA, and HIAA). For purposes of policy analysis, their common reliance on the third-party reimbursement principle is more significant than what distinguishes them from each other.

At least in concept, the simplest way to achieve universal coverage is for the Federal Government to serve as the insurer for everybody, as proposed, for example, in the "Kennedy-Mills" bill in 1974, a sort of "modified Medicare for everybody." The industry group bills seek to assure universal coverage through a mix of private and public programs. Long-Ribicoff would seek to close two of the main gaps in present coverage by a catastrophic illness plan for everybody and a medical assistance plan for the poor. The Nixon Administration proposed the Comprehensive Health Insurance Program (CHIP), essentially (1) mandated employer-employee private insurance meeting certain standards, (2)a State-operated assisted health care program for low-income and high-risk families, and (3) expanded Medicare.

My criticisms of universal third-party reimbursement insurance are developed more fully in Appendix 15. The essential point is that,from the point of view of economic incentives, the third-party reimbursement principle is not a rational way to finance medical care. Like the cause of air pollution, third-party reimbursement insurance gives people economic incentives to abuse a scarce resource. Third-party reimbursement insurance relieves the consumer of the additional cost of the services he receives, and therefore the incentive to conserve resources, without putting the incentive on the provider. On the contrary, fee-for-service and cost reimbursement reward providers for rendering more services, and more costly services, whether or not they are necessary, effective, or best for the patient. A rational economic system of health care financing would tie the physicians to the economic consequences of their decisions and hold them responsible for using total health care resources wisely. It would also allow consumers to realize the full benefits from choosing less costly systems of care.

The worst effect of universal third-party insurance would be to destroy the incentive of consumers and physicians to reorganize the delivery system in more cost-effective ways. It would deny consumers the opportunity to reap the benefit from choosing less costly systems or styles of care. Consumers would be relieved of most of the costs implicit in their choices, and larger reimbursements would be made on their behalf if they chose more costly providers. Similarly, with government-financed, open-ended demand for services where and when they want to deliver them, physicians would see little gain from accepting the discipline of an organized system.

If you must go along with universal third-party insurance, at a minimum you should be sure that there is a "freedom of choice" provision similar to what I have recommended for Medicare.

A universal third-party system operated by the Government would add roughly $60 billion to Federal outlays, or a net budgetary cost of $50 billion, with no good way of phasing it in. (Estimate based on Kennedy-Mills.[15])

2. The Health Security Act is designed to get away from third-party reimbursement and to shift health care financing to a per capita and prospective budgeting basis within a publicly determined total. The Act would assign the entire financing and management of NHI to the Federal Government. It would create a Health Security Board in DHEW to administer the program. It would levy taxes on payrolls, self-employment and unearned income, and match this with an equal sum from general revenue. The Board would establish an annual national budget, based on the cost of the program in the preceding year, adjusted for changes in prices, population and number of providers, not to exceed total receipts. Thus, there would be a firm lid on total health care spending. The Board would allocate the budget to each DHEW region on a per capita basis in categories for institutional services, physicians' services, dental services, drugs, appliances, etc. Within these totals, the Board would then contract for covered services with participating providers, i.e. providers who agree to make no charge to the patient for covered services. In brief, Health Security would create a system that is centrally and politically controlled, in which every participating provider gets all his money from the Federal Government. Spending for personal health care services would be set in the political process on the basis of national priorities rather than in the marketplace based on individual priorities.

Health Security has important strengths. It recognizes that the third-party reimbursement principle provides inappropriate economic incentives in medical care. It seeks to restructure health services into organized systems. Capitation financing, which it emphasizes, gives incentives for economic efficiency in use of total resources. Health Security seeks equity in the use of public funds. And it seeks to equalize per capita spending among regions and between HMOs and the fee-for-service sector.

Many of Health Security's weaknesses are summarized in the discussion of government monopolies and private markets.[17] But the main criticism of Health Security is that it cannot achieve its goals.[16] The Government cannot restructure the system by direct controls. Experience with other regulated industries, and with NHI in other countries, suggests Government would freeze the system in its existing patterns. The "Do no direct harm" rule has prevented the Government for years from closing unneeded PHS hospitals and military bases. Government attempts to close hospitals in obviously overbedded areas drown in a deluge of lawsuits and pressure from employee groups. Imagine the vested interests and the rigidity surrounding the history-based allocations among hospitals, doctors, dentists, etc. It would become much more important to provider groups to defend their allocation than to serve patients. The Health Security Act seems almost designed to freeze existing allocations and to protect existing jobs.

Further reason to doubt the ability of the Government to restructure the system comes from the recognition that the Federal Government has proved itself to be the enemy of HMOs. The list of counter-productive actions and policies is long and impressive. The anti-HMO bias has persisted too long and is too broadly based for it to be able to be written off as "another abuse of the Nixon Administration."[18] The experience suggests the the advocates of Health Security must be required to provide a realistic explanation of how the Government will actually function to restructure the system. They should not be permitted to claim good results based on good intentions and some abstract conception of what government ought to be.

The Health Security Act proposes to bring total spending under control by "top-down budgeting." Top-down budgeting may indeed bring total spending under control, but of itself, without competition, the mechanism has no built-in means for assuring that much useful output is produced. This is especially true of a medical care program whose output cannot be measured in any simple and adequate way. Look at the experience in our largest public health care systems. At least by civilian standards, the Defense Department operates and fills far too many beds. A recent study of the VA system concluded, "... there are too many acute beds being operated in the system... about half the patients in acute medical beds, one-third of the patients in surgical beds, and well over half the patients in psychiatric beds do not require--and are not receiving--the acute care services associated with these types of beds. These data provide additional evidence that many more VA hospital beds are being operated than are required to meet the needs of veterans... The VA has installed many expensive specialized medical facilities that, in many hospitals, are used at rates far below their capacity."[16] The point is that in the bureaucratic budgeting system, one strengthens one's case for more by doing a poor job with the budget one has. If the budgeting system at the institutional level is based on workload rather than capitation, it gives physicians and administrators incentives with respect to utilization that are similar to fee-for-service.

The Government is simply incapable of managing the Health Security Program. It does not have the organization and it cannot acquire the management capability on a sustained basis. To illustrate one of the problems, the Act provides that members of the Health Security Board will be paid at Executive Level IV. This means that the top management of the Program would be paid about 25% less than the average doctor. The Board might attract outstanding management talent to begin with, based on dedication to public service. But when it becomes clear what doing an effective job means, e.g. closing excess acute hospitals in some areas to pay for needed facilities in others, and Board members start feeling the wrath of citizens expressed through their Congressmen, and seeing the implementation of their plans tied up in court, the 2-year turnover typical of Assistant Secretaries in DOD and DHEW is sure to emerge. Running a large organization effectively requires long-term commitment by its managers; it cannot be done well on revolving two to four-year tours.

Finally, Health Security would add roughly $100 billion to Federal outlays in FY 1978 costs, or a net budgetary cost of $90 billion.[16] (Alternatively, it would add roughly $90 billion to public sector outlays.) And there is no way to phase it in. Health Security is an "all or none" proposal.

Exhibit 13

A Background Paper on Financially Troubled Hospitals

A Report of the HHS Task Force on Financially Troubled Hospitals

Prepared by: The Health Care Financing Administration
Office of Legislation and Policy
George Schieber, Saul Kilstein, and Claudia Sanders

INTRODUCTION

The Department of Health and Human Services (HHS) shares responsibility for assuring access to care for all of this country's citizens and accomplishing health care delivery system reforms. During 1979 and the beginning of 1980 HHS received requests for assistance from a number of hospitals claiming that they were unable to continue operations due to financial problems. Because there was no integrated Departmental mechanism to handle such inquiries, a task force was established to formulate processes and proposals to respond to these requests. The task force examined the problems faced by financially troubled hospitals, identified the resources within HHS available to deal with these problems, and developed alternative policy options.

This paper reflects the work of the task force. Specifically, this paper: (1) presents an estimate of the magnitude of the problem nationally; (2) reviews the causes of financial distress; (3) discusses the impact of existing HHS programs; and (4) outlines various short-term and long-term options for dealing with financially distressed hospitals.

DIMENSIONS OF THE PROBLEM

Approximately one-half of the nation's community hospitals, or about 3,000 hospitals, are located in urban areas. These hospitals account for 74 percent of total hospital beds and 83 percent of total hospital expenditures. There are slightly fewer (about 2930) rural hospitals, but they account for only 26 percent of total hospital beds and 17 percent of total hospital expenditures. Rural hospitals are typically small, averaging about 85 beds, or about one-third the size of the average urban hospital. Occupancy rates of rural hospitals average about 67 percent, significantly lower than the 76 percent average for urban hospitals. While there are commonalities between urban and rural hospitals, those problems contributing to their financial difficulties often reflect their different environments.

Determining the number and characteristics of financially distressed hospitals is difficult for a number of reasons:

- First, there is no basic, objective definition of financial distress;
- Second, there is a paucity of reliable information on an individual hospital basis that can be brought together nationally in a consistent and comparable manner;
- Third, without detailed studies, it is difficult to attribute financial distress to a hospital's particular operating characteristics; and
- Fourth, it is difficult to define deficits for public and non-profit institutions which often receive large supplemental appropriations from local governments or philanthropic gifts.

Despite these problems, some information can be obtained on hospitals' financial status from a sample of financial statements submitted with Medicare cost reports and from data submitted to the American Hospital Association (AHA). It should be noted that the revenue and expense data extracted from the Medicare financial statements are not used for reimbursement purposes, and, therefore, their reliability is untested. Data from the AHA are based on information voluntarily reported in an annual survey of the nation's community hospitals.

According to data from the AHA, the hospital industry, as a whole, is generating a surplus. In 1978 total revenues to community hospitals were $59.8 billion and total expenses were $58 billion, resulting in a 2.7 percent margin of "profit". While the industry as a whole is financially sound, data from both the AHA and the Medicare cost reports show that not all community hospitals are able to generate enough revenues to cover their expenses.

According to the Medicare data, in 1977 about 1400 hospitals, or approximately 24 percent of all community hospitals, had total expenses that exceeded their total revenues. In addition, about 300 hospitals, or five percent of community hospitals, reported that total revenues were less than 90 percent of total expenses. Similarly, data from the AHA indicate that in 1978 about 26 percent of all community hospitals had total expenses exceeding total revenues, and about 4 percent of these hospitals had total revenues which were less than 90 percent of total expenses. As shown in Tables 1 and 2, the hospitals which operated at a deficit tended to be small, publicly owned, and located in rural (non-SMSA) areas. Although the problem appears to be more severe in rural areas based on numbers of hospitals running deficits, in terms of numbers of beds and magnitude of deficit, the bigger problems are in urban areas.

While these figures indicate that a large number of hospitals are running deficits, it is important to understand the limitations of the data. First, deficits are quite common in this largely non-profit industry where hospital deficits attract philanthropic and State and local support. Second, an operating deficit in one year says little about an institution's overall net worth or its financial stability over a multi-year period. Third, deficits in certain instances may be an indication of the need to close all or part of an institution or to convert the facility to other uses. Finally, these data provide little insight into the causes of financial distress.

PROBLEMS CONTRIBUTING TO HOSPITAL FINANCIAL DISTRESS

Every hospital confronts a unique set of internal and external circumstances which will dictate how it will respond to adverse conditions. While weaker facilities might succumb to some combination of the following generic problem areas, others are able to compensate and survive. Any Federal strategy must therefore be able to provide assistance targeted to the critical problem area(s). It may ultimately be necessary to tailor assistance strategies for individual institutions.

Health Insurance: Perhaps the most serious problem some hospitals face is uncollected revenues due to the inadequate health insurance protection of their patient populations. It is currently estimated that 22 million people, most of whom are poor, have no health insurance at all, and another 20 million have inadequate coverage. Even recipients of medical assistance under the Medicaid program face varying degrees of financial protection as States can limit the amount, duration, and scope of benefits.

Compounding this problem is the growing number of undocumented aliens, estimated most recently by the Bureau of the Census at about five million. Most are indigent, have no health insurance, and in emergencies seek care from local community hospitals. While some PHS programs provide ambulatory care to individuals regardless of alien status, few finance inpatient hospital care.

Operating Costs: Operating expenses of both urban and rural hospitals are increasing at a high rate due to inflation, rapidly advancing medical technologies, excess hospital beds, and ineffectual planning. In many instances, individual hospitals' incomes have not kept up with expenses. In addition, urban hospitals are frequently burdened with aging or obsolete physical plants. Due to the difficult financial situation of some older hospitals, however, depreciation is not always funded. Instead those funds are being diverted to meet day-to-day operating expenses. As a result plans for renovation and modernization may be delayed. Rural hospitals, on the other hand, are more likely to be plagued by low occupancy rates. They are often located in isolated areas, serve a sparse population, and lack dependable emergency transportation systems. They are frequently limited in their ability to regionalize or share services and may find it necessary to provide a broader range of services than can be efficiently utilized.

Financing: Limits to public financing are also placing stress on hospital budgets. Local funding for public general hospitals is becoming increasingly constrained as a result of small (in the case of rural areas) or diminishing (in the case of urban areas) local tax bases. In addition, States and municipalities are pursuing general policies of fiscal austerity and in some cases are limiting expenditures and curtailing services. Federal health care financing programs limit payments to those costs associated with covered services provided to beneficiaries; they do not share in the costs of bad debts incurred by hospitals providing uncovered services or care to uncovered individuals. Private third-party payors are also limiting reimbursements.

Further, Federal and State cost containment efforts are forcing reductions in the rate of growth of hospital revenues. Some current cost containment efforts, conducted primarily through public reimbursement programs, have a disproportionate effect on hospitals serving the poor and the elderly. The Administration's hospital cost containment proposal, however, would achieve national savings on a more equitable basis. Hospitals, in any event, have less money to cover revenue shortfalls and operating exigencies.

Management: Bad management, manifested by poor accounting practices, inadequate collection efforts, lack of leadership, and an inability to utilize the most efficient staffing patterns, is frequently a contributing factor to a hospital's poor financial condition. This is more likely to be encountered in complex urban hospitals because they are generally large, have teaching affiliations, and provide multiple and complex health programs. Public hospitals are often further encumbered by an overlay of local government bureaucracy. Audits of municipal hospitals in one major city, for example, revealed that a significant proportion of uncollected revenues could have been collected from public and private third-party payors if better collection procedures had been employed. Rural hospitals, on the other hand, frequently encounter difficulty recruiting skilled administrators for their smaller facilities and may suffer from management deficiencies as a result. Further, smaller hospitals often assert that government regulations (e.g., Medicare's conditions of participation) are costly and burdensome to meet.

Health Service Providers: Recruitment of health care personnel and deficiencies in community-based primary care services also pose problems to hospitals. Low Medicaid reimbursement rates for outpatient physician services and ambulatory care, and a shortage of local physicians in the inner cities limit local patients' ability to obtain basic care in doctors' offices. Consequently, urban hospitals frequently must provide primary care to patients in facilities designed and staffed for emergency treatment.

Smaller hospitals find it harder to recruit staff because of their isolation, limited potential for career advancement, lack of opportunity for continuing education, and the limited technical resources a smaller hospital can offer. In addition, the rural/urban differentials for physicians' fees under the public health financing programs, as well as the primary care practitioner/specialist reimbursement differentials, all reduce the incentives for physicians to practice in rural areas. As a result, a rural hospital may lack sufficient medical staff to provide all necessary care and also operate at a cost-efficient capacity.

Closure of a financially troubled hospital could result in a net reduction in the amount or quality of health services delivered to the population currently served. Further, such a closure could have a secondary effect of threatening the financial stability of nearby hospitals if the uninsured and underinsured patient population carried by the closing hospital shifts to other institutions in the area. If there is only one hospital near the troubled institution, the financial problems probably will be transferred to the second institution (domino effect). Even if there are several hospitals in the same area, it is conceivable that lesser financial problems at each would become more serious even if each hospital absorbed only, for example, a portion of the non-paying load of the closing institution. Beyond the institutional impact, hospital closures may also reduce the attractiveness of a community for private providers of primary care. The resulting loss of physicians in private practice or the impediments created to recruitment of new primary care practitioners are likely to create new barriers to access to primary care services in the community.

FEDERAL CONCERNS AND STATUTORY AUTHORITIES

Federal Concerns: The Department is concerned about maintaining access to care for individuals in communities threatened by closure of essential hospital services. Some of these endangered institutions may serve as the principal source of primary health care services in certain, often low income areas. In addition, some facilities employ large numbers of community residents and are a major source of entry level jobs and upward mobility in the health professions, especially for minorities. Closure of these hospitals would threaten community residents' access to care and conflict with Administration objectives and responsibilities regarding employment. Further, HHS has an obligation to assure that no minority group bears a discriminatory burden from a reduction in access to health services.

An appropriate Federal response, however, should not presume that all hospitals in financial trouble should be saved. Federal assistance to financially troubled hospitals should be consistent with Department access and system reform objectives. Assistance should be directed towards assuring the provision of necessary health care services. At the same time, however, it must be consistent with and directed towards achieving a smooth transition to the Administration's National Health Plan. Department efforts should sustain the viability of those institutions which are necessary resources to the communities they serve. In addition, to the extent possible under the current tight budget situation, HHS action should increase access to appropriate care for our poorest, currently uninsured citizens.

Closure and conversion of excess hospital capacity is a fundamental component of the Administration's strategy for containing rising hospital costs. This country currently has an average of 4.5 beds per thousand population, although the National Health Planning Guidelines recommend less than four beds per thousand. This produces a national surplus of 130,000 hospital beds. Therefore, before any facility is given aid, the local health planning agency should determine the need for that facility, based on population-based planning and community circumstances, and on developing alternative approaches which ensure that quality of care and access to services are preserved. Involvement of health planning agencies would reduce the chance that the Department may sustain inefficient or underutilized facilities that probably should be allowed to close, phase down or switch to alternative forms of care.

Hospital closures are extremely controversial. While certain hospital closures may be justifiable on the basis of objective overall community health planning goals, civil rights considerations, costs, and other criteria, severe opposition can generally be expected from the locality affected. If the Department decides to establish a program to aid these hospitals, it may be desirable to let an impartial panel of qualified reviewers recommend which facilities ultimately should receive aid.

While there may be a Federal responsibility for providing aid to financially troubled hospitals in certain cases, it must be stressed that there is also an appropriate State and local role. State and local governments must continue their traditional support of public health programs and in certain cases will need to share responsibility with the Federal government in providing new aid to financially troubled institutions.

Establishment of Criteria for Aiding Financially Troubled Hospitals: Limited authority and financial resources require the development of specific criteria to select those hospitals to be assisted. Deriving such criteria, however, is difficult for three reasons. First, it is difficult to set criteria which are sensitive enough to correctly differentiate between hospitals deserving assistance and those which should not be assisted. Second, specific selection criteria may be contradictory (i.e., maintaining access for certain population groups and requiring hospital self-sufficiency). Third, limitations in hospital data impede our ability to establish quantitative norms for individual selection criteria and/or to analyze the impact on U.S. hospitals.

Nevertheless, on *a priori* grounds, general criteria can be established which target aid to financially distressed hospitals in a manner that assures access to area residents, is consistent with current financing arrangements, and achieves overall health system planning and reform goals. A non-exhaustive list of general criteria could include the following:

Access Criteria

- Alternative sources of care are not available or accessible, especially to minority group persons.
- The institution complies with PHS titles VI and XVI community service and uncompensated care requirements.
- A large portion of the hospital's patients are indigent and some proportion of the hospital's bills are uncollectable bad debts resulting from services provided to these individuals.

Financing Criteria

- The hospital is unable to remain in operation without Federal assistance.
- The hospital must submit a viable plan for self-sufficiency over time (including management improvements, service consolidation, etc.).
- State and local governments will have to maintain current efforts, and will be expected to contribute their fair share towards new assistance programs.

System Reform and Planning Criteria

- The institution must provide quality care.
- The hospital's problems must be subjected to a management analysis by an impartial outside review body, and the hospital must agree to take necessary corrective actions.
- State and local planning agencies must certify the appropriateness of the facility.
- The facility and related medical communities must be willing to make changes consistent with Federal system reform policies.

Current HHS Authorities: Major Department responsibilities in this area are defined through the Social Security Act and its amendments, the Public Health Service Act, and the Civil Rights Act of 1964. Broadly, the Department is authorized to finance covered health care services provided to Medicare and Medicaid beneficiaries, assure that such care is necessary and provided in appropriate settings, direct the allocation of resources through the health planning process, assist in the delivery of care in underserved areas, and directly provide care to specific underserved populations. In addition, under title VI of the Civil Rights Act of 1964, the Department is charged with the responsibility to ensure that recipients of Federal financial assistance (e.g., from Medicare, Medicaid, and PHS) do not discriminate on the basis of race, color, or national origin. The following sections describe those aspects of current authorities which impact on the financial condition of hospitals.

Programs Administered by the Health Care Financing Administration (HCFA)

HCFA Programs: Medicare and Medicaid, established under titles XVIII and XIX of the Social Security Act, provide health insurance and medical assistance to eligible beneficiaries and recipients. At present there are approximately 27 million Medicare and 23 million Medicaid beneficiaries. For FY 1980 Medicare payments to hospitals are projected to total $22 billion, while Federal and State Medicaid payments are estimated at $6 billion. Medicare reimbursements to hospitals are based on the reasonable costs of providing care to the program's beneficiaries. Except in those States with approved alternative reimbursement systems, Medicaid reimbursement for hospital inpatient care follows Medicare reimbursement principles.

Medicare: Basically any decision that Medicare makes on reimbursement practices is likely to affect financially troubled hospitals. For example, the decision to directly allocate Medicare payments for malpractice premiums on the basis of beneficiary claims experience may affect financially troubled hospitals, as well as other hospitals better able to absorb any resulting reimbursement reduction. However, there is one area of Medicare reimbursement, the policy on payment of bad debts, that may particularly affect hospitals in financial difficulty.

Medicare, as a matter of Congressional intent and Department policy, restricts its payments for bad debts to those incurred by hospitals in providing covered services to program beneficiaries. This policy arises from the Medicare principle that reimbursement will be limited to "reasonable" cost. Reasonable cost must be determined so that no part of the cost of care for beneficiaries is borne by other patients, and conversely, that Medicare and its beneficiaries do not pay costs attributable to other patients. Therefore, Medicare will reimburse a hospital if a beneficiary has failed to pay the deductible or coinsurance. It will not share, however, in reimbursement for other types of bad debts—such as those which arise from uncovered services or uncovered individuals.

One conceivable approach to helping financially troubled hospitals would be the revision of the current Medicare policy on payment of bad debts. Some believe that a legal argument can be made for treating bad debts as indirect costs of doing business and hence reimbursable under existing authority. The task force, however, concluded that the existing Medicare policy of denying reimbursement for costs associated with individuals and services not covered under the Medicare program is clearly a sound one and the most reasonable under the statute.

To change that policy might invite a very critical reaction on the part of Congress. In addition, as a practical matter, in the absence of new legislation it would be difficult to limit Medicare payment for bad debts only to hospitals in financial distress and to specified unrecovered costs determined to be legitimate Federal concerns.

Medicaid: States have considerable discretion in establishing Medicaid eligibility and benefit levels, as well as reimbursement rates. Most of these decisions profoundly affect financially troubled hospitals.

- Eligibility and Benefits. Over 40 percent of the poor, 16 million people, do not have Medicaid coverage either because their incomes are too high or because they do not meet categorical eligibility requirements (e.g., unmarried adults with no children). States have considerable discretion in setting standards for Medicaid eligibility and can limit the amount, duration, and scope of benefits (e.g., 10 days of hospitalization in Oklahoma). Over twenty States have income eligibility standards below 55 percent of the Federal poverty level ($4100 in 1980). Expanding Medicaid coverage for the poor would provide hospitals with added revenues and would greatly ease the plight of financially troubled hospitals serving large numbers of uncovered indigents. However, the impact of such eligibility expansions will be highly uneven and impossible to target. Hospitals in some of the southwestern States which currently have very restrictive eligibility standards will be helped significantly while those in states which currently have more liberal eligibility criteria, such as those in the Northeast, will not be helped as much.

- Reimbursement. States also have considerable discretion in establishing reimbursement rules. While most States generally follow Medicare reasonable cost principles for inpatient hospital services, they have significant latitude in setting rates for physician and outpatient hospital services. In 17 States Medicaid physician payment rates are less than 80 percent of Medicare levels. As a result, office-based physicians often refuse to treat Medicaid patients. Such patients are forced to seek primary care and treatment for routine ailments in more costly hospital outpatient departments and emergency rooms. Compounding this problem, however, many States also have established reimbursement rates for hospital outpatient department services which are below what hospitals calculate are the costs of providing care. Such State policies frequently put an additional strain on financially troubled hospitals.

Demonstration and Waiver Authority. HCFA has the authority to carry out research, demonstration, and evaluation projects and to waive current reimbursement principles for these projects. Under section 1110 of the Social Security Act, HCFA can provide funding for research and demonstration projects which promote the objectives of the Medicare and Medicaid programs. Under section 1115 of the Social Security Act, section 402 of the 1967 Social Security Amendments and section 222 of the 1972 Amendments, HCFA can provide funding for projects, as well as grant waivers. Under sections 222 and 402, HCFA may grant waivers on reimbursement regulations for Medicare and Medicaid payments, and under section 1115, HCFA may provide grants to projects conducted by States for their Medicaid programs.

In some cases, it may be possible to use demonstration and waiver authority to aid financially troubled hospitals. However, this authority is limited by statute and policy. For example, waivers must be directed towards the accomplishment of specific research or demonstration objectives and towards furthering the objectives of the Medicare and Medicaid programs. In addition, Medicare waivers cannot be granted for eligibility expansions.

Programs Administered by the Public Health Service (PHS)

PHS Programs: The Public Health Service Act provides the Department with a variety of authorities which could, given sufficient appropriations, be used to assist financially distressed hospitals and to assure the continued availability of health care services for the community served.

Health Resources Administration (HRA): HRA has authority to award grants, loans, and loan guarantees to individual facilities or groups of hospitals for closure and conversion of unnecessary beds and services. Some of these authorities are operational, while others have no funds currently available. These programs are integrated with the health planning process to assure that the community interest, and not just the needs of an individual hospital are served. Proposal review includes an assessment of the facility's appropriateness, mix of services, bed-population ratios, occupancy rates, length of stay and the potential impact on minorities served within the community.

Specific authorities include the following:

- Health Planning Agencies. Under P.L. 93-641 and the 1979 amendments to the Public Health Service Act, health planning agencies play an integral role in decisions related to the allocation of health resources. As the agencies carry out their reviews for appropriateness of services and certificate of need, they consider a wide range of criteria on the merits of individual projects or facilities. Certificate of need regulations promulgated in 1979 include criteria specifically related to maintaining access to services, including meeting the health needs of members of medically underserved groups. In addition, under the Health Planning Ammendment of 1979, it appears that closures or conversions which involve a termination of a health care service or a significant reduction in bed capacity and also involve a capital expenditure will be subject to a certificate of need review.

- Conversion and Discontinuance of Unneeded Hospital Services. Sections 1641-1644 of the PHS Act provide for grants to be made available for voluntary closure and conversion of unnecessary hospital services. Authorized by the new health planning amendments, there are no current appropriations for such grants, and no appropriations are requested in the President's revised FY 1981 budget. The program is authorized at levels of $30 million in FY 1980, and $50 million in FY 1981.

- Loans and Loan Guarantees. Sections 1601 and 1602 of the PHS Act provide authority for the Department to give loans and loan guarantees for approved closure and conversion projects, correction of Life-Safety Code violations, and development of outpatient facilities. The Department has already committed $1.3 billion for these purposes. The President's budget for FY 1981 states that during FY 1981 no commitments for loans or loan guarantees will be made. Furthermore, to qualify for such loans (if they were made available), the hospital must provide evidence of financial viability sufficient to protect the fiscal interests of the Federal government. Thus, the hospitals most in need of financial assistance might have the greatest difficulty qualifying for such loans.

- Project Grants for Life-Safety Code Violations and Outpatient Facilities. Section 1610 of the PHS Act authorizes the Department to make grants to facilities for (a) the correction of Life-Safety Code violations and (b) outpatient medical facilities. For section 1610(a), $50 million is authorized in both FY 1980 and FY 1981. For section 1610(b), $15 million is authorized for FY 1980 and FY 1981. No appropriations for these sections, however, are included in the FY 1980 or FY 1981 budgets.

- Default Authority. Under title XVI of the PHS Act, the Department is authorized to expend funds to prevent hospitals from defaulting on title VI or XVI loans. Managerial, legal, and technical assistance may be provided to prevent such defaults. This is *not* a grant program but, rather, a Federal set-aside fund designed to back the government's guarantee in case of default or to take action to prevent a default.

- Uncompensated Care and Community Services Assurances. HRA is responsible for enforcing the community service assurance provisions under section 1602(6)of the PHS Act. Under this provision hospitals which received funding under title VI or XVI must ensure that their services are available to all members of the community.

  HRA also enforces the Hill-Burton "free care" provisions. This requirement, under which a hospital that received Hill-Burton funding is expected to provide a certain amount of charity care, has a two-edged effect. A financially sound hospital is required to provide a certain dollar volume of uncompensated care annually, proportionate to its Hill-Burton obligation or its operating revenues. Fulfillment of this obligation by such viable hospitals may relieve some pressure on financially troubled community hospitals. Conversely, to the extent that financially troubled hospitals must also comply with the "free-care" provision, this requirement may exacerbate their financial predicament. Hospitals in serious financial trouble, however, may defer meeting their free care obligations until such time as they are financially able to provide such services.

Health Services Administration (HSA): HSA programs provide support for high quality, comprehensive medical care in medically underserved areas. This authority is particularly applicable where current facilities are unable to provide efficient and cost-effective care to the community. Most frequently, the need exists where there is a shortage of appropriate medical personnel and/or the lack of appropriate facilities to provide the services most needed.

Specific authorities include:

- Grants to Hospital Affiliated Primary Care Centers. Section 328 of the PHS Act authorizes grants to public general and private not-for-profit hospitals to plan, develop, and operate primary care centers within their own institutions. They are to be staffed to provide comprehensive and continuous primary care in medically underserved areas. One million dollars is budgeted for FY 1980 for developmental purposes; $9.7 million, to support continuing projects, has been requested for FY 1981. The program is authorized at $25 million for FY 1980 and $30 million for FY 1981.

- Community Health Centers. Section 330 of the PHS Act established the Community Health Centers Program. This program focuses on the development of health services delivery capacity and the support of ambulatory health care projects located in rural and urban medically underserved areas. Current funding under this program is $319 million; $343.4 million has been requested for FY 1981. The program is authorized at $405 million for FY 1980 and $472 million for FY 1981.

- National Health Service Corps. Section 331 of the PHS Act established the National Health Service Corps (NHSC). Communities and facilities (including hospitals) designated as critical health manpower shortage areas are eligible for assignment of NHSC personnel. Currently, about 1,850 NHSC personnel are assigned to 448 communities. Total budget for loans and operations under this program is $72.8 million in FY 1980; $87.2 million has been requested for FY 1981. The program is authorized at $82 million for FY 1980 and must obtain new authorizations for FY 1981.

- Maternal and Child Health and Crippled Children's Services. Title V of the Social Security Act authorizes grants to States for specified services provided to mothers and children and crippled children. As this program is primarily one of providing formula grants to the States, the Department has relatively little control over its usage. Funding for FY 1980 is $345.5 million, and appropriations of $357.4 million have been requested for FY 1981. The program is authorized at $400 million for both FY 1980 and FY 1981.

- Research and Demonstrations. Section 340 of the PHS Act authorizes the Department to fund research and demonstration projects in urban and rural locations which directly relate to the provision of health care. Fourteen million dollars were appropriated for these purposes in FY 1980; no appropriations have been requested for FY 1981. The program is authorized at $24.5 million for FY 1980 and $27 million for FY 1981.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA): ADAMHA's grant and contract programs provide support for specific research, training, and service projects or programs which address alcohol, drug abuse, and mental health needs. Hospitals are among the institutions eligible to receive support under programs including:

- Drug Abuse Community Service Programs. The objectives of this program are to reach, treat, and rehabilitate narcotic addicts, drug abusers, and drug dependent persons. Drug abuse service projects may provide detoxification and institutional or community based aftercare. Appropriations for this program amount to $161 million for FY 1980; $161 million have been requested for FY 1981. Authorization levels are $169 million for FY 1980 and $185 million for FY 1981.

- Community Mental Health Centers—Comprehensive Services Support. This program provides grants to support comprehensive mental health services through community mental health centers. FY 1980 appropriations for this program total $290.3 million; $322.2 million have been requested for FY 1981. Authorization levels for FY 1980 vary for different components of the program and include some open-ended authorities. New authorizations will be necessary for FY 1981.

- Alcoholism Treatment and Rehabilitation/Occupational Alcoholism Service Program. This program offers project grants for programs to provide alcohol abuse and alcoholism treatment services and to coordinate and integrate services within the broader context of accessible community based resources. FY 1980 appropriations are $78.7 million; the FY 1981 budget request for this program is $108.3 million. The FY 1980 authorization level is $102.5 million; for FY 1981, $115 million is authorized.

Concerns of the Office of Civil Rights (OCR)

Office of Civil Rights Responsibilities: Also relevant to this discussion is the enforcement of title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973. These authorities provide that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, national origin, or handicap under any program or activity receiving Federal funds. OCR is involved in the application of this doctrine to health care facilities receiving Federal funds, e.g., Medicare, Medicaid and PHS monies.

OCR is concerned that the Department, in seeking to achieve the legitimate objectives of reducing unnecessary hospital bed capacity and containing costs, not unwittingly promote actions that would disproportionately affect minorities or other disadvantaged or medically underserved populations. Discrimination may occur where the closing of a hospital has a disproportionate effect on minority group persons who cannot obtain alternative or substitute services because those services are not available or accessible to them.

Blacks, Hispanics and other minority group persons living in inner cities often rely on the services offered at a particular hospital, and could be adversely affected by a reduction (either by relocation or termination) of those services. In investigating civil rights complaints, OCR will focus primarily on two factors: (1) whether the reduction will have an adverse effect on those patients who use the facility; and (2) whether the adverse effect, if any, falls disproportionately on minority patients. Where OCR finds a disproportionate adverse impact, the hospital will be required to establish that the reduction is necessary to achieve legitimate objectives that are unrelated to race or national origin, and that the objectives cannot be achieved by other measures having a less disproportionate adverse effect.

Current Legislative Proposals

Current Legislative Initiatives: Several important pending legislative proposals would directly or indirectly aid financially troubled hospitals, principally by expanding coverage for the poor. Proposals such as the Administration's Child Health Assurance Plan (CHAP) and the National Health Plan (NHP) could provide some relief to these hospitals by extending insurance coverage to many currently uncovered, poor individuals. CHAP will extend Medicaid coverage to an additional two million poor children and 100,000 pregnant women. If CHAP is enacted, $510 million in additional Federal and State funds will be available to pay for the health care of these 2.1 million currently uncovered individuals. While not earmarked for any specific hospital or group of hospitals, these funds should provide substantial fiscal relief to a number of financially troubled institutions.

The Administration's National Health Plan (NHP), if enacted, would provide comprehensive coverage to an additional 10 million low income individuals by eliminating the current Medicaid categorical restrictions and establishing a minimum income level below which all persons would be covered. NHP would also help overcome some of the current state-by-state differentials and inequities in Medicaid reimbursement rates for outpatient services. NHP would assure fair and uniform reimbursement rates for outpatient services provided to the poor, the disabled, and the elderly covered under the new HealthCare structure. NHP would thus provide substantial financial relief to all hospitals but especially to those serving large numbers of elderly and indigent persons.

It should be noted that neither of these new programs will cover undocumented aliens. While the PHS has grant programs which pay for health care services provided to uncovered individuals, including undocumented aliens, funding for these programs is currently limited. Moreover, major expansions of coverage to undocumented aliens might be problematic since taxpayers would be asked to underwrite the costs of these services when other health and social programs for needy citizens are being severely strained or curtailed. Nevertheless, an argument can be made that the problems of undocumented aliens are a Federal concern and not a local responsibility. Consequently, inaction at the Federal level would result in an unfair continued reliance on local tax bases to underwrite the cost of care for these individuals.

OPTIONS

Federal strategies for dealing with financially troubled hospitals may be structured around existing programs and authorities or can be based on new programs specifically tailored to aid these hospitals. Options for aiding financially troubled hospitals can be separated into long-term and short-term approaches. A case can also be made for no new initiatives given the lack of reliable information on the magnitude of the problem and the current austere budgetary climate.

Long-term approaches concentrate on overall health systems reforms. Some of these approaches would provide beneficiaries with protection against health care expenses by expanding insurance coverage. Other approaches would provide aid to hospitals by changing reimbursement principles. Short-term approaches would give aid to individual financially distressed hospitals and could provide assistance through a grant, loan, or demonstration program. These approaches require mechanisms and criteria to target funds to selected hospitals with legitimate financial needs.

Federal funds should not merely replace State and local funding sources; nor should they be used to subsidize inefficient management or inappropriate facilities and services. Hospitals which should be closed on the basis of objective planning, access, financial, and civil rights criteria should not be encouraged to continue operating. State and local governments should be active partners and assume their appropriate share of responsibility in providing assistance.

The options presented are not mutually exclusive. Various combinations of options can be considered in order to provide a multifaceted approach for aiding financially troubled institutions. Thus, while the National Health Plan might be viewed as a long-term source of relief to many financially distressed hospitals, other short-term efforts might be needed in the meantime. Further, the options are potential solutions to the problems of financially troubled hospitals from an HHS perspective. Any approach chosen needs to be coordinated with the programs and concerns of States and other agencies.

The range of options includes:

Take No New Action

- Initiate no new programs.

Short-Term Options

- Use existing Medicare and Medicaid waiver and demonstration authorities and continue to seek broader authority in this area;
- Seek increased appropriations for existing PHS grant and loan programs; and
- Obtain new legislation to establish grant and/or loan programs to provide unrestricted forms of aid.

Long-Term Options

- Expand health insurance coverage through early implementation of NHP or through new legislation for expansion of Medicaid eligibility and reimbursement provisions; and
- Require Medicare and Medicaid hospital reimbursements to hospitals to include payment for a proportionate share of the costs associated with bad debts incurred for necessary and appropriate care provided to uncovered individuals (either in specially selected hospitals or in hospitals which have a Hill-Burton obligation to provide uncompensated care).

I. Take No New Action

Given the current knowledge base and budgetary climate, HHS may not want to take any new actions to increase hospital reimbursements.

Option 1: Do not initiate any new programs or activities.

Pros

1. For the time being, the problem could be viewed essentially as one for the States to solve.
2. No increase in Federal spending is consistent with the current budgetary and fiscal climate.
3. Inaction would cause certain inefficiently run hospitals to close and would keep pressure on localities to make more radical reforms in their health care delivery systems.
4. Given the current insufficiency of reliable information, the appropriate action could be to undertake no new Federal initiatives.

Cons

1. Some financially troubled hospitals which should be aided on the basis of objective planning, access, civil rights, or other criteria might be forced to close.
2. Financially troubled hospitals may refuse to treat uncovered or inadequately covered individuals.
3. The Department would not have an adequately funded and focused approach for dealing with financially troubled hospitals.
4. This action might be viewed as HHS backing off from its overall health systems responsibilities.

II. Short-Term Options

A. Medicare and Medicaid Options

Financially troubled hospitals could be aided by using existing Medicare and Medicaid demonstration and waiver authorities as well as continuing to seek enactment of new legislation to broaden these authorities. New legislation is needed to increase the authorization and appropriation levels available for full Federal funding for Medicaid demonstrations. Legislation is also needed to expand Medicare demonstration and waiver authorities to allow for eligibility demonstrations.

Option 2: Increase use of existing Medicare and Medicaid demonstration and waiver authorities, and continue to seek enactment of legislation to broaden these authorities.

Pros

1. Implementation of some elements of this option could be initiated immediately.
2. Information from these demonstrations would be extremely useful in designing future Medicaid eligibility expansions and implementing NHP.
3. New legislation could provide HHS with broader authority to experiment with NHP eligibility and reimbursement provisions which would, at the same time, aid financially troubled hospitals.
4. Demonstrations could be targeted to the poorest individuals in the catchment areas around financially troubled hospitals or to situations where alternative or substitute services are not available or accessible.
5. Restructuring of the local health care delivery system would be achieved.

Cons

1. Waiver and demonstration authorities currently have specific limitations which may reduce their applicability to certain hospital problems. They are time-limited; they must be granted for unique research/demonstration projects which are directed towards meeting the objectives of the Medicare and Medicaid programs; and they have procedural restrictions (i.e., section 1115 waivers can only be awarded to a State Medicaid agency).
2. Such demonstrations might not provide sufficient aid to hospitals suffering from special problems, such as providing care to large numbers of undocumented aliens.

3. Attempts to apply current demonstration/waiver authorities on a large scale basis beyond their traditional use would be controversial and might lead to litigation and Congressional repeal of authorities.

4. Congress may be unwilling to give the Department greater authority to waive program requirements.

B. PHS Options

The Department could seek increased funding levels for currently authorized PHS programs and statutory authority and appropriations for new grant or loan programs specifically designed to aid financially troubled hospitals.

Option 3: Seek increased Congressional appropriations for currently authorized PHS programs.

Pros

1. Since Congress has already authorized these programs, appropriations could be approved quickly.

2. Grants and loans can be targeted to specific institutions and to specific detailed problem areas.

3. Administrative mechanisms are already in place.

Cons

1. Several diverse programs, with different selection criteria, timing of awards, etc., would have to be coordinated in order to have a systematic impact on financially troubled hospitals which face multiple problems.

2. Grant programs that provide payments for uncovered individuals are quite limited in scope and emphasize outpatient care only.

3. Specific appropriation levels for each program inhibit flexibility in both awarding and using grant and loan funds.

4. Some existing loan/loan guarantee programs require financial viability as a precondition for granting assistance.

5. OMB and Congress have previously been unwilling to fund these programs, even at currently authorized levels.

Option 4: Seek new legislation for an HHS. grant and/or loan program specifically designed to aid financially troubled hospitals (existing PHS grant and loan programs would need to be coordinated with the new program).

Pros

1. HHS would have general authority to make payments to financially troubled hospitals.

2. Aid could be targeted directly to specific institutions.

3. Specific criteria would be established to determine when a hospital is eligible for aid.

Cons

1. A new program could cause confusion unless careful coordination were made with existing grant programs.

2. An administrative structure would be needed to decide which hospitals would get the appropriated funds.

3. Congress and OMB may be unwilling to appropriate sufficient funds.

4. Such a program may be perceived as a long-term "bail-out" for inefficient hospitals.

5. Department support of a new PHS grant program may result in diminished approriations for existing programs.

III. Long-Term Options

A. Health Insurance Coverage and Reimbursement Expansions

The problems of financially troubled hospitals which result from limited health insurance coverage and low outpatient reimbursement rates can be alleviated by expanding health insurance coverage for all poor people and increasing reimbursement for ambulatory care services. This will result in a major infusion of funds for all hospitals serving the poor and the elderly, and will provide health insurance protection for large numbers of people. This action can be accomplished either through a special Medicaid legislative initiative or through early enactment of NHP.

Option 5: Seek early enactment and implementation of Phase I of NHP.
(Cost: $17.2 billion in 1980 dollars)

Pros

1. Would provide health insurance for our poorest citizens.
2. Expanded coverage would help eliminate one of the major problems faced by financially troubled hospitals, treatment of the uninsured poor.
3. Increased physician and hospital outpatient department reimbursements will provide major financial relief to many financially troubled hospitals.

Cons

1. Financial benefits from eligibility expansions and reimbursement changes could not be targeted to specific financially troubled institutions or geographic areas.
2. Would be extremely costly to States and the Federal government.
3. Congressional passage of a program of this magnitude may be unlikely at the present time.
4. These expansions would not help certain uncovered groups such as undocumented aliens.

Option 6: Seek legislation to expand Medicaid eligibility and outpatient reimbursement rates.
(Cost: $100 million to $5 billion)

Pros

1-3 Same as Option 5.

4. Congress may be more willing to adopt a limited Medicaid package than a comprehensive national health insurance program.

Cons

1-4 Same as Option 5.

5. Might be viewed as a backing off from NHP.

B. Increased Medicare and Medicaid Reimbursement for Bad Debts

Financially troubled hospitals could be aided by allowing Medicare and Medicaid reimbursements to include payments for providing care to uncovered individuals. These increased reimbursements could be provided to hospitals selected according to specific need criteria or to hospitals fulfilling their Hill-Burton "uncompensated care" requirements.

Option 7: Seek legislation to require Medicare and Medicaid hospital reimbursement to include payments under defined circumstances for their share of the costs associated with hospital bad debts due to care provided to uncovered or inadequately covered individuals. (Cost: Depends on the number of hospitals involved and the types of bad debts for which reimbursement would be paid. If Medicare and Medicaid paid their share of costs associated with total bad debts in all hospitals, it would cost between $500 million to $1.5 billion).

Pros

1. Could provide substantially increased reimbursement to hospitals in a precarious financial condition due to bad debts arising from the provision of care to large numbers of uncovered indigents.

2. Would channel most assistance to those hospitals with large proportions of Medicare and Medicaid patients.

Cons

1. Use of Medicare funds to pay for care for uncovered or inadequately covered individuals would be a major departure from the statutory requirement of paying only for the costs of covered services to Medicare beneficiaries.

2. Could impose additional costs on States, unless the States reduce their Medicaid services.

3. From an equity perspective, unless general revenue contributions to the Medicare Part A Trust Fund are mandated, it would be inappropriate to use these monies, which are raised through a regressive payroll tax, to support financially troubled hospitals.

4. Would establish a de facto medical assistance program controlled by the hospital, not the government.

Option 8: Provide Medicare and Medicaid reimbursement for their share of the costs associated with services provided in fulfillment of the Hill-Burton "uncompensated care" requirement.
(Cost: About $100 million)

Pros

1-2 Same as Option 7.

3. Would reduce political opposition to the new Hill-Burton requirements, and would provide a greater incentive for compliance.

Cons

1-3 Same as Option 7.

4. Not all financially troubled hospitals have received Hill-Burton funds, and not all hospitals which have received Hill-Burton funds are financially troubled.

5. Might be viewed as a backing off from the requirement to provide uncompensated care, and an admission that HEW is unable to achieve compliance.

Table 1.—MEDICARE COST REPORT DATA
Distribution of Hospitals by Ratio of Total Revenue to Total Expense and Selected Characteristics: National Estimates, 1977

	Total Revenue*/Total Expense Ratio		
Urban/Rural	Less than 1.00	1.00+	Totals
SMSA			
Number	471	2252	2723
Percent	17.3	82.7	100.0
Non-SMSA			
Number	927	2166	3093
Percent	30.0	70.0	100.0
Type of Control			
Non-Profit, Non-Government			
Number	692	2569	3261
Percent	21.2	78.8	100.0
For-Profit, Non-Government			
Number	164	571	735
Percent	22.3	77.7	100.0
State and Local Government			
Number	542	1278	1820
Percent	29.8	70.2	100.0
Bed Size			
0-99			
Number	994	1957	2951
Percent	33.7	66.3	100.0
100-299			
Number	281	1656	1937
Percent	14.5	85.5	100.0
300-499			
Number	75	515	590
Percent	12.7	87.3	100.0
500+			
Number	49	289	338
Percent	14.5	85.5	100.0

Number of hospitals in each cell may be off by +1 or -1, due to rounding error.

*Total revenue equals revenue that the hospital received from all sources (patient and non-patient revenue) net any allowances and deductions such as bad debts, Blue Cross discounts, etc.

Table 2.--AMERICAN HOSPITAL ASSOCIATION DATA
Distribution of Hospitals by Ratio of Total Revenue to Total Expense and Selected Characteristics: National Estimates, 1978

	Total Revenue*/Total Expense Ratio		
	Less than 1.00	1.00+	Totals
Urban/Rural			
SMSA			
Number	551	2008	2559
Percent	21.5	78.5	100.0
Non-SMSA			
Number	768	1685	2453
Percent	31.3	68.7	100.0
Type of Control			
Non-Profit, Non-Government			
Number	731	2349	3080
Percent	23.7	76.3	100.0
For-Profit, Non-Government			
Number	95	340	435
Percent	21.8	78.2	100.0
State & Local Government			
Number	493	1004	1497
Percent	32.9	67.1	100.0
Bed Size			
0-99			
Number	777	1452	2229
Percent	34.9	65.1	100.0
100-299			
Number	391	1487	1878
Percent	20.8	72.2	100.0
300-499			
Number	90	518	608
Percent	14.8	85.2	100.0
500+			
Number	61	236	338
Percent	20.5	79.5	100.0

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* Total revenue equals revenue that the hospital received from all sources (patient and non-patient revenue) net any allowances and deductions such as bad debts, Blue Cross discounts, etc.

Addendum

On June 24, 1980 after careful consideration of the options presented by the task force, Secretary Haris announced her decision on an HHS strategy for assisting certain financially troubled hospitals. The basic features of the HHS approach are:

- establishing a coordinated HHS operating structure to assure consistency among HHS programs and to respond to requests for assistance;
- using existing Medicare and Medicaid demonstration and waiver authorities;
- seeking enactment of legislation providing for expanded Medicare and Medicaid demonstration and waiver authorities; and
- seeking increased appropriations in FY 82 for certain existing PHS grant and loan programs.

This strategy is aimed at assuring the provision of necessary and appropriate health care services for individuals in communities threatened by closure of essential hospital services. It will allow the Department to be responsive to areas of critical need, while at the same time develop a knowledge base upon which the eligibility expansions, service reform and reimbursement objectives of the Administrations' National Health Plan can be tested and refined. Furthermore, this approach is consistent with both the Department's system reform objectives and current Federal budgetary priorities. Under this strategy, assistance will be provided to those institutions which are providing care to our poorest citizens, and which are determined to be needed on the basis of objective access, planning, and system reform criteria. Federal funds, however, will not be used to "bail out" inefficient hospitals or as a substitute for State and local funds. State and local governments must assume their appropriate share of responsibility in providing assistance.

In order to implement this strategy, an HHS coordinating committee will provide guidance to the Departmental components involved in this effort and will monitor their progress. Members of the committee include the Under Secretary, Nathan Stark; the Deputy Administrator of the Health Care Financing Administration, Earl M. Collier, Jr.; the Deputy Assistant Secretary for Health of the Public Health Service, Charles Miller; and the Assistant Secretary for Planning and Evaluation, John Palmer.

Demonstrations which seek to improve the effectiveness of the Medicare and Medicaid programs as well as provide aid to some vital financially troubled hospitals will be conducted by the Health Care Financing Administration (HCFA). Using existing waiver and demonstration authorities, HCFA will undertake a limited number of projects to explore issues such as closure and conversion, targeted expansions of Medicaid eligibility, the role of public general hospitals, and capitation reimbursement arrangements. A special solicitation, to be issued in the Federal Register in September, will provide details and criteria on the demonstration projects.

rtment will also vigorously pursue passage of legislation to expand waiver and demonstration authorities. Two legislative changes are sought. The first change would expand the waiver and demonstration ity under titles XI, XVIII, and XIX of the Social Security Act to allow o waive certain additional program requirements under Medicare and the program. Current Medicare demonstration and waiver authorities limit jects to reimbursement experiments and do not permit waiver of program igibility requirements. Further, there is no waiver authority under the RO program. The current Medicaid waiver authority, on the other hand, permits road experimentation with all aspects of the Medicaid program. By enacting a new general demonstration and waiver authority that would permit the same authority for Medicare and PSRO programs as for Medicaid, HCFA will be able to conduct integrated demonstration projects.

The second legislative change would expand the ceiling on the amount of full Federal funding available for section 1115 demonstration projects. Normally, any Federal funds expended under section 1115 must be matched by the State on the basis of the State Medicaid matching rate. Currently, only $4 million in Federal funds (of which HCFA is allocated $1.7 million) can be expended without required State matching.

In addition to using demonstration and waiver authorities, the Department anticipates seeking increased funding in FY 82 for Public Health Service programs that assist financially troubled hospitals and the populations they serve. Relevant authorities for which additional appropriations may be sought include Grants to Hospital Affiliated Primary Care Centers (section 328 of the PHS Act), Grants for Closure and Discontinuance of Unneeded Hospital Services (sections 1641 - 1644 of the PHS Act), and Project Grants for Life Safety Code Violations and Outpatient Facilities (sections 1610(a) and (b) of the PHS Act).

Overall, the HHS strategy will assure the the financial viability of those threatened vital institutions which serve many of the poorest individuals in this country. It will also develop a knowledge base for future programs, support system reform objectives, promote hospital management improvements, and create a more effective partnership with State and local governments.

Exhibit 14

REPORT OF THE TASK FORCE ON PUBLIC GENERAL HOSPITALS OF THE AMERICAN PUBLIC HEALTH ASSOCIATION*

TASK FORCE

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*Report to be presented by the Task Force from 2:00 to 3:30 p.m., Monday, October 16, 1978, at the Los Angeles Hilton Hotel, at the 106th Annual Meeting of the American Public Health Association, Los Angeles, California.

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I. CHARGE TO THE TASK FORCE

The Task Force and its membership was established by the Executive Board of the American Public Health Association with the following charge:

> "to assess the effects of recent public general hospital closings on the health of the populations formerly served by them, and to propose (if indicated) an APHA position on the issues involved."

The Task Force agreed that its goal would be the creation of a Report based on facts and which would lead to an informed policy for the American Public Health Association on issues involved with Public General Hospital closings and their potential effects on the populations served. (See Section V below)

II. CURRENT STATUS OF PUBLIC GENERAL HOSPITALS

1. The recent Commission report on Public General Hospitals noted that public general hospitals are an important national resource, and serve vital community functions.[1]
   a. They represent 33% of the community hospitals in the United States, and 24% of short term general hospital beds.
   b. With only 24% of beds, they account for 45% of all visits to organized outpatient departments in community hospitals (excluding referral and emergency visits).
   c. They train almost 40% of medical and dental residents and 20% of other health professionals who are trained in community hospitals.
   d. Publicly-owned university hospitals account for two-thirds of all university hospitals.
   e. Almost 50% of hospitals and 40% of beds in rural areas are publicly-owned. More than half are the only hospitals located in the counties they serve.

f. In the 100 largest cities, publicly owned public general non-university hospitals represent 9.3% of all non-university general hospitals. These hospitals account for 14.7% of beds, 45% of outpatient visits (excluding referral and emergency visits) and 27% of emergency visits. In these 100 cities these public general hospitals

- average 422 clinic visits a day and 210 emergency visits a day (twice as many of the latter as any other category of hospital);
- provide special services in far greater proportion than their number; 21% of the psychiatric emergency programs in all urban community hospitals and 26% of all alcohol detoxification and treatment units.
- in 50% there are neonatal intensive care units, and in one third there are burn care units.
- train almost 20% of medical and dental residents and 10% of all other health professions trainees.

2. Despite the important functions, public general hospitals and in particular, urban public general hospitals, are considered to be in crisis.*

a. Because of undercapitalization, many of them are housed in old and deteriorated physical plants, thereby increasing operating costs, making it difficult to provide the highest quality of care, and making them unattractive to patients.[2] One Study found that public hospitals had 18% less assets per unit of service than private hospitals.[3]

b. Many urban public hospitals have inadequate space for their intensively used outpatient and emergency departments.[4]

c. Public hospitals lack sufficient operating funds. Since they serve large numbers of uninsured patients, their costs must be met by tax levies. It was found, that there is an average operating deficit

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*In what follows, the Commission on Public General Hospitals defined urban public general hospitals as non-university publicly owned hospitals in the 100 largest cities; others such as Cooney, Roemer and Ross used different criteria.

of 17% in large urban public hospitals as compared to 4% in a comparison group of private hospitals.[5] The move to cut taxes and balance city budgets threatens public hospitals further. In addition, uncertain revenues from year to year make planning and budgeting an impossibility.

d. Urban public general hospitals are understaffed in relation to comparison non-public hospitals.[6,7]

e. Public hospitals are often hampered in their planning and management by bureaucratic encumbrances growing out of their relationship to city governments. (Examples: salary limitations, special procedures for purchasing, inflexible line item budgets, lack of sufficient authority at the operating level.)[8,9]

In spite of these problems, the urban public general hospital has been adaptable to and responsive to community needs, has had more community participation, has been more publicly accountable, has been more likely to provide services other than through fee-for-service, and has provided quality of care no less satisfactory than its wealthier counterparts.

3. The problems of the public general hospital, particularly the urban public hospital, cannot be understood without examining the history of these institutions. Their historical role and their relationship to the private sector has led to their chronic underfinancing.

III. HISTORICAL PERSPECTIVE[10,11,12]

Public general hospitals originated in the almshouse infirmaries established by local governments to care for the poor, including the sick poor, as early as colonial times. Later on, in the late 18th century and early 19th century, the infirmaries separated off from the almshouse and became independent institutions supported by local tax monies. At the same time, private charity hospitals and infirmaries began to develop. In New York City these private institutions received a grant from the City government to care for the indigent sick. Both public and private hospitals were institutions which mainly provided food and shelter for the impoverished sick. There was little that medicine could do at that time to cure illness, and the middle class was treated at home by private doctors.

It was not until well into the 19th century that the private charity hospitals began trying to attract middle class patients. Recent research on New York City indicates that the change came in part as a result of the crisis in financing during the depression of the 1890s. The depression stimulated the growth of charitable institutions as an expanding urban population became dependent on assistance. At the same time there was a decline in private contributions to these organizations, which were forced to turn to the City for greater financial support. The proliferation of these charity organizations began to strain the City budget since each was paid a flat grant. Reformers instituted payment on a per diem basis, and only for those patients who were truly destitute.

Some private institutions lost money with this arrangement. Since contributions from private benefactors had also decreased, these hospitals had to charge patients in order to meet their financial needs. They also began trying to attract middle class patients. They did this in two ways: by providing services and amenities which distinguished between paying and non-paying patients, and by making the hospital a desirable place for private physicians to treat their own patients. As paying patients became more necessary for the survival of the private hospital, the number of beds available for non-paying patients was reduced. The public institutions then tended to become the only source of care for those who could not pay for their care. By the end of the 19th century, cities had already established the precedent of reimbursing private hospitals for the care of indigent patients; the former almshouse infirmaries had become the hospitals for those who could afford to go nowhere else, thus remaining totally dependent on tax dollars for their support.

These relationships and special functions became further entrenched with the advent of private health insurance during the 1930s. The economic depression had undermined the financial base of private hospitals because no one could afford to pay for hospital care. The American Hospital Association joined with the struggling insurance companies to organize the voluntary insurance plans. This system guaranteed the voluntary hospitals a regular source of income by providing middle class patients with the purchasing power to pay for private hospital services. But the success of this system was possible only if private hospitals could restrict themselves to revenue-generating patients. The public hospital, therefore, was critical to the survival and growth of the private hospital sector since it provided a source of care for the non-revenue generating patients. Thus the new insurance

> was discrimination in the choice of a neighbor. I believe most Senators are willing to concede that an open housing policy should not be in this bill.... If that is so, I think it should be made clear. 34/

Moreover, it was apparently understood that Title VI applied to the federally assisted medical health care programs in existence at the time of its passage 35/ and to Medicare at the time that program was enacted. 36/ Thus, it appears that the legislative meaning given to the term "contract of insurance" concerned funds different in important respects from those disbursed by the Federal Government from the Federal treasury under Medicare.

34/ 110 Cong. Rec. 13435 (1964). The exclusion was similarly understood in the House by its sponsors there. Representative Celler, Chairman of the Judiciary Committee, sponsor and floor leader for the bill in the House, explained the exclusion in the debates before the House. He said:

> The financial assistance programs covered are only those involving grants, contracts or loans. The bill does not cover insurance and would not of course affect banks' accounts insured by the FDIC....

110 Cong. Rec. 1519 (1964). Congressman Celler also listed social security benefits and veteran's benefits as outside the scope of Title VI but as they are not programs or activities receiving Federal financial assistance their inclusion was never contemplated.

35/ House Hearings, supra, note 24 at 1545-1546. (Testimony of Anthony J. Celebrezze, Secretary of Health, Education and Welfare.)

36/ In a statement that did not explicitly distinguish Medicare Parts A and B, Senator Hart stated:

> In addition to the new economic independence it will create, I am hopeful that the bill will promote first-class citizenship in another fashion also. We decided last year, and wrote into law, that Federal tax funds collected from all the people may not be used to provide benefits to institutions or agencies which discriminate on the grounds of race, color, or national origin. This principle will, of course, apply to hospital and extended care and home health services provided under the social security system, and will require institutions and agencies furnishing these services to abide by Title VI of the Civil Rights Act of 1964.
> 111 Cong. Rec. 15813 (1965).

Cf. also 111 Cong. Rec. 15803 (1965) (statement of Senator Ribicoff).

> The exclusion relates to, as the language says, other than a contract of insurance or guarantee. So FDIC (Federal Deposit Insurance Corporation) and all activities pertaining thereto are eliminated. The Federal Housing Administration is eliminated. 31/

Senator Pastore, the Senate floor manager for Title VI, also explained the reason for the amendment:

> The reason why we have excluded contracts of insurance or guaranty is that we do not want this section to affect, let us say, guarantees of deposits in banks. 32/
>
> We do not want that section to affect FHA housing. That is precisely why the exception is put in the section. 33/

It thus becomes clear that section 605 which exempts contracts of insurance was added to the bill to assure the removal of Title VI jurisdiction from activities undertaken with federally insured non-Federal funds. Senator Long, sponsor of the amendment that added section 605, explained:

> /This amendment7 is intended to make sure that this bill does not do what it's sponsors say it does not do.../T/he distinguished manager of the bill said that § 601...would not apply to a bank which might be a member of the national banking system and would not apply to a state bank insured by the Federal Deposit Insurance Corporation. As I understand, they are required to be so insured. This is the problem: The question is whether it could be construed to mean that a state bank which must be insured by the Federal Deposit Insurance Corporation would be considered as being under a federally assisted program. The sponsors of the bill say that is not intended. If it were construed to be under a federally assisted program, it would be said that a person would be discriminated against because someone would not want to sell him his home.... In other words, § 601 could be construed to be an open housing ordinance in every city in America on the ground that no building and loan association or any lending agency that has guarantees from a Federal program could make a loan where there

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31/ 110 Cong. Rec. 13378 (1964).

32/ *Id.* at 1345.

33/ *Id.* at 1346.

Message to Congress urging the adoption of the legislation 26/ and both the House 27/ and Senate 28/ bills that became the Civil Rights Act of 1964 all originally included contracts of insurance. However, during the hearings before the House Subcommittee of the Committee on the Judiciary, questions arose concerning contracts of insurance. 29/ Consequently, the bill was amended to exclude contracts of insurance.

Senator Humphrey, the Senate floor leader for the 1964 Civil Rights Act, explained the reason for the exclusion:

26/ The Presidential Message on Civil Rights and Job Opportunities. Doc. No. 124 of June 19, 1963, reported in II Civil Rights: Hearings Before Subcomm. No. 5 of the House Comm. on the Judiciary, 88th Cong. 1st Sess. 1454 (1963) (hereafter, House Hearings) stated:

> ...it would be better at this time to pass a single comprehensive provision making it clear that the Federal Government is not required, under any statute, to furnish any kind of assistance--by way of grant, loan, contract, guaranty, insurance or otherwise--to any program or activity in which racial discrimination occurs. (Emphasis added)

27/ H.R. 7152, 88th Cong. 1st Sess. § 601.

28/ S. 1731, 88th Cong. 1st Sess. § 601. S. 1750, 88th Cong. 1st Sess. § 601.

29/ House Hearings, *supra*, note 24 at 1497-1500. (Colloquy between Representative Cramer and Willard W. Wirtz, Secretary of Labor.)

> Mr. Cramer: That is the point. I don't think we should expect to legislate in a vacuum so far as knowing what programs would be affected by the words, particularly loan, insurance, guarantee, and otherwise, there.
>
> Mr. Wirtz: There is no difficulty with the question and we will be in a position to give you a specific answer.
>
> Mr. Cramer: In other words you have Federal deposit insurance relating to savings and loan institutions and banks. If a bank makes a loan or a savings and loan institution makes a loan to a contractor for a building of a home, is that contractor subject to these provisions simply because the money comes from an institution with FDIC insurance?

Id. at 1498.

This memo will first analyze the applicability of the contract of insurance exemption to Part B Medicare and will then discuss the relationship between payment methods and Title VI jurisdiction.

Contracts of Insurance

The provisions of Title VI apply to "...Federal financial assistance to any program or activity, by way of grant, loan or contract other than a contract of insurance or guaranty..."; 21/ the principal purpose of which is to assist the recipient in providing services to a particular class of individuals. This restriction on the scope of Title VI is repeated in section 605 of the Act, which states:

> Nothing in this subchapter shall add to or detract from any existing authority with respect to any program or activity under which Federal financial assistance is extended by way of a contract of insurance or guaranty. 22/

It is thus necessary to determine whether the supplemental Medicare program is a contract of insurance within the meaning of that term as employed in the statute. As the Medicare program was adopted subsequent to the enactment of Title VI, 23/ it is not possible to determine specific legislative intent at the time Title VI was considered and debated by Congress concerning the applicability of the term "contract of insurance" to that particular program. Nevertheless, the legislative history of the exclusion discloses a legislative intent to affect programs markedly dissimilar to Medicare. Insertion of the term "other than contracts of insurance or guaranty" in section 602 24/ of the Act and the adoption of section 605 25/ were clearly designed to assure that programs or activities financed with loans from non-Federal sources were not subject to the prohibitions of the title merely because such loans were federally insured. In particular, it was the express legislative understanding that the restriction was particularly concerned with assuring that Title VI did not apply to home mortgages obtained from federally insured institutions.

Under the original bill, contracts of insurance were included within those Federal funds subject to a cut off if used discriminatorily. The President's

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21/ 42 U.S.C. § 2000d-1 (1976).

22/ Codified at id. § 2000d-4.

23/ The Civil Rights Act of 1964 was adopted July 2, 1964, and the Social Security Act Amendments of 1965 establishing the Medicare program were adopted July 30, 1965.

24/ Codified at 42 U.S.C. § 2000d-1 (1976).

25/ Codified at id. § 2000d-4.

As the Commission on Civil Rights previously noted in its report, *The Federal Civil Rights Enforcement Effort--1974*, "HEW's support of its position /that Title VI does not extend to cover Medicare Part B/ evidences varying rationales." 18/ It appears that the primary reason which the Department advances to support its view is that "Medicare Part B is excluded from the scope of Title VI as a 'contract of insurance.'" 19/ The Department has also claimed that Title VI does not apply to programs such as those in Part B, in which payment is made directly to the ultimate beneficiary. 20/

18/ To Extend Federal Financial Assistance, *supra*, note 5 at 118-119.

19/ In the 1965 opinion of the HEW General Counsel (see text accompanying note 6, *supra*), the rationale was advanced that payments under Medicare Part A constitute Federal financial assistance within the meaning of Title VI because as "reimbursement/s/ equal to cost they in fact redound to the financial benefit of providers of service as a class." HEW Internal Memorandum from Alanson W. Willcox, General Counsel to Robert M. Ball, Commissioner of Social Security, October 18, 1965, at 1 (hereafter HEW Memo I). Under such an analysis, it was stated, monies disbursed under Part B could not be described as Federal financial assistance because they are limited to 80 percent of the reasonsable costs. *Id.* at 3. In the 1966 opinion (see text accompanying note 6, *supra*), the General Counsel reiterated the position taken the preceding year but repudiated the original supporting rationale. The 1966 memorandum concluded that payments under Part A in that they "are designed to finance the program or activity of a non-Federal institution or agency would be within the scope of Title VI even if there were no element of financial benefit to the recipients." HEW Internal Memorandum from Alanson W. Willcox to Robert M. Ball, December 30, 1966 at 1 (hereafter, HEW Memo II). Because such an analysis does not distinguish programs that reimburse reasonable costs from programs that reimburse only 80 percent of reasonable costs, the rationale advanced in HEW Memo I for excluding Part B from Title VI coverage was no longer tenable. The General Counsel, nevertheless, concluded in a footnote with minimal analysis that Medicare Part B is excluded as a contract of insurance. HEW Memo II, *supra*, at n.10.

20/ This rationale is presented in both Memos I and II. See note 19, *supra*. HEW Memo I stated that "/i/t is clear that Title VI does not apply to programs in which payment is made by the Federal Government directly to the ultimate beneficiary, such as the Social Security cash benefit program, and it would appear that the same principle is applicable to Part B of Title XVIII /Medicare/." Memo I at 3. However, because Part B provides for some payments directly to providers the Memo based its conclusion of exclusion not so much on this "direct payment" rationale as on the less than complete nature of the reimbursement. *Id.* *See* note 19, *supra*. HEW Memo II, while premising exclusion of Part B from Title VI on the contract of insurance theory, also discussed the "direct payment" rationale. Memo II at 5, 8-9.

activity. 11/ The basic Medicare program, Medicare Part A, Hospital Insurance Benefits for the Aged, 12/ provides basic and compulsory medical insurance covering the costs of inpatient hospital care and post-hospital care in nursing facilities and at home 13/ for persons age 65 or over who are recipients of social security. 14/ Payments for services provided under the Hospital Insurance Plan are disbursed from a statutorily established Federal Hospital Insurance Trust Fund that is financed through a separate payroll tax paid by employees, employers and the self-employed. 15/

Medicare Part B is a voluntary, supplementary health care plan which pays 80 percent of a patient's costs for various medical, health and home care services regardless of whether these services are provided in a hospital, clinic, office or home. 16/ Disbursements under the supplemental program are from a separate Federal Supplementary Medical Insurance Trust Fund which is funded in part by the payment of premiums and in large part from Federal general revenues. 17/

11/ Total Federal outlays for health purposes are estimated to be $49.1 billion in 1979, $53.4 billion in 1980 and are projected to grow to $64.2 billion in 1982. Financing and providing health care services represents the largest amount of Federal spending for national health needs. Federal outlays for health care services are estimated to be $44.5 billion in 1979, $48.5 billion in 1980 and $59.1 billion in 1982. Medicare outlays represent approximately 65 percent of the health care services expenditures. Medicare outlays are estimated to be $29.1 billion in 1979, $32.1 billion in 1980 and $40.5 billion in 1982. The Budget of the United States Government, Fiscal Year 1980, 231-237.

12/ 42 U.S.C.A. §§ 426, 1395-1395b-1, 1395c-1395i, 1395x-1395rr (1974 and Supp. 1980).

13/ *Id.* at 1395d.

14/ 42 U.S.C.A. § 1395c (Supp. 1980) states that Medicare is available to: "(1) Individuals who are age 65 or over and are entitled to retirement benefits under subchapter II /Social Security/ of this chapter or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits under subchapter II of this chapter or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have endstage renal disease."

15/ *Id.* at § 1395i.

16/ 42 U.S.C.A. §§ 1395k, 1395-1, 1395m (1974 and Supp. 1980).

17/ *Id.* at § 1395t.

she reiterated the position taken in those opinions that Title VI, while applicable to Federal funds disbursed under both Medicaid and Medicare Part A, does not apply to funds disbursed under the Medicare Part B program.

This memorandum presents an analysis of the position presently held [7] by the Department of Health and Human Services. It is our view that the Department of Health and Human Services should reconsider its position that Title VI jurisdiction does not extend to private physicians who receive monies under Medicare Part B.

Title VI and Medicare

Title VI of the Civil Rights Act of 1964 provides that:

> No person...shall, on 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. [8]

To enforce this prohibition, the Title empowers Federal agencies to cut off funds from activities determined to be in noncompliance. [9]

The principal health activities and programs sponsored by the Department of Health and Human Services are Medicare, Medicaid and categoried grants for health and welfare aid. [10] Medicare is the largest Federal health

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[7] In her letter, the Secretary stated that the General Counsel of the Department was once more reviewing the question.

[8] 42 U.S.C. § 2000d (1976).

[9] *Id.* at § 2000d-1.

[10] The different and various categorical grant health and welfare programs, such as Aid to Families with Dependent Children, 42 U.S.C.A. §§ 601-610 (1974 and Supp. 1980), Maternal and Child Health Services, 42 U.S.C.A. §§ 701-710 (1974 and Supp. 1980), and Supplemental Security Income for the Aged, Blind and Disabled, 42 U.S.C.A. §§ 1381-1385 (1974 and Supp. 1980), are not discussed in this memorandum although Federal financial assistance extended under all three mentioned programs is subject to the prohibitions of Title VI. *Cf.* 45 C.F.R. § 80 App. A (1979).

UNITED STATES COMMISSION ON CIVIL RIGHTS

Washington, D. C. 20425

DATE: October 7, 1980

REPLY TO ATTN OF: OGC

SUBJECT: Applicability of Title VI to Medicare Part B

TO: Louis Nunez
Staff Director

At the April 1980 Commission consultation on Civil Rights Issues in Health Care Delivery, Dr. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation/Health, Department of Health and Human Services, 1/ testified 2/ concerning the Department's interpretation of Title VI of the Civil Rights Act of 1964 3/ as not applicable to funds disbursed under Medicare Part B. 4/ As a result, the Commission sent a letter to the Secretary of Health and Human Services requesting her to set forth the Department's interpretation of Title VI insofar as activities of private physicians receiving payments under Medicare and Medicaid are concerned. 5/ The Secretary responded by letter dated June 9, 1980, enclosing copies of opinions from the General Counsel's Office of the Department dated October 18, 1965, and December 30, 1966. 6/ In her letter,

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1/ At the time of the consultation the present Department of Health and Human Services was included within the Department of Health, Education and Welfare, Pub. L. No. 96-88, §509, 93 Stat. 695, October 17, 1971.

2/ Draft transcript for Wednesday, April 16, 1980 at 86-69.

3/ 42 U.S.C. §§ 2000d-2000d-6 (1976).

4/ 42 U.S.C.A. §§ 1395-1395b-1, 1395j-1395w, 1395x-1395rr (1974 and Supp. 1980).

5/ The Commission had previously expressed awareness of the position taken by the Department and had questioned its accuracy. See, United States Commission on Civil Rights, IV The Federal Civil Rights Enforcement Effort--1974; To Extend Federal Financial Assistance 118-119 (1975). (Hereafter "To Extend Federal Financial Assistance.")

6/ In addition, the Secretary enclosed an additional memorandum from the General Counsel of the Department of Health, Education and Welfare (see note 1, supra), dated July 5, 1968, reiterating the position that Title VI does not affect Medicare Part B funds and copies of the District and Circuit Court opinions in the case, Trageser v. Libbie Rehabilitation Center, Inc., 426 F. Supp. 424 (E.D. Va. 1977) aff'd on other grounds 590 F.2d 87 (4th Cir. 1978).

Exhibit 15

APR 24 1980

Honorable Patricia Roberts Harris
Secretary of Health, Education,
and Welfare
Washington, D.C. 20201

Dear Secretary Harris:

The U.S. Commission on Civil Rights sponsored a two-day consultation on the civil rights aspects of health care delivery on April 15-16, 1980. Dr. Karen Davis, Deputy Assistant Secretary for Planning and Evaluation at the Department, made an excellent presentation on some of the legislative initiatives currently under review in the field of health.

During Dr. Davis' testimony a question arose regarding interpretation of Title VI of the Civil Rights Act of 1964 as it applies to private providers of health services (i.e., medical doctors). The Commissioners have expressed interest in obtaining more information about the Department's position on this issue. In that connection, would you be kind enough to provide us with any opinions prepared by your Office of General Counsel that interpret the Department's position relating to the application of Title VI to private practitioners. We should also appreciate receiving any decisions rendered by the courts relating to the issue with which your Office of General Counsel is familiar. Your assistance will be appreciated.

Sincerely,

SIGNED LOUIS NUÑEZ

LOUIS NUÑEZ

28. Report of Health and Hospitals Corporation, op.cit. p. 19; Report on Municipal Hospitals 1975-1976. City Hospital Visiting Committee of the United Hospital Fund of New York, p. iv.

29. See Schwartz, J.L. et.al, op.cit.

30. Berry, R. E. Cost Efficiency in the Production of Hospital Services, Milbank Memorial Fund Quarterly, Health and Society, Summer, 1974.

31. Craig, J., Koleda, M. The Urban Fiscal Crisis in the United States, National Health Insurance and Municipal Hospitals, International Journal of Health Services, vol. 8, No. 2, 1978.

32. Cooney, Roemer and Ross, op.cit.

33. Based on extensive but not complete reviews. Cited in this section in particular, are the following:

    i APHA. Medical Care in a National Health Program. AJPH 34:1252-1256, December, 1944.

    ii Statement by the Subcommittee on Medical Care. The Quality of Medical Care in a National Health Program, 1949; reprinted pp. 17-43 in vol. 1. Medical Care in Transition: Reprints from the AJPH. U.S. Government Printing Office, 1964.

    iii Resolutions and Policy Statements/Position Papers adopted by the Governing Council. AJPH. (Jan. or Feb.) 1971 through 1978.

34. Personal communication from A. Yvonne Russell, Ph.D., M.D., Director of Medical Institutions and Associate Dean, Stanford School of Medicine, California.

17. Personal communication from Mr. Joseph Lynaugh, President, Health and Hospitals Corporation of New York City, to whom thanks are extended for his thoughtful critique of an earlier draft of this report.

18. Ziegler, M.L. et.al, A Method for Ongoing Evaluation of New York State Medicaid and Blue Cross Reimbursement Provisions, working paper prepared for New York City Health Systems Agency, by the Division of Health Administration, Columbia University School of Public Health, Winter, 1978; and see also, for a more specific analysis, Weinstein, B.M. Differential Reimbursement in Public Hospitals: A Viewpoint in a Specific Situation, in Readings on Public General Hospitals, op.cit.

19. Pavellas, op.cit.

20. Report of Health and Hospitals Corporation, op.cit.

21. Shonick, W. The Public Hospital and Its Local Ecology: Some Relationships Between the Plight of the Public Hospital and the Plight of the Cities, paper presented at APHA Annual Meeting, October, 1976.

22. Schwartz, J.L. et.al, Health Care Costs and Services in California Counties: Report of the County Health Care Costs Study. State of California Department of Health, Sacramento, February 1978, Chapter IV, pp. 47 - 83.

23. Minority Health Chartbook. American Public Health Association. U.S. Government Printing Office, 1974.

24. Medical Care Chartbook. University of Michigan School of Public Health, Bureau of Health Economics (the most recent is the sixth edition).

25. See Lynaugh, J. op.cit.

26. Andersen, R., Greely, R., Kravits, J., and Anderson, O.W. Health Service Use. National Trends and Variations. DHEW Publication No. (HSM) 73-3004, October, 1972, and see also Wilson, R.W. and White, E.L. Changes in Morbidity, Disability, and Utilization Differentials between the Poor and the Nonpoor: Data from the Health Interview Survey: 1964 and 1973. Medical Care. 15, 8:636-646, 1977.

27. See, for example, Reynolds, R.A. Improving Access to Health Care Among the Poor - the Neighborhood Health Center Experience. Milbank Memorial Fund Quarterly/Health and Society. 54:47-82, Winter, 1976, and see also Lerner, M. and Stutz, R.N. Have We Narrowed the Gaps Between the Poor and Nonpoor? Part II. Narrowing the Gaps, 1959-61 to 1969-71: Mortality. Medical Care. 15, 8:620-636, 1977.

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2. Cooney, J. Roemer, M. and Ross, M. Large Urban Public Hospitals Ambulatory Services Contemporary Status, UCLA School of Public Health, November, 1971 (U.S. Dept. of Commerce NTIS PB - 210 517)

3. Pavellas, R.A. The Effects of Capital Expenditure Controls on Small Rural Public General Hospitals, in Readings on Public General Hospitals, Hospital Research and Educational Trust. Chicago, 1978.

4. Cooney, Roemer and Ross, op.cit.

5. Ibid

6. Ibid

7. Brown, M.G. Public General Hospitals: Important Factors in the Delivery of Patient Care, in Readings on Public General Hospitals, op.cit.

8. Cooney, Roemer and Ross, op.cit.

9. Wolfe, S., Sherer, H. Public General Hospitals in Crisis: An Overview of National Trends with A Specific Look at Baltimore, Philadelphia, St. Louis and New York City, Coalition of American Public Employees, Washington, D.C., September, 1977. (completely revised second edition currently in progress by Richardson, H.S., Wolfe, S.)

10. Rosner, D. A Once Charitable Enterprise: Health Care in Brooklyn, 1890 - 1915, dissertation manuscript, Harvard University, June, 1978.

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12. Shryock, R. Medicine and Society in America, 1660 - 1880, Cornell University Press, 1960.

13. Brown, op.cit.

14. Blue Cross.- Blue Shield of Greater New York, Who Uses Ambulatory Care Services? Ambulatory Care Study No. 1-3, June, 1975.

15. Report of Health and Hospitals Corporation, New York City, November, 1977.

16. Ibid

The Task Force on Public General Hospitals has deemed it a privilege to be of service to the Association.

Acknowledgments

Thanks are extended to Ms. Martha E. Lassiter for preparation of this manuscript, and to Ms. Susan Hoffman, who provided research assistance. Special thanks to Ms. Hila Richardson, a member of the Task Force, for her leadership role in providing technical input and review of work from other settings.

Under such arrangements the affiliation agreements between public general hospitals and teaching institutions and their university hospitals ought to be sharply redefined so that the professional staffing arrangements provided through such agreements meet the health care needs of the communities to be served.

6. PROPOSED AMERICAN PUBLIC HEALTH ASSOCIATION ACTIONS

It is recommended that the American Public Health Association either retain the Task Force on Public General Hospitals for at least an additional year, or create a Standing Committee in order to continue study and review of the impact of closings. In particular, it is necessary to attempt to develop a study of the impact of closings on the populations served. Nowhere in the country has this taken place. Such a leadership stance by the American Public Health Association would be extremely valuable. As well, a substantial number of details need to be worked out on approaches to legislative remedies for the existing fiscal difficulties of public general hospitals on the one hand, and in order to review alternative strategies for governance structures on the other. It should be clearly stated that such studies would place the public general hospitals into the context of the entire hospital system; such studies would not be conducted as though the public general hospitals were a separate breed.

Finally, the Task Force recommends to the American Public Health Association either the publication of this report or alternative mechanisms for its dissemination so that it may be discussed and reviewed by various constituent groups across the country.

Even if there are ideal governance structures, of course, there will still be financing problems if there are insufficient tax levels to support those who are underinsured, if there are discriminatory reimbursement practices, and related activities that preclude parity for the public general hospitals. A poignant example has been provided from Santa Clara Valley Medical Center, California, an affiliate of Stanford University School of Medicine. Wage freezes and hiring freezes after the passage of Proposition 13 meant that even the emergency room and the burn unit were forced to close at times. At least 20 per cent of the acute care nursing positions were going unfilled.[34]

5. ALTERNATIVE REIMBURSEMENT FORMULAS AND STAFFING ARRANGEMENTS

Careful consideration should be given to providing resources so that the public general hospitals can give leadership in developing prepaid group practice - health maintenance organization models to defined population groups on their premises, or in satellite settings linked to their premises. As well, major supports are needed in order to develop and apply payment mechanisms other than traditional fee-for-service in such settings. Thus, in urban and rural communities, it should be possible, and indeed it is highly desirable to introduce new professionals, such as nurse practitioners, midwives, and related personnel as substitutes for the much more expensive and not necessarily more competent physician staffing arrangements that have traditionally tended to prevail. Such arrangements need to be linked to expanded outreach and home care services.

in the organization and delivery of health services.

For this reason, the Task Force, consistent with American Public Health Association priorities and its earlier statements on the matter, strongly supports the goals and purposes of a National Health Service.

The Task Force supports the 1976 and 1977 Association resolutions on a National Health Service and supports the letter written by the President of our Association to the President of the United States as published in the September 1978 issue of the Nation's Health, reaffirming the basic principles of a national health plan.

4. CHANGES IN GOVERNANCE STRUCTURES

There are two questions here: how does the private system become more accountable? how does the public system maintain its level of accountability?

Public general hospitals must be freed from the smothering overview provided by agencies outside the public hospitals that attempt to control both their budgets and all of the related operations. For this reason, clearly spelled out prospective budgeting ought to be provided for public general hospitals and the total number of dollars budgeted ought to be under the full control of their hospital Boards.

With public financing of health services there is no reason why the same criteria that apply to public hospitals ought not to be applicable concerning governance structures within the rest of the hospital system.

In some states, changes are needed in regulatory mechanisms regarding reimbursement, and in those states where applicable, relating to cost containment legislation so that waivers are provided for public general hospitals to enable them to achieve capitalization and operational parity with other institutions in the community.

3. NATIONAL HEALTH SERVICE OR NATIONAL HEALTH INSURANCE?

There is clear and unequivocal evidence of the failure of voluntary health insurance in the United States. There is a continuing level of shifting coverage with private insurance and indeed with public insurance on a categorical basis so that large numbers of persons are totally uncovered or are relatively uncovered with respect to the extent and depth of their insurance coverage. This places an unbearable load on low and middle income persons and shifts the use of services from prevention and ambulatory care to the more costly use of inpatient services. At the same time, it is important to emphasize that private hospitals are no longer private, since the great majority receive the bulk of their income from the public purse; they remain private only in terms of their requirements concerning accountability on the one hand, and their private governance and management structures on the other.

Evidence from other countries, for example such as Canada, suggest that universal coverage health insurance while extremely useful, does not lead to a restructuring of the health care delivery system and perpetuates the components of inflation that are then used as an excuse for not proceeding with further major reforms

2. SHORT TERM LEGISLATIVE STRATEGIES: At the federal level special fiscal supports are required for both rural and urban public general hospitals for both capitalization and operating costs in order to permit certain such institutions to come up to parity with many private hospitals. This will enable them to maintain their levels of service in the absence of an equitable financing mechanism that underwrites the cost of health services for those unable to pay.

At the federal level, questions relating to improved capitalization and protection against arbitrary closures have been addressed by Public Law 93-641 but should be spelled out more explicitly with respect to the definitions of Medically Underserved Areas. By Medically Underserved Areas, the Task Force does not necessarily refer to a narrowly defined geographic catchment location.

The Health Planning Amendments of 1978 contain under Section 1675(d) authorizations for grants to public hospitals for renovations, modernization and related construction. Such authorization, if enacted and appropriated, would help local governments with undercapitalized public hospitals.

Legislation such as the so-called Beilinson amendments in California ought to become more widespread at the state level in order to prevent arbitrary or capricious closings or shrinkages of public general hospitals without adequate evidence concerning the possible effects.

1977 meeting the Association approved a resolution spelling out criteria for Assessing National Health Service proposals.

As well, at each of its past three meetings (1975, 1976, 1977), the Association has officially expressed concerns: in 1975 and 1976 about the public hospital crisis in New York City; and in 1977 about special supports needed for hospitals -- both public and non-public -- that serve the disadvantaged and the poor.

While a complete review has not been made of the Association position on these matters through time, clearly the pattern has been in the direction of support for a one-class system of care, including hospital system, financed through the public sector and under public sector control.

IX CONCLUSIONS AND RECOMMENDATIONS

1. The Task Force concurs with the position of the Commission on Public General Hospitals that public general hospitals are a valued national resource and need to be preserved and strengthened. This Task Force, however, takes the broader position that public hospitals should be strengthened, not just to remove their separate and unequal status, but because they already represent one-third of all community hospitals and two-thirds of all university hospitals, and because all American hospitals are increasingly dependent on public sector dollars for their viability.

The Subcommittee noted that APHA had recommended in its 1944 statement that services should be financed through social insurance supplemented by general taxation, or through general taxation alone. The goal was to be universal coverage. Implicit though not explicit, in this was the notion that the two class system of care would be eradicated and the notion also that health care is a service, not a business, but a service that needs to be run in a business-like fashion. For this reason, the Subcommittee emphasized the importance of good administration and efficiency, and linked to this, explored alternative ways to reimburse both professional providers and hospitals.

Given these progressive positions of the 1940s, it is not surprising that in 1970 the Association recommended a national health program to include democratically constituted, consumer-majority policy making bodies at every level of administration and with

- universal coverage
- comprehensive benefits
- financing through general taxation and social insurance
- reform of the delivery system
- public accountability
- governmental economic leverage to influence reforms in delivery
- revamped state facility and personnel licensing programs

The 1970 resolution was reiterated in 1976 when the Association voted to support a National Health Service and to establish an APHA Task Force on proposals for a National Health Service. And at its hospital deficits: but why should they when increasingly this is seen as a social responsibility of the country as a whole?

VIII PAST APHA RESOLUTIONS AND POSITIONS[33]

Since the American Public Health Association is by definition concerned with the health and the health services of defined populations it is not unexpected that the Association has been in the vanguard to attempt to assure quality care and equal access to both personal and public health services through equitable financing, organizational and service delivery arrangements.

For example, in 1944 the Association adopted a policy statement on Medical Care in a National Health Program. A more detailed statement by the Subcommittee on Medical Care was subsequently published, in 1949, entitled The Quality of Medical Care in a National Health Program. This Subcommittee, which was chaired by Dean A. Clark, emphasized the scope and content of an adequate medical care program: objectives and definitions of quantitative and qualitative adequacy were provided and then, components of good quality were spelled out. These included, among others

- professional and related personnel
- hospitals and related facilities, including regional coordination
- relationships of hospitals and health departments
- social and economic aspects
- discriminatory practices
- financing and financial stability

4. Likewise, the public institutions could serve the poor and nonpoor of a community. They can continue to find ways to free themselves of the bureaucratic restrictions of direct control by overhead agencies of government while remaining publicly accountable.
5. As institutions with potentially stable full time professional staffing arrangements, public hospitals have the potential to become institutions modeled on the health maintenance organization concept. For example, Baltimore City Hospital, staffed by a non-profit physician group, has been able to exercise control over quality and to attract a broader base of patients in that institution.

These proposals overlap in some respects and are contradictory in others. The defenders of the public hospitals are not all agreed about the future directions these institutions should take -- neither are the detractors. The kinds of proposals that are being offered or experimented with have been summarized in the foregoing.

Some have, of course, argued that governments should move away from sponsorship and operation of hospitals. It is not clear why this is so when government is increasingly expected to, has to, and does, pick up the tab for all hospital services. There is every reason why, with equitable capitalization and operational cash flow, that public hospitals can provide services and be financially stable within any array of American hospital services. This would be even more likely if there were first dollar health insurance mechanisms. It is not true, based on the data, that people travel far away when they can obtain access to care near at hand. It is also a fact that the public hospitals have shown remarkable staying power even since the advent of Medicare and Medicaid. There is substantial and growing evidence that local governments cannot or will not pick up the tab for public or other in their services, rather than be reflective of the needs of the community being served. Their behaviors may also be largely reflective of their financial and reimbursement incentives rather than reflective of community needs.

6. Public general hospitals, given adequate funding and related supports can serve whole communities as they already do in parts of the country.

7. In their staffing, public hospitals may be more reflective of the racial, cultural and ethnic composition of the community.

The reality of the maintenance and strengthening of public general hospitals has led to various alternative visions for their future. Some of these include:

1. Since historically they have specialized in outpatient and emergency care, public general hospitals -- especially in cities, should become the locus for a new system of primary care which links community centered primary care units with back up services at the public hospital. At the same time, all must be guaranteed access to the inpatient facilities of private hospitals.

2. Since many public hospitals exist in medically underserved areas, they should not be considered for closing. Rather, in the development of regionalized health care plans the decision about whether to keep or close down public general hospitals should be made on the basis of the overall needs of the community. Public hospitals should become part of such regionalized plans that assure every person a place to go for both inpatient care and for outpatient care.

3. Since private hospitals are supported by large amounts of public funds, they can surely no longer be considered as private organizations even when they are voluntary and not-for-profit. New statutory and regulatory provisions have begun to make them more accountable. Since they will continue to receive even more public funds, they should be required to move toward greater levels of accountability, full disclosure concerning conflicts of interest of Board members, and associated changes in the composition of their Boards. Their Boards, at present, are in general undemocratic and self perpetuating.

effort to phase out the American public hospital system. Those who have taken such positions have done so based on rhetoric, personal opinions and often bogus arguments, in the absence of the hard data. To the extent that studies have been made, they are referenced in this work and in the work of the Commission on Public General Hospitals.

Public general hospitals serve important community functions and should be strengthened:

1. As long as there is a system of hospital financing which pays only for certain services and certain categories of people there will need to be a public hospital system where anyone has the right to go. The public general hospitals serve people who have no other source of care.

2. Even if national health insurance were implemented, public general hospitals would be needed. They would also have more equitable access to fiscal resources without depending on local taxes. With full insurance, demand for care would likely increase. In addition, most plans do not cover all people and all services. The public hospitals would have to provide for those people or services which were excluded.

3. Given the special kinds of problems they treat and the conditions under which they function, public general hospitals are not inefficient. Studies controlling for scope of services have found no difference in costs between public and voluntary hospitals.[30]

4. It is unproven that patients have abandoned the public system since the advent of Medicaid. Data suggest that following an initial drop, utilization in most cities returned to previous rates or actually increased.[31] It should also not be surprising that many people prefer to use public hospitals because they are nearby. They are often located where they are needed.[32]

5. The public general hospital is the more publicly accountable hospital, and so is more likely to respond to the needs and demands of the community. Private hospitals may reflect the biases of their clinicians

2. With their own separate community Boards and with the particular government concerned purchasing services from them?

3. As public benefit corporations which are publicly accountable but independent of direct government control?

4. As hospital districts with separate taxing powers?

D. What should be their functions?

1. Should they specialize more in some of the functions which they have historically provided -- outpatient care, emergency and trauma care, sociomedical problems?

2. Should they continue to perform at the levels of private, secondary and tertiary care, depending on geography and other factors, but become part of regionalized systems which include both public and private institutions under Public Law 93-641? Would their role then really be determined based on the particular local needs and other resources available in the area?

3. To what extent should they continue to function as teaching and research institutions?

4. Who benefits and who should benefit from their functioning?

E. What should be their relationship to other health agencies?

1. Should they try to establish links with existing neighborhood health centers, district health centers run by health departments, and shared health facilities in their neighborhoods and beyond?

VII APPROACHES TO SOLUTIONS

The fiscal crisis of state, and to an even greater extent, local governments has led many localities to consider closing or cutting back on the services of their public hospitals in order to reduce the size of the local appropriation. But the Task Force found literally no one expert working in the hospital field, or who had made studies of the matter, who advocated a broad based

VI ISSUES RELATING TO PUBLIC GENERAL HOSPITALS

Discussion of the future role of public general hospitals has generally identified the following policy issues for consideration:

A. How should public general hospitals be financed?

1. Should they continue to be financed by a combination of third party payments for some of their patients and tax levies to make up the difference?
2. Should the county, metropolitan area, state or federal government take over a larger share of their financing?
3. Should they be financed on an institutional basis with yearly global budgets which take into account the kind and amount of services performed both on the inpatient and ambulatory sectors?
4. Should they be financed by providing everyone with health insurance and then letting patients choose where they will go?
5. If so, should they be given additional funding through special legislation in order to bring them up to parity with non-public hospitals where required?

B. What should be their relationship to the private sector?

1. Should they try to copy the private hospital sector in obtaining patients, grants, research and related activities?
2. Should they delimit their services (for instance in order to emphasize outpatient care) and thereby develop a more complementary relationship with the private sector?
3. Should their already established affiliation agreements with private institutions, in order to staff their medical facilities, be modified or changed. How?
4. Should they be turned over to voluntary institutions? Or leased, or given to management corporations?
5. Should they allow private practitioners to admit their own patients to the public hospitals?

C. How should they be governed?

1. Directly under governmental administration at the appropriate level of government?

in the absence of a more substantial explanation, the Task Force interprets this as an indicator of reduced access to needed care.

Reduced levels of eligibility for Medicaid, coupled with reduced staffing patterns, have resulted in a reduction of services. It would be foolish to expect otherwise. Reducing access to service by the poor whether they be black or non-black, old or young, urban or rural, during periods of economic recession and unemployment, and when needs for health care may actually increase, deprives the most needy part of the community of its most needed services and related jobs. It is therefore obvious that the population that already uses public hospitals will be most affected by any changes in available services from such institutions. And travel access to alternative sites for persons of limited income with limited eligibility for coverage will reduce the use of services even further. This means that the anticipated health status outcomes will be adverse in the long run. And this is entirely aside from the devastating effect of killing a community resource which is the prime employer of its low income residents.

Given the vast amounts expended on biomedical and related research, it seems reasonable to expect research to be done in assessing the impacts of potential closings before they take place. This is why it is necessary to apply, without waivers, statutory and regulatory requirements to assess the potential effects of closings and service reductions before, not after, they occur.

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And while some have shown that new kinds of services and altered financing mechanisms have narrowed the gaps between poor and non-poor in access to and use of services,[26] there is evidence that poverty area residents continue to use medical services at a lower rate than other United States residents, and that differences in mortality rates between the poor and non-poor have in fact widened.[27] In fact, the Task Force assumes that poor and traditionally uninsured or underinsured populations would generate more, not equal or fewer services, than would the general population if there were truly equal access to health services.

It is a fact, for example in New York City, that the closings of public hospitals and reductions of service have led to a cut in the public hospitals' work force of 10,000 or 25% since early 1975; the negative service effects of this have been documented by the prestigious outside body, the United Hospital Fund of New York City.[28] This situation has been replicated in a number of other parts of the country, for example in California and Philadelphia. Twenty county hospitals closed in California between 1965 and 1977, and a further 14 were sold, leased, transferred or let out to management contractors.[29]

The Task Force does not have evidence that closing public hospitals or reducing their services leads to a guaranteed service from other institutions. In fact, for example in New York City, harsher eligibility requirements have led to a sharp decline in use of ambulatory services by the poor in both public and private hospitals, and this is also occurring in other parts of the country:

But it would appear to be irresponsible on the part of governing officials to close out or to reduce health services to potentially underserved, low income populations, without clear evidence that no harm will result. The California Beilinson amendments to Chapter 2.5 of the Health and Safety Code, Section 1442 mandates the production of evidence that alternative services will exist when proposals are made for county hospitals or medical facilities to close, eliminate services, or transfer management.

And the most recent amendments to the federal Health Planning Law (PL 93-641) require Health Systems Agencies to carry out studies to demonstrate the potential effects of closings.

It is reasonable to assume that most people will agree that withdrawing services from areas or populations most in need of such services is likely to be harmful. The Task Force has attempted to make reasonable inferences, from the <u>potential</u> effects on access to care, use of services, and outcomes, of closing or relocation of facilities or health services.

There are abundant data to suggest that persons in poverty areas (where public hospitals are often located) use health services less often than do the non-poor, come for care later, stay longer when admitted, and may have less satisfactory outcomes. These data have been summarized by the American Public Health Association[23] and over the years by the University of Michigan,[24] among others. New York City is in the process of developing a study to look at comparative case mixes in public compared to private hospitals.[25]

As has been clearly shown for California by Schwartz and his co-workers, shifting the costs of Medicaid from nation to state to county has been a major contribution to closures, sales, leases, transfers and contracting out of public county hospitals in that state.[22]

The foregoing chronic problems have been aggravated further by the general fiscal crisis which impacts heavily on local governments. Since public hospitals have been underfinanced for years, they pose easy targets for those who cut budgets and are anxious to reduce a city's or a county's deficits. These problems could be largely averted by a fair and equitable federal health policy which would include a universal coverage federal health care financing mechanism, but that does not subtract from the seriousness of the present reality for the cities.

V. IMPACT OF CLOSINGS

The Task Force was unable to locate hard specific data that assess the effects of recent public general (<u>or any other</u>) hospital closings on the health of the populations formerly served by them. This is hardly surprising, but nevertheless troublesome. Such a narrow specific study would have to have built into it detailed knowledge of (1) patterns of use of the affected facility, and its patient origins; (2) sample or other surveys of the populations served; (3) follow-up outcome studies, and/or health status and socio medical indicator studies, in order to determine the "effects on health status", <u>not</u> health.

needed funds become available to cities with major ambulatory care work loads.[17]

4. In setting hospital rates, public hospitals are often penalized for their unusually high volume of outpatient and emergency visits,[18] or not rewarded for providing services with less basic tools and resources (in terms of assets) per unit of service than private hospitals.[19]
5. While all hospitals have both greater disallowances and stricter eligibility requirements under Medicaid as compared to Medicare or Blue Cross, public hospitals tend to suffer more because they have a larger percentage of Medicaid patients than do non-public hospitals. As a result, cost containment efforts by the states fall disproportionately hard on public hospitals.[20]
6. In addition, the type of financing represented by Medicaid undermines public institutions. As patients are thrown on and off the Medicaid rolls, due to changes made in eligibility requirements, or as the result of unemployment and associated loss of health insurance benefits, public hospitals' finances are thrown into disarray. Patients for whom they could once get reimbursement now appear at their doors requiring free service. And the growing resistance to increasing tax levels, particularly property taxes, has made it impossible for cities and counties with a concentration of low income families to make up for these lost hospital revenues.[21]

their gross patient care revenue that is obtained from outpatient services is lower than the corresponding percentage for any other group of hospitals.[13] This is due to the fact that outpatient care is inadequately reimbursed by the third-party payers, and that in addition, the public hospitals treat more outpatients who have no coverage. A study of hospitals in New York found that 43% of the patients visiting the outpatient and emergency departments of public hospitals had no form of insurance as compared to 27% in the voluntary hospitals.[14]

2. In some states Blue Cross has paid for psychiatric care in private hospitals but not in public hospitals. Blue Shield has not paid private physicians for their members hospitalized in public hospitals.[15]
3. Until this year, public hospitals, for example in New York City, were not eligible for ambulatory care deficit funds allocated to hospitals with a high percentage of outpatient care.[16] And as has been noted by Lynaugh, head of the Health and Hospitals Corporation of New York City, cities as different as Chicago, Los Angeles, Philadelphia and New York City, have been unable to accept federal Urban Health Initiatives funds because of HEW regulations concerning governing board requirements. There is an urgent need for federal HEW and its regional offices to interpret its regulations so that the urgently

As a result of the greater resources available to the private medical centers, public hospitals began having increasing problems attracting highly qualified research and medical personnel.

With the "mainstream" of health care thus firmly established in the private medical centers, and with the growth of the private insurance plans to pay for this care, the role of the public hospital as dumping ground for the medically indigent tended to become even more entrenched.

IV. CONTINUING DISCRIMINATION

The advent of Medicaid and Medicare reinforced this unequal status even though most such patients continued to use the public hospitals. Since third-party payment systems fund only certain categories of patients, and certain categories of services, and since Medicaid eligibility and coverage are on shifting sands, public hospitals today, as in the past, are left to treat patients with no insurance, and to provide services which are unreimbursed, poorly reimbursed, or with a social stigma. Because of their greater ability to exclude what they don't want, private hospitals are more able to adjust to changing requirements of third-party payers. This ability to adjust services to what is reimbursable depends on the existence of the public hospitals to pick up the rest.

Examples of direct and indirect discrimination include the following:

1. Public general hospitals in large cities have the highest percentage of total patient care effort attributable to outpatient services, but the percentage of

scheme reinforced the existing distinctions in financing and function between the private and public hospital: privately insured patients would tend to use only the private hospitals; uninsured patients would tend to use only the public hospitals.

While the public hospitals continued to specialize in services needed by the population they care for (such as care for TB patients and patients with other communicable diseases, outpatient and emergency services) the Blue Cross plans developed around the needs of the private hospitals and the inpatients they served. Thus, reimbursement for ambulatory care has been minimal under most Blue Cross plans; provision of outpatient care was not a major function of the private hospital, in part because private patients could afford to pay for the services of private physicians.

Over the years many public hospitals became respected centers for teaching, research, and medical care. However, the post-World-War II period saw the tremendous influx of federal money into the private medical schools and hospitals associated with them. Large private medical centers with their expensive research equipment and programs, their up-to-date capabilities for medical care, and their modern, pleasant accommodations were able to attract high quality administrators, physicians and researchers, as well as large numbers of patients.

In addition, these private medical centers were able to function with relative autonomy, to appoint their own trustees, develop capital funds, control their budgets, apply for grants, purchase equipment, supplies and services competitively.

Further analysis of the operation of the Supplemental Medical Insurance program reveals that it not only does not function as a contract of insurance as that term is meant in Title VI but that, in fact, neither is it an insurance program at all as the term is commonly understood. 37/ The mere denomination of a statutory enactment as insurance does not transform the provisions of a social welfare program into an insurance contract. Were this so, Medicare Part A would also be beyond the reach of Title VI. Rather, analysis as to the operation of any particular program is required.

The opinion of the General Counsel of the Department of Health and Human Services 38/ that Medicare Part B is an insurance program, relies on Lynch v. United States. 39/ In Lynch, the Supreme Court held that the government could not unilaterally abrogate its obligations under a statutorily constructed post World War I scheme whereby the Federal Government provided life insurance to policyholders who had converted federally subsidized War Risk Insurance to yearly renewable term life insurance. 40/ The Court's analysis in Lynch was that the nature of the "earned right" there enjoyed precluded the government from arbitrarily, unilaterally, and completely repudiating its obligations. This analysis is not relevant to the issue of the relationship between Medicare Part B and Title VI. Title VI is not an arbitrary repudiation of contractual obligations, but rather a statutory scheme that empowers a responsive cut-off of Federal funds subject to judicial review upon the failure of a recipient to take corrective action subsequent to an administrative determination of unlawful discrimination. 41/ Reliance on Lynch also ignores the subsequent Supreme Court characterization, in Flemming v. Nestor, 42/ of the "conceptualizations /that buttressed Lynch/ regarding 'earned rights' and 'gratuities' as 'hardly profitable.'" 43/

37/ It is a fundamental principle of statutory construction that terms employed in statutes are assumed to have their commonly understood meaning, Malat v. Riddell, 383 U.S. 569 (1966), subject only to being consistent with legislative intent. National R.R. Passengers Corp. v. National Assoc. of R.R. Passengers, 414 U.S. 453 (1974).

38/ HEW Memo II, supra, note 17 at 8 n.10.

39/ 292 U.S. 571 (1934).

40/ Id.

41/ The analogy to Lynch is further strained as governmental action under Title VI effectuates the statutory purpose, whereas the Court in Lynch found that the refusal there to honor obligations was inconsistent with the statutory purpose of maintaining public credit. 292 U.S. at 580. Federal action pursuant to Title VI is consistent with the title's purpose of assuring that Federal revenues obtained without regard to race or color are only used to fund programs similarly nondiscriminatory.

42/ 363 U.S. 603 (1960).

43/ Id. at 610.

In *Flemming*, the Court reviewed the Social Security program and concluded that it is non-contractual in nature and does not vest accrued property rights in the beneficiaries of the program. 44/ Of primary concern to the Court was its view that Social Security is social welfare legislation 45/ and that "/t/o engraft upon /such legislation/ a concept of accrued property rights would deprive it of the flexibility and boldness in adjustment to ever changing conditions which it demands." 46/ Moreover, the inquiry into the statutory scheme, which the Court stated it was required to undertake, 47/ found two additional aspects of the scheme significant. The Court held that both the fact that "eligibility for benefits and the amount of benefits do not *in any true sense* depend on contributions to the program through the payment of taxes, but rather on the earnings record of the primary beneficiary," 48/ and that Congress statutorily retained "/t/he right to alter, amend, or repeal any provision" of the Act, acted to deny the contractual nature of entitlement. 49/ This latter provision applies to both parts of the Medicare program with the same force as it did and does to Social Security. 50/ Additionally, eligibility for supplemental medical coverage under Part B is similar to eligibility under the Social Security system. Like Social Security, the program is paid for by those ineligible who are gainfully employed and those who employ them, and is not in any true sense dependent on contributions to the program. 51/ Initially, this is not

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44/ *Id.* at 608-612. The Court noted that the right to benefit under the program rested on a legislative determination as to the justness of claims that the benefits had been earned. "/T/he practical effectuation of that judgment has of necessity called forth a highly complex and interrelated statutory structure. Integrated treatment of the manifold specific problems presented by the Social Security program demands more than a generalization. That program was designed to function into the indefinite future, and its specific provisions rest on predictions as to expected economic conditions which must inevitably prove less than wholly accurate, and on judgments and preferences as to the proper allocation of the Nation's resources which evolving economic and social conditions will of necessity in some degree modify." *Id.* at 610.

45/ *Id.* at 609.

46/ *Id.* at 610.

47/ *Id.* at 608.

48/ *Id.* at 609 (emphasis added).

49/ *Id.* at 611. Codified at 42 U.S.C. § 1304 (1976).

50/ 42 U.S.C. § 1304 (1976).

51/ *Id.* at §§ 401-431 (1974 and Supp. 1980). Flemming v. Nestor, *supra*, note 38 at 609.

apparent; the statutory plan appears to require eligible beneficiaries to fund one-half of the program. 52/ A number of factors, however, operate to reduce the share of the cost covered by premiums to around 30 percent. 53/ A ceiling has been placed on increases in the monthly premium rate for beneficiaries age 65 and over prohibiting increases greater than increases in benefits received under Social Security. 54/ Therefore, to the extent health care costs increase faster than Social Security benefits, the share of the Federal Supplementary Medical Insurance Trust Fund funded by the general revenues of the Federal Government increases and the share funded by premiums decreases. Additionally, the vast majority of those who receive benefits under this program are recipients of Social Security and their Supplemental Medicare premiums are paid for from deductions in their entitlements under that program. 55/ Flemming itself establishes the independence between receipt of benefits and contributions under the Social Security program. 56/ In this regard, also, the Social Security Act Amendments of 1965, which established the Medicare Program, included a seven percent increase in Social Security benefits 57/ that was tied to the passage of Medicare, 58/ further demonstrating the extent to which premiums are not in fact paid by contributions from individuals.

Medicare Part B is, therefore, not merely federally subsidized health insurance, but an almost entirely federally funded social welfare program designed to assure the availability of health care for older Americans. In that funds for the program derive almost completely, albeit circuitously, from general revenue and specific payroll tax sources paid by those not eligible

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52/ 42 U.S.C. § 1395 (1974 and Supp. 1980).

53/ Telephone interviews with Virginia Grey, Program Operations, Health Care Finance Administration, Department of Health and Human Services (Aug. 6, 8, 1980).

54/ 42 U.S.C.A. § 1395r(c) (Supp. 1980). Additionally, states are encouraged to pay the premiums for many of those eligible for Supplemental Medical Insurance who are eligible for Medicaid under the various state plans, 42 U.S.C.A. § 1395y (1974 and Supp. 1980), under which Federal matching grants reimburse more than 50 percent.

55/ Id. at § 1395s.

56/ 363 U.S. at 609.

57/ Pub. L. No. 89-97, Title III, § 301, 79 Stat. 362-364. The seven percent across the board increase in cash benefits had a floor of $4, $1 more than the $3 monthly premium established by statute for the inception of the supplemental program.

58/ 111 Cong. Rec. 15803 (1965) (statement of Senator Ribicoff).

for benefits, it is the "insurer" who is paying the "premiums," and hence the program is not insurance at all. 59/

Direct Payments to the Beneficiaries

The Department of Health and Human Services also suggests that assistance provided under Medicare Part B is not subject to Title VI because such assistance is provided as direct payments to beneficiaries. 60/ Title VI, however, makes no distinction between direct and indirect Federal financial assistance. The legislative history of the Act demonstrates an understanding that Title VI applies to Federal funds extended both directly and indirectly. 61/ The misimpression that Title VI does not apply to direct payments of Federal funds arises from its long acknowledged inapplicability to Social Security payments. 62/ The exclusion of Federal funds under Social Security, however, results not from the method of disbursement but, rather from the absence of any program or activity.

Distinguishing between direct and indirect payment of Federal assistance, while possibly a useful rule of thumb for determining Title VI applicability, has no basis in law. Direct payments of Federal funds for a particular restricted use are, if they assist a particular intended program or activity, within the jurisdiction of Title VI. Direct payments for an unspecified use, though, are outside the scope of Title VI. Quite simply, if unrestricted funds are directly paid, there can be no program or activity, and Title VI by its very terms is inapplicable. Direct payments of Federal assistance where receipt is not contingent upon participation in or the use of a service provided by a program or activity are not covered by Title VI. However, payments that are so conditioned, even though disbursed directly, are subject to Title VI. Title VI prohibits racial and national origin discrimination by the recipients of that assistance as between the beneficiaries of any program receiving Federal assistance.

59/ Even if considered as subsidized insurance, the extent of subsidization should be sufficient to remove the plan from inclusion in the contract of insurance or guaranty restriction of Title VI. When Federal financial assistance is extended via a contract of insurance and the Federal Government also pays the premiums on that insurance such assistance cannot support an activity or program which excludes or denies participation on the basis of race, color, or national origin and be consistent with the purpose of both Title VI and its limitation.

60/ See note 18, *supra*, and accompanying text.

61/ House Hearings, *supra*, note 24 at 1542 (testimony of Anthony J. Celebrezze, Secretary of Health, Education and Welfare).

62/ House Hearings, *supra*, note 24 at 2773 (letter from Nicholas Katzenbach, Deputy Attorney General to Comm. on the Judiciary, House of Representatives). *See also*, 110 Cong. Rec. 8426 (1964) (statement of Senator Ribicoff).

Thus, in Bob Jones University v. Johnson, 63/ "Federal cash payments made directly to veteran students upon enrollment at an approved school were held to constitute Federal financial assistance to the University, which was therefore subject to the requirements of Title VI. 64/ As the Federal district court stated, the "method of payment...does not change the nature of the program or the basic role of the schools participating in the program." 65/

Applicability of Title VI to Medicare Part B

Supplemental Medical Insurance Benefits are clearly Federal financial assistance and are not excluded from Title VI as either contracts of insurance or by reason of the method of their payment. A determination of the applicability of Title VI to Medicare Part B requires only a straightforward programmatic analysis of the structure and legislative history of the statutory plan to determine who the intended beneficiaries and recipients are and what programs or activities are being assisted in what manner. Much of this analysis has already been undertaken within the preceding discussion.

The program and activities 66/ assisted under Medicare Part B are clearly those medical services for which payments will be made under the statute when provided to eligible individuals. Thus, it becomes apparent that the recipients of Federal funds under Part B are the health care providers and the beneficiaries are those for whom such care is provided. Whether participation in the program by recipients results in financial gain for them is irrelevant. 67/ As was discussed, Part B generally contemplates direct payments to beneficiaries but such payment is contingent upon their receipt of those health services which the statute is designed to assist. Indeed, ascertaining the intended beneficiaries and the intended recipients under this program is assisted by the fact that provision is made

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63/ 396 F. Supp. 597 (D.S.C. 1974) aff'd. 529 F.2d 514 (4th Cir. 1975).

64/ Id. at 602-604. Cf. also McGlotten v. Connally, 338 F. Supp. 448, 461 (D.D.C. 1972) (assistance extended through the tax system subject to Title VI).

65/ 396 F. Supp. at 603.

66/ The terms "program" and "activity" are synonymous. 110 Cong. Rec. 2487 (1964) (Colloquy between Representatives Waggoner and Celler).

67/ HEW Memo II, see note 17, supra. Bob Jones University v. Johnson, supra, note 63 at 603.

for payment directly to providers. 68/ It thus appears that Medicare Part B is subject to Title VI, and the Department of Health and Human Services is mistaken in its present view.

Eileen M. Stein
EILEEN M. STEIN
General Counsel

68/ 42 U.S.C.A. §§ 1395n, 1395u (1974 and Supp. 1980).

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 9 1980

Mr. Louis Nunez
Staff Director
U.S. Commission on Civil Rights
Washington, D.C. 20425

Dear Mr. Nunez:

I appreciate the U.S. Civil Rights Commission's interest in the question of Title VI jurisdiction over private physicians. Private physicians receive funds provided by the Department primarily through the Medicaid and Medicare Part B programs. This Department's position is that payments under Medicaid (and to health care providers such as hospitals under Medicare Part A) constitute Federal financial assistance triggering Title VI jurisdiction. Accordingly, these programs are listed in the Department's Title VI regulation, 45 C.F.R. Part 80, under Appendix A, which describes some of the Federal financial assistance programs to which the Title VI regulation applies.

The Department's longstanding position has been that we do not have Title VI jurisdiction by virtue of Medicare Part B payments to private physicians. I have enclosed copies of the three original General Counsel opinions on this subject. The Office of the General Counsel is once more reviewing the question of Title VI jurisdiction over private practitioners who receive payments under Medicare Part B, but not under Medicaid. If the General Counsel's Office revises its opinion on this question, I will be happy to forward it to you.

I have also enclosed copies of the District Court and Court of Appeals decisions in Libbie Rehabilitation Center v. Trageser. This is the only written opinion of which we are aware that specifically addresses the question of whether Medicare is Federal financial assistance. The District Court in Trageser found that Medicare was not Federal assistance within the meaning of Title VI. (The decision does not explicitly differentiate between Parts A and B, but since nursing homes receive Medicare dollars only under Part A, it is possible to argue that the decision was limited to Part A.) The Court of Appeals affirmed the lower court's decision on other grounds, but seems not to have adopted the District Court's holding on Medicare. To our knowledge, no other court has addressed the issue in writing. However, in *Cook* v. *Ochsner Foundation Hospital*, Docket No. 70-1969, the District Court in New Orleans ruled orally that Medicare Part A was Federal financial assistance. No ruling was made on Medicare Part B since the case involved Title VI compliance of hospitals, not individual physicians. In fact, we know of no case that has looked at the applicability of Title VI to Medicare Part B.

I hope this information is helpful to you. Please do not hesitate to let us know if we can be of further assistance.

Sincerely yours,

Patricia Roberts Harris

Enclosures

EMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

RETYPE - September 9, 1977

DATE: October 18, 1965

: Mr. Robert M. Ball
Commissioner of Social Security

M : Alanson W. Willcox
General Counsel

JECT: Applicability of Title VI of the Civil Rights Act of 1964 to Title XVIII of the Social Security Act

You have asked to be advised concerning the application of Title VI of the Civil Rights Act of 1964 and Executive Order 11246 to the administration of the Health Insurance for the Aged Act.

Title VI of the Civil Rights Act provides that no person on grounds of race, color, or national origin shall be excluded from participation in, or be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. The first question for consideration is whether payments to providers of services under Part A of Title XVIII constitute such assistance.

The term "Federal financial assistance" is not defined in Title VI. In most contexts the purchase of either goods or services at cost does not constitute assistance, but the present instance is peculiar in that reimbursement equal to cost will in fact redound to the financial benefit of providers of services as a class. This conclusion, for which there is abundant evidence, results from the relatively low income of a large proportion of the aged population, the inadequacy of payment by public welfare agencies for health services, and the practice of most health institutions of providing a substantial volume of service to poor persons at less than cost and in some cases without charge. A measure of financial relief to health institutions was plainly intended by Congress through the creation of a mechanism for meeting costs that have heretofore been met only in part. Although the motivating consideration in the enactment of this Part was plainly the hardship to aged persons and their families, the firm Congressional insistence upon adequacy of payment for services evidences a purpose--albeit a secondary one--to ameliorate present inequities in the distribution of the costs of institutional care by relieving the institutions of deficits incurred in serving aged persons.

Under these circumstances it would not be unreasonable to conclude that payments under Part A to providers of services constitute Federal financial assistance within the meaning of Title VI of the Civil Rights Act. That Congress intended Title VI to apply is indicated by statements in the Senate by several of the principal sponsors of the Health Insurance for the Aged Act. Thus, Senior Ribicoff stated:

> "For most general hospitals, the only thing new that the law will require--since most hospitals will already have rejected racial discrimination--will be that they have a utilization review plan." Cong. Rec., July 7, p. 15233.
>
> He further said:
>
> "Beyond these conditions, necessary to assure safety and high quality of care, and to avoid improper or excessive utilization of facilities, hospitals and other institutions have only to enter into an agreement not to charge patients for services paid for under the hospital insurance program, and to abide by title VI, of the Civil Rights Act." Id., p. 15234.
>
> Senator Hart said:
>
> "In addition to the new economic independence it will create, I am hopeful that the bill will promote first-class citizenship in another fashion also. We desided last year, and wrote into law, that Federal tax funds collected from all the people may not be used to provide benefits to institutions or agencies which discrimiate on the grounds of race, color, or national origin. This principle will, of course, apply to hospital and extended care and home health services provided under the social security system, and will require institutions and agencies furnishing these services to abide by title 6 of the Civil Rights Act of 1964." Id., p. 15243.

Senator Pastore then stated that he associated himself with everything Senator Hart had said.

No contrary view was expressed. We conclude that Title VI of the Civil Rights Act is applicable to payments under Part A to providers of services, and that no institution or agency is entitled to participate under that Part unless it undertakes to abide by Title VI. Such an undertaking may be evidenced either by execution of the Department's Form 441 or by appropriate addition to an agreement made pursuant to Section 1866 of the Social Security Act. 1/

A different conclusion is reached with respect to Part B. This Part creates what is essentially a system of indemnity insurance. The primary right against the Government, so far as concerns "medical and other health services," is that of the beneficiary to be paid (subject to the deductible) 80 per cent of certain medical and related expenditures. It is clear that Title VI does not apply to programs in which payment is made by the Federal Government directly to the ultimate beneficiary, such as the Social Security cash benefit program, and it would appear that the same principle is applicable to Part B of Title XVIII. The fact that the right to payment may in some circumstances be assigned to physicians or others does not, we believe, alter the nature of the program or convert it into a program of Federal financial assistance. Although the Part also provides for some payments directly to "providers of services" on behalf of beneficiaries, these are limited to 80 per cent of the reasonable costs, and could not be described as Federal financial assistance. It is therefore unnecessary to consider whether the right of a beneficiary under Part B constitutes "a contract of insurance" such as to be expressly excluded by section 602 of the Civil Rights Act from the operation of Title VI.

There remains for consideration the effect of Executive Order 11246 (superseding Executive Order 10925), requiring nondiscrimination in employment under Government contracts.

1/ Title VI provides its own procedure for termination of Federal financial assistance, including opportunity for hearing and judicial review. The only requirement of section 1866 not met by the Title VI procedure is reasonable notice to the public. The regulation spelling out this requirement should be broad enough to include a Title VI termination.

An institution or agency which meets the qualifying conditions specified in or pursuant to the Act is given by section 1866 a statutory right, 2/ upon filing the agreement required by that section, to participate in the program and to receive the payments provided by sections 1815 and 1833. The Secretary, in turn, is required by statute to make the stipulated payments. The terms of the arrangements between the Secretary and a provider of services are thus spelled out in the statute, and there is no room for negotiation or bargaining concerning such terms. The provider, it is true, must undertake certain promissory commitments, and these will be enforceable as contractual obligations, but the Secretary undertakes nothing beyond what is required of him by law. Although the resulting relationship can perhaps be viewed as constituting a contract (an offer by Congress to all qualified providers, and an acceptance by each provider when it files the required undertakings), the governmental action in creating the arrangement is wholly statutory and the Secretary's role at this point is wholly ministerial. We are of opinion that this arrangement does not constitute a Government contract within the meaning of Executive Order 11246.

A different situation obtains, however, with respect to agreements with fiscal intermediaries under Part A (section 1816), contracts with carriers under Part B (section 1842), and agreements with State agencies (section 1864) and others (section 1874) relating to various aspects of administration. All of these sections contemplate contractual relationships in the usual sense of the term. In none of these cases has Congress spelled out in detail the content of the agreements, and in all of them the particulars will necessarily be developed administratively. The fact that section 1864 directs the Secretary to make an agreement if a State is willing and able to do so, or that section 1842 directs him "to the extent possible" to contract with carriers for the payment of physicians' charges, does not deprive him of a broad range of discretion in developing the terms of agreements under these sections. In absence of some overriding reason to the contrary, Executive Order 11246 controls the

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2/ This right, as we have seen, is modified by Title VI of the Civil Rights Act. This modification does not introduce any element of discretion, or authorize the Secretary to impose terms other than those stipulated by Congress.

Secretary's discretion by requiring the inclusion of nondiscrimination provisions. Congress legislated presumably with knowledge of the substantially identical requirement under Executive Order 10295, and did not forestall its applicability either expressly or by any provision inconsistent with it.

We conclude, then, that Title VI of the Civil Rights Act of 1964 is applicable to Part A of Title XVIII of the Social Security Act but not to Part B, and that Executive Order 11246 is applicable to agreements and contracts under sections 1816, 1842, 1864, and 1874 but not to agreements under section 1866.

AWW

UNITED STATES GOVERNMENT · DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
Memorandum

TO : Mr. Robert M. Ball, Commissioner of Social Security — DATE: December 30, 1966

FROM : Alanson W. Willcox, General Counsel

SUBJECT: Applicability of Title VI of the Civil Rights Act to payments to Providers of Services under Medicare

In advising you that title VI of the Civil Rights Act is applicable to Part A of title XVIII of the Social Security Act, my memorandum of October 16, 1965, stated:

"The term 'Federal financial assistance' is not defined in Title VI. In most contexts the purchase of either goods or services at cost does not constitute assistance, but the present instance is peculiar in that reimbursement equal to cost will in fact redound to the financial benefit of providers of services as a class." The memorandum went on to explain the reason that payment of cost would, under the peculiar circumstances of title XVIII, provide a financial benefit to health institutions generally. It then pointed out that sponsors of the hospital insurance legislation in the Senate had expressed the view that title VI would be applicable to it. On these grounds the memorandum concluded that title VI applies to Part A of title XVIII of the Social Security Act.

Further consideration has led me to believe that this conclusion was placed on unnecessarily narrow grounds, and that payments to providers of services under Part A of title XVIII would constitute "Federal financial assistance" even if there were no element of financial benefit to the recipients.

The Department regulation under title VI defines "Federal financial assistance" as including "(1) grants or loans of Federal funds *** and (5) any Federal agreement, arrangement or other contract which has as one of its purposes the provision of assistance." (45 C.F.R. 80.13(e)) All grant and loan programs are thus covered by title VI, but Federal contracts and other arrangements are covered only if there is a purpose to provide "assistance." The regulation, in other words, does nothing to clarify the meaning of the statute as it applies to contracts and other arrangements. It has been generally agreed that "ordinary Government procurement" is not covered, but beyond that agreement there has heretofore been little exploration of the problem.

Title VI can have meaningful application only to those contracts and arrangements which contemplate the provision of [illegible] or benefits to identifiable groups of persons, but where this [illegible] case, I no longer believe that financial benefit to the contractor or other recipient of Federal funds (in the sense of increase of the recipient's net assets) provides the appropriate test of the applicability of title VI. The statute speaks of assistance to a "program or activity." (Secs. 601, 602) There is no basis in the text of the statute for an assumption that net economic benefit to the payee of the Federal funds is a necessary or even a relevant factor in determining what is "Federal financial assistance."[1]

In the case of a grant program it is clear from the purpose of the statute, as well as from the regulation, that financial advantage to grantees, in the sense of improvement of their net financial position, is not essential to the coverage of the program under title VI. To hold otherwise would largely nullify title VI, by limiting its operation to construction or other capital grants. Typically, a noncapital grant is designed to enable the grantee to undertake a new activity, or to expand or improve its existing activities, at a cost at least equal to and often greater than the amount of the grant. Even a general support grant is commonly conditioned on "maintenance of effort" in order to avoid use of Federal funds to replace existing expenditures. Rarely does a noncapital grant constitute a net financial benefit to the grantee; essentially, such grants are designed to benefit those whom the grantees serve.

It is not unusual for a grant to replace payments that would, in the absence of the grant, be made to the grantee by others. This most frequently occurs as a part of a grant for a broader purpose, as in the case of traineeship grants to institutions which may enable them to pay both tuition charges and living allowances for the trainees. But an institutional grant limited to tuition charges would unquestionably be "Federal financial assistance" as defined in the regulation, and almost as obviously it would fall within the meaning of the statute. The same would be true of a grant to pay the cost of stated medical or hospital services for a specified group of persons. By authorizing grants which wholly or in part replace payments that would otherwise be made to the grantees for their services, Congress has evidenced its belief that some persons who ought to receive such services will otherwise either forego them for financial reasons or suffer undue financial hardship in paying for them. This being so, the grant clearly constitutes assistance to

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[1] The third sentence of section 602 authorizes "the termination of or refusal to grant or to continue assistance under such program or activity to any recipient as to whom ***." Reference to the recipient in this phrase is necessarily a reference to the person or entity from which money is to be withheld, and is wholly consistent with the earlier statutory language that predicates application of title VI on assistance to a "program or activity"--ordinarily, to a program or activity of a recipient or subrecipient.

the "program or activity" of the grantee in that its services are made more readily available.

The statute itself (sec. 602) makes clear that assistance may take the form of contracts as well as of grants. If a contract were made for the provision of the same services to the same people as the grants referred to above, with payment measured in the same way, the purpose to assist the "program or activity" of the contractor would be equally clear. The payment would hardly cease to be financial assistance merely because performance was to be assured by promissory commitment rather than by condition.2/

The classic distinction between grant and contract is that the former is appropriately used when the purpose is to further the program or activity of a nonfederal institution or agency, whereas the latter is used to secure performance of some part of a program or activity of the Federal Government itself. This distinction is not always easy to draw even in theory,3/ because where the objectives of the Government and its payee are similar it may be difficult to say whether the "program or activity" being furthered is that of the Government or that of the payee. For most cases, nevertheless, the distinction is a valid one, and one that seems also appropriate to a determination whether, in the words of the regulation, an "agreement, arrangement, or other contract *** has as one of its purposes the provision of assistance." Contracts, that is to say, which are designed to finance the program or activity of a nonfederal institution or agency are as clearly within the scope of title VI as though they were cast in the form of grants. For reasons discussed below, it seems clear that the payments authorized by Part A of title XVIII of the Social Security Act fall within this description.

The legislative history of title VI, like its text, supports the view that all expenditures designed to assist a "program or activity" of the recipients are covered by the title, whether made as grants or

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2/ Most contracts, and most arrangements that can be likened to contracts, do involve a promise to render services, whereas grants ordinarily involve no such promise. In this respect, as pointed out below, the relationship created by Part A of title XVIII of the Social Security Act, although it may properly be considered contractual, resembles a grant in that the provider makes no promise to render services.

3/ In practice the distinction has become still less clear, contracts being used where grants would seem clearly the appropriate mechanism, and vice versa.

pursuant to contracts. The history also delineates certain classes of expenditure which Congress deemed not to constitute assistance, but so delineates them as to indicate persuasively that hospital insurance payments are not among the excluded classes.

The broad language of section 601 is supported by the broad context in which title VI was presented to Congress by the Kennedy Administration. In the message accompanying the proposed Civil Rights Act of 1963, President Kennedy requested the Congress "to pass a single comprehensive provision making it clear that the Federal Government is not required, under any statute, to furnish any kind of financial assistance--by way of grant, loan, contract, guaranty, insurance or otherwise--to any program or activity in which racial discrimination occurs."[4] In support of this request for legislation, the President alluded to the demands of "simple justice" and the need for clear statutory authority for administrative action.[5] The Administration bill was introduced in the House as H.R. 7152 by Congressman Celler, Chairman of the Committee on the Judiciary, and was referred to a subcommittee of that Committee. Attorney General Robert Kennedy testified on title VI of this bill as follows:

> ". . . Many programs and activities carried on by State and local governmental authorities and by private enterprises receive financial assistance or backing from the Federal Government. The benefits of such programs and activities unquestionably should be available to eligible recipients without regard to race or color . . ."

It is thus apparent that the measure was designed and presented as a provision applicable to all measures of Federal financial assistance, of whatever kind. The most explicit attempt to define its application resulted from a request by Congressman Cramer, during the hearings before the House Committee on the Judiciary, that the Attorney General submit a list of programs or activities which would be included in title VI as it then read. The Attorney General responded[6]:

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[4] House Document No. 124, 88th Cong., 1st Sess., at 12.

[5] Ibid.

[6] Hearings before the House Committee on the Judiciary on H.R. 7152, as amended by subcommittee No. 5, 88th Cong., 1st Sess., at 2731.

> "We are making up a list . . . It is going to be every program of the Federal Government where Federal funds are expended, so that they are expended in a way that does not discriminate against a portion of our citizens. That is the purpose of it. There are going to be several hundred programs".

This statement, it should be noted, embraced expenditures under contracts as fully as grants.

In presenting the requested list to the Committee subsequently, a letter from the Deputy Attorney General explained the omission of two groups of activities which he said could not fairly be described as programs of Federal financial assistance: first, activities carried out directly by the Federal Government through its own personnel, together with "ordinary Government procurement"; and second, activities involving payments by the Federal Government directly to the ultimate beneficiaries.7/ Both these kinds of activity, the letter noted, are administered Federally without regard to race, color, or national origin, and are in any event subject to the Fifth Amendment's prohibition of discrimination; thus, they would not be materially affected by title VI if it were applicable.

This letter was relied upon during the debate on the bill in the House of Representatives as delineating the intended coverage of title VI. Similar views were expressed by proponents of the measure in the Senate. It can hardly be questioned that Congress accepted the views expressed in this letter, except as "contracts of insurance or guarantee" were subsequently excluded.

It is plain that the benefits under Part A of title XVIII of the Social Security Act do not fall within the activities which the Deputy Attorney General had described as being outside the scope of title VI. The services for which the Government pays are not furnished by Government personnel, and they do not constitute "ordinary Government procurement." Unlike Social Security cash benefits, they are not furnished by the Government directly to the ultimate beneficiaries. Thus, they are clearly not embraced in the categories of Federal expenditure which the Deputy Attorney General and the Congressional sponsors of the legislation said were excluded.

Hospital insurance benefits, it is true, are in some respects unique, and since they were not in existence when the Civil Rights Act was debated and passed we should consider whether they fall within the rationale, even though not within the terms, of any of the exclusions stated in the

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7/ House Judiciary hearings, at 2273.

letter of the Deputy Attorney General. No argument is needed to show that they do not fall within the reasons given for the principal exclusions set forth in that letter since, as noted above, the benefits are not provided directly by Federal personnel and are not provided directly to the ultimate beneficiaries. Can they, nevertheless, be considered as "ordinary Government procurement"--or, indeed, as any other kind of "Government procurement"--or likened in any reasonable way to such procurement?

When the Government "contracts out" services which it is obligated to provide and which it normally provides through its own personnel (such as the medical care of veterans or merchant seamen), the process is sufficiently like "Government procurement"--and it is so clearly subject to the restraints of the Fifth Amendment--that it arguably may fall outside the scope of title VI of the Civil Rights Act. But even if this is so, the hospital insurance provisions of the Social Security Act bear no resemblance to such "contracting out." In all respects relevant to coverage under the Civil Rights Act, these provisions are akin, not to programs involving direct Federal operation, but to programs under which Federal funds assist in financing operations conducted by others.

The relation of a provider of services to the Government under title XVIII, although it may be considered as a contractual relation, partakes not at all of the characteristics typical of a procurement contract. The provider does not contract to provide anything; apart from civil rights requirements, it promises only that <u>if</u> it serves a beneficiary of the program it will look to the insurance system for payment of all but specified items.[8] The scope of services to be furnished is determined essentially by the provider and not by the Government.

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[8] The relation of the Government to a provider of services, at the point of time at which payment is made, would seem to be most accurately described as a unilateral contract. Although the Government's offer of payment is conditioned on the existence of the provider's general agreement referred to in the text, no obligation of payment arises until services (which the provider is under no commitment to render) are in fact provided to an eligible patient. When this occurs, the standing offer of payment would seem to ripen into a contractual, as well as a statutory, obligation.

The fact that the Government's relation to the beneficiaries is clearly noncontractual in nature (<u>Flemming</u> v. <u>Nestor</u>, 363 U.S. 603 (1960)) does not militate against this analysis of its relation to providers of services.

Existing institutions are continuing to serve the same persons who would use their services if title XVIII had not been enacted, or who would do so but for financial barriers. New institutions are likewise wholly free to select their clientele. Finally, institutions meeting the quality and civil rights requirements have a statutory right to participate in the program--a provision paralleled in "mandatory" grant programs but quite out of character in a procurement activity.

The Government has not undertaken in title XVIII either to provide health services or to assure that they will be available. Providers are not acting for the Government, are not discharging an obligation the Government has assumed, but rather, are going about their own business with Government help. They are also contributing to the achievement of a governmental purpose, it is true, but they are doing so in the same sense that grantees contribute to achieving the purpose of a grant program.

In the respects here relevant, then, payments to providers, although contractual, are more akin to grants than to procurement contracts. Essentially, the Government is paying providers to carry on the "program or activity" which they have been organized to perform and have long been performing; to serve the same public they have been serving, with the same right in each provider to accept or reject individual patients; hopefully, to serve more patients, and to serve them better; and finally, to serve them almost without cost to the patients or their families. Both the purpose and the general method of its effectuation are, in the respects here pertinent, indistinguishable from a grant to pay the cost of specified medical services. As fully as by grants, the "program or activity" or providers is being assisted.

Dr. Edwin L. Crosby, director and executive vice president of the American Hospital Association, said when the program went into operation:

> "The enactment of Public Law 89-97 (Social Security Amendments of 1965), commonly called Medicare, will be a great boon to hospitals financially. Both hospitals and the medical profession have given thousands of hours of free care every year since the profession and hospitals took root in this country. Medicare will lift this enormous financial burden from hospitals and enable them to improve their facilities, broaden their services, train their personnel on a continuing basis, and take other steps to continue the improvement of patient care."[9]

9/ The Atlantic, July, 1966, p. 106.

Here is clear testimony that title XVIII of the Social Security Act provides financial assistance to the programs and activities of hospitals.

It remains to point out that Part A of title XVIII of the Social Security Act is not excluded from title VI as being a "contract of insurance or guaranty." This is so because Part A of title XVIII does not provide for the making of any contract which contains any element either of insurance or of guaranty. Although the Government's obligation to make payment to providers of services is contractual in nature, the obligation is a direct and primary one. The Government does not insure the provider against any risk or guarantee any payment to it by a third party; title XVIII, indeed, precludes the provider, to the extent of the Government's payment, from making any charge to the patient or others. Clearly, the Government's obligation to providers is primary, not secondary, and clearly it is not insurance.

The right of the beneficiaries of the Part A program, on the other hand, although it is properly described as social insurance, is a statutory and <u>not</u> a contractual right. It has been squarely decided by the United States Supreme Court that statutory social insurance is not a "contract of insurance."[10]

Although some remarks during the Congressional debate on title VI might suggest that Social Security cash benefits were excluded from that title by the phrase "contract of insurance," it seems reasonably plain, as the following colloquy in the Senate indicates, that their noncontractual nature was recognized and that their exclusion rested on the fact that these cash payments are made by the Government directly to the ultimate beneficiaries:

> "Mr. Robertson . . . The money is paid out pursuant to a bill enacted by Congress. There is no contract. We have said that when men and women reach a certain age, they will be paid a pension. Congress makes the statement, but there is no contract . . . If it were not a contract, section 602 would not exempt it . . .

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[10] <u>Flemming</u> v. <u>Nestor</u>, <u>supra</u>, note 8.

The voluntary insurance system created by Part B of title XVIII, on the other hand, is truly contractual in nature. Cf. <u>Lynch</u> v. <u>United States</u>, 292 U.S. 571 (1934). That system, therefore, even if it might otherwise fall within the scope of title VI as set forth in this memorandum, is excluded as a contract of insurance.

> "Mr. Ribicoff. The Senator is correct when he says it is not specifically exempted, but it does not have to be exempted. If the Senator will look to the preceding line, he will observe that it is not a program or activity. Since the social security payment to an individual is not a part of a program or activity covered by Title VI in the first place, it need not be specifically exempted."[11]

As both parties to this interchange recognized, benefits which have been authoritatively denominated as noncontractual cannot reasonably be deemed to constitute a "contract of insurance." If Social Security cash benefits are not within the exclusion in section 602, no more are Social Security hospital benefits.

As stated in my earlier memorandum, the only members of Congress who spoke on the point indicated that title VI would be applicable to the hospital and related benefits under Part A of title XVIII. I believe that their view was correct.

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[11] 110 Cong. Rec. 8426 (April 20, 1964).

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND
OFFICE OF THE SECRETARY

RETYPED: October 11, 1977

July 5, 1968

TO : Mr. Melvin Blumenthal
Assistant General Counsel

FROM : Alanson W. Willcox
General Counsel

SUBJECT: Application of Title VI of the Civil Rights Act to Medicare

Finding that Art Bess was out of town and apparently had not had opportunity to talk with Ruby Martin about our current problem, I spoke to her, and she had Lou Rives' call me. After some discussion Lou and I agreed that, although we both regret omitting some institutions from title VI coverage, the risk involved in shifting a second time our analysis of the application of title VI to Medicare is not justified by the relatively few, and probably small, institutions which will escape coverage. As Lou was authorized to speak for Ruby, and in view of the urgency of a decision, I took it upon myself to advise Tom Tierney to proceed on the basis that institutions are not covered by title VI if their sole source of Federal financial assistance is Part B of Medicare.

Because the same questions may arise in other contexts, I will make the following record of my present views:

I think the relation between SSA and a Part B enrollee is a contract. I see no satisfactory distinction between this and the war risk insurance involved in the Lynch case, which I believe was also substantially subsidized by the Government. The fact that this is merely a part of the program which is generally noncontractual in nature seems to me no reason for a contrary result. Surely the State agreements under title II are contactual, even though other title II benefits are not.

There is considerably more doubt, I agree, that a contract is a "contract of insurance" within the meaning of section 602 of the Civil Rights Act. It is arguable that that phrase was addressed only to situations where the insured is engaged in a program or activity receiving financial assistance, rather than the ultimate beneficiary of such a program or activity. This is a tenuous distinction at best, however, and one which would have made very difficult the exclusion of individual practitioners. Even as an original matter, I should have been reluctant to encumber title VI coverage with distinctions so difficult to explain.

cc Mr. Bess
Mr. Rivers
Mr. Barrett
Mr. Yourman

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

FILED
AUG 17 1977
CLERK, U. S. DIST. COURT
RICHMOND, VA.

NOVELLA H. TRAGESER :
:
v. :
: CIVIL ACTION
: NO: 77-0191-R
LIBBIE REHABILITATION CENTER, :
INC., etc. :

O R D E R

In accordance with the memorandum this day filed, and deeming it just and proper so to do, it is ADJUDGED and ORDERED that defendant Libbie Rehabilitation Center, Inc. t/a Libbie Convalescent Home's motion of 3 August 1977 to dismiss the above styled action be, and the same is hereby GRANTED.

Let the Clerk send a copy of this order and the memorandum to all counsel of record.

D. Dortch Warriner
United States District Judge

Date: 16 August 1977

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

FILED
AUG 17 1977
CLERK, U. S. DIST. COURT
RICHMOND, VA.

NOVELLA H. TRAGESER :
:
v. : CIVIL ACTION
: NO: 77-0191-R
LIBBIE REHABILITATION CENTER, :
INC., etc. :

MEMORANDUM

Pursuant to Rule 12(b) of the Federal Rules of Civil Procedure, defendant seeks in its motion of 3 August 1977 to dismiss the above styled action. As plaintiff's responsive brief and defendant's rebuttal brief have both been timely filed with the Court, the matter is now ripe for disposition.

A brief summary of the facts may be helpful. The defendant is a private corporation which operates a nursing home in Richmond, Virginia for profit. It enjoys no tax-exempt status nor was construction of its nursing home funded under the Hill-Burton Act. Defendant receives payments for services rendered under the Medicare, Medicaid and Veteran's Administration programs and is subject to inspection by the State Department of Health.

Plaintiff, the Director of Nursing of said nursing home, suffers from retinitis pigmutosa, a progressive hereditary visual impairment. During a regular inspection of the nursing home in April of 1976, a representative of the Department of Health commented on plaintiff's failing eyesight. That comment was reported to defendant's Board of Directors. On 7 June 1976, the Board of Directors resolved to replace plaintiff as Director of Nursing as soon as possible. Some three months later plaintiff tendered her resignation, effective 8 September 1975 and left defendant's employ.

Plaintiff's complaint alleges that in terminating her employment, defendant engaged in State action and acted under color of law so as to violate Amendments V and XIV of the United States Constitution and 42 U.S.C. § 1983. Plaintiff further alleges that defendant engaged in discrimination in violation of Section 794 of the Federal Rehabilitation Act of 1973, 29 U.S.C. § 701, et seq.

To satisfy the State action requirement of Section 1983, plaintiff argues that regulation by the State renders action by the nursing home State action within the meaning of Section 1983. Defendant argues that the weight of authority is contra to plaintiff's position and cites, among others, Moose Lodge 107 v. Irvis, 407 U.S. 163 (1972) and Jackson v. Metropolitan Edison, 419 U.S. 345 (1974). A careful reading of these two cases readily shows that more than mere regulation is necessary to constitute State action. As enunciated by the Supreme Court in Jackson, the test for State action in the context of State regulation is whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself. 419 U.S. at 351. As the decision in the instant case to replace plaintiff as Director of Nursing was that of the defendant's Board of Directors and not the State, such nexus as set forth in Jackson does not exist.

In support of her State action argument, plaintiff further argues that receipt of federal funding in the form of Medicare, Medicaid and Veteran's Administration programs by defendant's nursing home transforms the acts of the nursing home into those of the State. Plaintiff cites Doe v. Charleston Area Medical Center, 529 F.2d 638 (4th Cir. 1975) as authority. In Doe a woman desiring an abortion brought a class action against a privat medical center which refused to perform abortions except to save the life of the mother, such refusal being based in part on a State abortion law. The Fourth Circuit held that federal jurisdiction existed as State action was present. Plaintiff argues that Doe is binding in the case at bar as Doe involved a private hospital which received Medicare and Medicaid funds. Doe is readily distinguishable, however, as the Fourth Circuit based its holding that State action was present not on the basis of federal funding but rather on the fact that in Doe the defendant's anti-abortion policy, being based on West Virginia's criminal abortion statute, involved the State sufficiently to constitute the policy "State action" under 42 U.S.C. § 1983. In the instant case nothing in the stipulations supports any State sanction - at most a suggestion. Although plaintiff argues that defendant's Board of Directors based its dismissal of plaintiff on State accredidation requirements, such position is supported nowhere in the record. Indeed, the State Department of Health did not even list plaintiff's handicap as a deficiency.

Finally, plaintiff alleges a claim under Section 794 of the Federal Rehabilitation Act of 1973, 29 U.S.C. § 701, _et seq_. Unlike Title VII of the Civil Rights Act, 42 U.S.C. § 2000e-5, _et seq_, or the Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621-634, the Federal Rehabilitation Act provides no specific grant of a private cause of action. There is no clear legislative history of Section 794 indicating a Congressional intent to provide a handicapped employee with a private right of action against his private employer. Furthermore, as Section 794 only pertains to "any program or activity receiving Federal financial assistance," jurisdiction cannot be invoked by plaintiff as defendant's nursing home has not received such assistance. The federal funds received by the nursing home are not "federal assistance" but rather payment for services rendered. Federal judges receive federal salary checks each month but it is not supposed that this is "assistance. It is presumed that they are being paid an approximation, at least, of what they should be compensated for judging. Even if Section 794 creates a private right, which is not decided here, no such right could reasonably be contended for in the absence of a showing that said nursing home is a "program or activity receiving federal financial assistance."

An appropriate order shall issue.

D. Dortch Warriner
United States District Judge

Date: 16 Aug. 1977

Novella H. TRAGESER, Appellant,

v.

LIBBIE REHABILITATION CENTER, INC., t/a Libbie Convalescent Home, Appellee.

No. 77-2224.

United States Court of Appeals, Fourth Circuit.

Argued June 7, 1978.

Decided Dec. 18, 1978.

A registered nurse, handicapped by retinitis pigmentosa, sought reinstatement after she was terminated from her employment by a nursing home because of deterioration in her eyesight. The United States District Court for the Eastern District of Virginia, 462 F.Supp. 424, at Richmond, D. Dortch Warriner, J., dismissed the complaint, and the nurse appealed. The Court of Appeals, Butzner, Circuit Judge, held that the Comprehensive Rehabilitation Services Amendments of 1978 foreclosed the nurse's claim under the Rehabilitation Act of 1973 and that lack of governmental action precluded recovery under federal civil rights statutes.

Affirmed.

1. United States 🔑82(1)

Registered nurse, handicapped by progressive retinitis pigmentosa, could not maintain private action under Rehabilitation Act of 1973 to redress employment discrimination in view of her inability to show that primary objective of federal financial assistance to nursing home, her former employer, was to provide employment. Rehabilitation Act of 1973, §§ 2 et seq., 500 et seq., 501, 504, 505(a)(1, 2) as amended 29 U.S.C.A. §§ 701 et seq., 790 et seq., 791, 794, 794a(a)(1, 2); Civil Rights Act of 1964, §§ 601 et seq., 604, 701 et seq., 42 U.S.C.A. §§ 2000d et seq., 2000d-3, 2000e et seq.; U.S.C.A.Const. Amends. 5, 14.

2. Civil Rights 🔑13.5(3)

State action such as to permit nursing home to be held accountable under federal civil rights statute for employment discrimination was not shown by fact that nursing home received medicare and Veterans Administration benefits or by virtue of action of state inspector who, noting that registered nurse's eyesight had deteriorated, asked what nursing home intended to do about it. 42 U.S.C.A. § 1983.

G. Timothy Oksman, Richmond, Va. (Farino & Oksman, Richmond, Va., on brief), for appellant.

Lewis T. Booker, Richmond, Va. (Charles S. McCandlish, Hunton & Williams, Richmond, Va., on brief), for appellee.

United States of America (Drew S. Days, III, Asst. Atty. Gen., Walter W. Barnett and Judith E. Wolf, attys., Dept. of Justice, Washington, D. C., on brief), and National Federation of the Blind (John F. Rick, Richmond, Va., on brief), amici curiae in support of appellant.

Before BUTZNER and HALL, Circuit Judges, and ROBERT F. CHAPMAN, District Judge for the District of South Carolina, sitting by designation.

BUTZNER, Circuit Judge:

Novella H. Trageser appeals the district court's dismissal of her complaint alleging that the termination of her employment at Libbie Rehabilitation Center constituted handicap discrimination in violation of § 504 of the Rehabilitation Act of 1973, the fifth and fourteenth amendments to the Constitution, and 42 U.S.C. § 1983. We affirm because § 120(a) of the Comprehensive Rehabilitation Services Amendments of 1978 forecloses her claim under the Rehabilitation Act of 1973, and lack of governmental action precludes recovery on the other grounds.

I

Libbie, a private corporation, operates a nursing home for profit in Richmond, Virginia. It receives substantial income from the state and federal governments in the form of Medicare, Medicaid, Veterans Administration, and welfare payments. The purpose of these payments is to compensate for treatment of specified patients who are entitled to the benefits. The home is subject to inspection by the Virginia Department of Health.

Trageser, a registered nurse, was hired in 1971 and promoted to director of nurses in 1975. Her sight is impaired by a condition known as retinitis pigmentosa, which is hereditary and progressive.

On April 28, 1976, the certification officer from the Virginia Department of Health conducted a regular inspection of the nursing home. The inspector told the administrator of the home that Trageser's eyesight had deteriorated since the last inspection and asked what the home intended to do about it. The administrator relayed these comments to the board of directors. At its meeting on June 7, 1976, the board resolved to dismiss her. Upon learning of this decision, Trageser resigned.

Trageser then brought this action seeking reinstatement, back pay, and an injunction against payment of federal financial assistance to the home unless she was reinstated. The district court treated the termination of her employment as tantamount to discharge, but it granted Libbie's motion to dismiss the complaint for failure to state a claim upon which relief could be granted. *See Trageser v. Libbie Rehabilitation Center*, 16 E.P.D. ¶ 8117, 17 F.E.P. Cases 398 (E.D.Va.1977).

II

[1] Trageser bases her claim on § 504 of the Rehabilitation Act of 1973[1] which provides as follows:

> No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

In § 120(a) of the Comprehensive Rehabilitation Services Amendments of 1978, Congress added, among other provisions, § 505(a)(2)[2] which states:

> The remedies, procedures, and rights set forth in title VI of the Civil Rights Act of 1964 shall be available to any person aggrieved by any act or failure to act by any recipient of Federal assistance or Federal provider of such assistance under § 504 of this Act.

Title VI contains the prototype of § 504 of the Rehabilitation Act. *See Lloyd v. Regional Transportation Authority*, 548 F.2d 1277, 1280 and n.9 (7th Cir. 1977). Section 601 of Title VI[3] provides as follows:

> 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 broad prohibition of § 601 is, however, qualified by § 604,[4] which creates the following limitation:

> Nothing contained in this subchapter shall be construed to authorize action under this subchapter 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.[5]

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[1] 29 U.S.C.A. § 794 (1975).

[2] Act of November 6, 1978, Pub.L. No. 95-602, § 120(a), H.R.Conf.Rep. No. 95-1780 on H.R. 12467, 95th Cong., 2d Sess. 29 (1978), 124 Cong.Rec. H12675 (daily ed., Oct. 12, 1978) (to be codified as 29 U.S.C. § 794a(a)(2)).

[3] 42 U.S.C. § 2000d.

[4] 42 U.S.C. § 2000d-3.

[5] The § 604 restriction on enforcement of fair employment practices is tempered in appropriate cases by availability of the remedies of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, *et seq.*, and of 42 U.S.C. § 1983.

Although § 604 expressly curtails the authority of federal departments and agencies, it also restricts private suits. Thus, because of § 604, Title VI does not provide a judicial remedy for employment discrimination by institutions receiving federal funds unless (1) providing employment is a primary objective of the federal aid,[6] or (2) discrimination in employment necessarily causes discrimination against the primary beneficiaries of the federal aid.[7]

Title VII of the Civil Rights Act of 1964[8] provides the primary statutory remedies for racial and ethnic discrimination in employment. Recognizing this, Congress supplemented the Rehabilitation Act by including in § 120(a) of the 1978 amendments a new subsection 505(a)(1)[9] which makes the pertinent remedies, procedures, and rights of Title VII available to federal employees who complain of handicap discrimination in employment in violation of § 501 of the Rehabilitation Act.[10] Congress also could have utilized Title VII to define the rights and remedies of a person in Trageser's position who must rely on § 504. Instead, for employees of private institutions receiving federal financial aid, § 120(a) of the 1978 amendments makes available only the remedies, procedures, and rights of Title VI, which, as we have noted above, contains the restriction of § 604. The distinction that § 120(a) draws between the relief available to federal employees and that available to employees of private institutions receiving federal assistance could not have been inadvertent. We therefore conclude that we must apply the limitation contained in § 604 of Title VI to § 504 of the Rehabilitation Act in literal compliance with § 120(a) of the 1978 amendments.[11]

We cannot accept Trageser's contention that the 1978 amendments are inapplicable to her 1976 dismissal. We must decide this case in accordance with the law as it exists at the time we render our decision " 'unless doing so would result in manifest injustice or there is statutory direction or legislative history to the contrary.' " *Cort v. Ash,* 422 U.S. 66, 76–77, 95 S.Ct. 2080, 2087, 45 L.Ed.2d 26 (1975). In the absence of legislative history to the contrary, the explicit incorporation of § 604 of Title VI simply confirms a plausible reading of § 504 as originally enacted. *See, e. g.,* Guy, The Developing Law on Equal Employment Opportunity for the Handicapped: An Overview and Analysis of the Major Issues, 7 U.Balt.L.Rev. 183, 207 (1978). We therefore find no manifest injustice in applying the amendments to illuminate this case which was pending when they were enacted.

A private action under § 504 to redress employment discrimination therefore may not be maintained unless a primary objective of the federal financial assistance is to provide employment. There has been no such allegation in this case; nor could there be one. Viewing the complaint in the light most favorable to Trageser, in compliance with Federal Rule of Civil Procedure

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[6] *See, e. g., Quiroz v. City of Santa Ana,* 17 E.P.D. ¶ 8631 at p. 7221 (C.D.Calif.1978); *Feliciano v. Romney,* 363 F.Supp. 656, 672 (S.D.N.Y. 1973).

[7] *See Caufield v. Board of Education,* 583 F.2d 605 (2d Cir. 1978); *United States v. Jefferson County Board of Education,* 372 F.2d 836, 883 (5th Cir. 1966).

[8] 42 U.S.C. § 2000e, *et seq.*

[9] Section 505(a)(1) (to be codified as 29 U.S.C. § 794a(a)(1)) provides in pertinent part:

> The remedies, procedures, and rights set forth in section 717 of the Civil Rights Act of 1964 . . . including the application of sections 706(f) through 706(k) . . . shall be available, with respect to any complaint under section 501 of this Act, to any employee or applicant for employment aggrieved by the final disposition of such complaint, or by the failure to take final action on such complaint.

[10] 29 U.S.C. § 791.

[11] The Secretary of Health, Education, and Welfare has promulgated regulations to implement § 504 of the Rehabilitation Act of 1973. *See* 45 C.F.R. Part 84 (1977). He has not, however, had an opportunity to conform those regulations to the 1978 amendments incorporating § 604 of Title VI.

12(b)(6), we nevertheless hold that she cannot prevail on her § 504 claim.[12]

III.

[2] Trageser also based her complaint on 42 U.S.C. § 1983, the fourteenth amendment, and the equal protection component of the due process clause in the fifth amendment. We conclude, however, that the district court correctly granted Libbie's motion to dismiss these claims.

Section 1983 requires Trageser to show that Libbie acted under color of either a state law or regulation or a state-enforced custom. *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 148, 161–69, 90 S.Ct. 1598, 26 L.Ed.2d 142 (1970). To establish a denial of equal protection of the laws in violation of the fifth and fourteenth amendments, Trageser is required to do more than merely allege governmental regulation of the nursing home. She must demonstrate that Libbie's ostensibly private conduct was in reality an act of either the state or federal government. There must exist "a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351, 95 S.Ct. 449, 453, 42 L.Ed.2d 477 (1974). To satisfy this requirement, Trageser relies on (1) Libbie's receipt of public funds and (2) the state inspector's role in Libbie's decision to dismiss her.

Libbie did not participate in the Hill-Burton construction program which "subjects hospitals to an elaborate and intricate pattern of governmental regulations, both state and federal." *See Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959, 964 (4th Cir. 1963). Consequently, our decision in *Simkins* which detected state action in the operation of participating hospitals does not control here. Moreover, we have previously held that the receipt of Medicaid funds does not convert private medical care to state action. *Walker v. Pierce*, 560 F.2d 609 (4th Cir. 1977). For similar reasons, we decline to ascribe state action to Libbie's receipt of Medicare and Veterans Administration benefits.

To show state action, Trageser also relies on the query of the state inspector who, noting that her eyesight had deteriorated, asked what Libbie intended to do about it. The inspector did not include this observation about Trageser among the deficiencies found at the home, and Trageser does not allege that the state would or could impose any sanctions on Libbie if it continued to employ her. Libbie's subsequent decision to dismiss her, therefore, cannot be considered an action of the state itself. *See Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351, 95 S.Ct. 449, 42 L.Ed.2d 477 (1974).

Consequently, neither Libbie's receipt of patients' benefits nor Virginia's regulation of the home constitutes state action sufficient to sustain the § 1983 and constitutional claims.

The judgment of the district court is affirmed.

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12. Trageser's reliance on *Davis v. Southeastern Community College*, 574 F.2d 1158, 1159 (4th Cir. 1978), is misplaced. That was not an employment discrimination case. She also relies on several § 504 employment discrimination cases, decided prior to the 1978 amendments. *See, e. g., Drennon v. Philadelphia General Hospital*, 428 F.Supp. 809, 814–16 (E.D.Pa. 1977); *Gurmankin v. Costanzo*, 411 F.Supp. 982, 989 (E.D.Pa.1976), *aff'd on other grounds*, 556 F.2d 184 (3d Cir. 1977) (dicta). These cases, however, did not address the application of § 604 of Title VI.

Exhibit 16

NATIONAL HEALTH LAW PROGRAM (NHeLP)

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2401 MAIN STREET
SANTA MONICA, CALIFORNIA 90405
TELEPHONE: (213) 392-4811

SYLVIA DREW IVIE
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DAVID F. CHAVKIN
Managing Attorney

24 March 1980

Chairperson Charles Rangel
Subcommittee on Health
Committee on Ways and Means
House of Representatives
1102 Longworth House Office Bldg.
Washington, DC 20515

The Hon. Charles Rangel:

What follows are a few of the documented instances which have come to our attention in which poor minority persons have suffered racism in seeking access to health care. These are the examples I promised you at your February 29 hearing in Washington on financially troubled hospitals:

1. ARIZONA - HISPANICS AND BLACKS

A. On February 25, 1977, Raoul Garcia was riding home from school with two friends. The truck in which he was a passenger was struck by a train when crossing the railroad tracks. One passenger was instantly killed. The driver, Frank Calzada, an 18-year old fair-skinned Mexican American, and Raoul Garcia, a 17-year old dark-skinned Mexican American, were taken by Associated Ambulance Service to Boswell Memorial Hospital at 5:45 p.m.

Raoul Garcia had a massive head injury. The ambulance paramedic administered the following on route to the hospital: established airway, oxygen, splinted broken bones, spinal board, EKG strip, vital signs, and established I.V. Both Frank and Raoul were unconscious when they arrived at Boswell Hospital.

Boswell Hospital called Raoul's home and spoke to his 20-year old sister, Maria, regarding the method of payment. A Boswell representative asked for Raoul's parents to sign some papers, but his parents were not home.

Frank Calzada was admitted as an in-patient to Boswell Hospital. Apparently, his family had medical insurance. At 6:36 p.m., Raoul Garcia was transported by Associated Ambulance Service to Maricopa County General Hospital in Phoenix. He was admitted through the emergency room by Doctor David Buchanen. Raoul was unconscious for approximately two and one half weeks. He remained in the hospital for approximately six weeks.

Raoul underwent rehabilitative therapy at another hospital for another six weeks, and has made an excellent recovery.

Raoul lives with his family at 11714 Soledad Street, P.O. Box 340, El Mirage, Arizona 85335. He may be contacted through his attorney, Michael Piccarreta, Esq., 3440 North 16th Street, #8, Phoenix, Arizona 95016, telephone number (602) 248-8200.

B. On June 2, 1977, and approximately seven times previously, Mr. Inis Hernandez sought medical care through the Boswell Hospital Emergency Room.

Mr. Hernandez presented his insurance identification care. He was informed that the hospital would not accept this insurance, and that he would have to pay for his own care. These unpaid emergency room bills are currently the subject of litigation.

Mr. Hernandez is being represented by Legal Services for Farmworkers, Community Legal Services, 12221 Grand Avenue, P.O. Box 999, El Mirage, Arizona 85335, telephone number (602) 974-5848, by Angel Saenz -N. Mr. Hernandez lives at 15607 Sunny Lane, Surprise, Arizona 85345.

C. On March 7, 1977, eight-year old Diane Ramirez was bitten and mauled by a German Shepherd dog. She was taken by her mother to the emergency room at Boswell Hospital. Approximately 15 minutes later, her father, Ramiro Ramirez, arrived at the hospital and spoke to the cashier. He presented his medical insurance cared, and was told by the clerk that only Blue Cross or Blue Shield Medical Insurance was accepted by the hospital. The clerk then required cash payment, which Mr. RAmirez was unable to make. Finally, Mr. Ramirez persuaded her to take down the information on his medical insurance card. Subsequently, Mr. Ramirez received a bill for this emergency room visit.

Diane was seen by Doctor Bolle (phonetic), who gave her stitches in her arm and leg. He did not remove her dress or slip, and did not see the bleeding wounds on her back. After returning home, Mr. Ramirez noticed that Diane was still bleeding on her back and that her slip was bloody. Mr. and Mrs. Ramirez took her back to the emergency room at Boswell. They asked the receptionist for the name of the doctor who had previously treated Diane, and she refused to give the information they requested. After about half an hour, Mr. Ramirez persuaded the receptionist to have Diane seen by a physician. Doctor Bolle said that he had not seen these wounds on his initial examination. He refused to let Mr. Ramirez accompany Diane into the treatment room. Diane was crying with pain and fear.

About a week later, Mr. Ramirez took Diane to his family doctor, Doctor Rhumba, Thunderbird Medical Center, 5422 West Thunderbird Road, in Glendale, Arizona, to have the stiches removed. One of Diane's wounds was infected, and the doctor said that it was because they had not been cleaned thoroughly when she was seen in the emergency room. Diane still gets infections in that wound and has deep scarring on her legs.

The Ramirez family resides at 14006 Third Avenue in El Mirage, Arizona 85335.

Walter O. Boswell Memorial Hospital is located at 10401 Thunderbird Boulevard, P.O. Box 10, Sun City, Arizona 85351, telephone number (602) 977-7211. It is a community hospital, not for profit, which has been in operation since November 1970. Medicare monies provide 85% of its total reimbursement. It was constructed to provide for the acute medical and surgical needs of a predominately geriatric clientele. It is located within the walls of Sun City, a white, upper middle-class retirement community. The surrounding communities of El Mirage, Surprise, and Peoria are predominately low and middle-income Chicano communities. Many of the residents are brown-skinned, Spanish-speaking farm laborers.

(Source: Title VI complaint filed with Colin C. Rorrie, Jr., Bureau of Health Planning and Resources Development of Health Resources Administration, DHEW, on July 24, 1978 by Robyn E. Brown, Esq., Urban Indian Law Project, 3200 North Seventh St., Phoenix, AZ 85012, (602) 279-1622.)

D. Steve Neal is a Black man from Phoenix, Arizona who suffered spinal cord injuries in a car accident in November, 1977, which left him a quadriplegic. Mr. Neal was told by his doctors that he could regain the full use of his bladder and possibly more of his fingers if he had the right kind of rehabilitation services. He sought unsuccessfully those services from Hill-Burton hospitals for over a year at the time of this documentation.

Mr. Neal was told that Good Samaritan, a Hill-Burton hospital, had the best rehabilitation services for his problem. When he contacted the hospital and requested uncompensated care, he was told there was no such program. Subsequent inquiries were unanswered by the hospital. Mr. Neal did not, as a consequence, get the rehabilitation that he needed.

(Source: Testimony from transcript of hearings on proposed Hill-Burton regulations, HRA, DHEW, 12-5-78, pp. 13-17.)

E. Mrs. C. is a Mexican-American woman who recently separated from her husband and is 10 months pregnant. Her immigration status is that of lawful permanent resident. Her husband is a U.S. citizen from an area north of the city of Yuma. She applied for county medical assistance in December of 1979. (Arizona is the only state which does not have Medicaid. Medical services for the indigent are by statute the legal obligation of the counties.) At that time the eligibility worker advised her that by applying for county assistance she was becoming a public charge and that one of the terms of her immigration was that she would not become a public charge within a certain period of time. By applying for aid, the worker told her, she was committing fraud and as a result could be deported. As of this date she has not been certified for county benefits.

F. Mr. R is also a lawful permanent resident living in Yuma County. He was involved in an automobile accident in which he was at fault. Neither driver had auto insurance. Mr. R did not have medical insurance of his own or through his employer. He was admitted to the only area hospital, a private non-profit hospital with a Hill-Burton obligation. Following his emergency treatment, his condition was stabilized. The financial affairs officers for the hospital contacted him and requested to see his papers. When it was determined that he was born in Mexico, the U.S. Border Patrol was informed of his condition and inability to pay the bill. The Border Patrol came to the hospital and attempted to convince him to be transferred to a Mexican facility in Mexicali, Mexico. He agreed to go voluntarily. The Border Patrol transferred him to the hospital by use of a Red Cross ambulance. The gentleman was never evaluated for eligibility under the county standards, the Hill-Burton regulations, or the migrant program. The Border Patrol, although without any authority to back up their threats, intimidated this man into believing he had to go back to Mexico for his medical care. He needed further surgery, but the hospital and doctors were refusing to give it to him in order to make the transfer to the Mexican hospital more attractive.

(Source: Anne Ronan, Esq., Community Legal Services, 164 So. Fourth Ave., Yuma, AZ 85364, (602) 782-7511.

2. TENNESSEE - BLACKS

A. At 9:00 P.M. on July 22, 1977, Ammie Thomas was taken by her mother, Mrs. Elizabeth Turner, to the emergency room of St. Joseph's East. St. Joseph's East is a non-profit church-affiliated hospital built in Memphis in 1974. It is certified to take Medicare patients, 42 U.S.C. §1395, and has participated in other federally-funded programs such as an Emergency Medical Services planning grant.

Ms. Thomas had been suffering for two days with severe pain in her side accompanied by some vaginal bleeding. She was examined by house staff who diagnosed the presence of ruptured ectopic pregnancy (a pregnancy in which the fetus is lodged in the fallopian tubes, a condition causing extreme pain and potentially threatening the life of the mother). Ms. Thomas had no private physician but was eligible for Medicaid. The hospital staff informed her that the hospital did not take Medicaid patients. A letter was typed giving the preliminary diagnosis and referring the patient to the City of Memphis Hospital, the only entirely publicly-financed facility in the city.

Because the public hospital is overcrowded and understaffed, Mrs. Turner declined to take her daughter to that facility. Instead, she took her to the Methodist Central Hospital, a large, non-profit facility, built with Hill-Burton funds and certified to take Medicare patients. She was seen in the emergency room, told that the hospital did not take Medicaid patients, and was referred again to the City of Memphis Hospital.

Mrs. Turner then took her daughter to the City of Memphis Hospital emergency room. She was informed that they would see her but only after they had treated a number of cases that were more serious in nature than hers. After 3 hours of waiting in extreme pain, Ms. Thomas was taken back to Methodist Central by her mother at 1 A.M..

The staff person with whom they spoke on re-entry to Methodists told Ms. Thomas "that she was a stupid girl, that they had told her to go to the City Hospital, and why was she back here again?" Ms. Thomas explained that she was in severe pain and could not get help there. The staff person repeated that the hospital did not take Medicaid patients, at least not for "female problems" which is what she said Ms. Thomas had.

At this point, Mrs. Turner called her employer, a woman for whom she worked as a domestic servant. The employer spoke with a staff person and Ms. Thomas was thereafter admitted at 3 A.M., treated and discharged the following day.

(Source: Title VI and Hill-Burton Community Services complaint filed with Harry P. Cain, Bureau of Health Planning and Resources Development, DHEW, on October 7, 1977 by Don Donati, Memphis Legal Services, 46 N. 3rd St., Memphis, TN 38103 (901)526-5132; Sylvia Drew Ivie, National Health Law Program, 2401 Main St., Santa Monica, CA 90405, (213) 392-4811; Beth Lief, NAACP Legal Defense and Education Fund, 10 Columbus Circle, Rm. 2030, New York, NY 10019, (212) 586-8397.

B. Many black people, even those who have Medicaid reimbursement, are unable to secure nursing home placements in Tennessee due to racial discrimination. For example, Julia Tobes is a 113-year old black woman who is a resident of Memphis and currently lives in St. Joseph's Hospital. She was admitted to the hospital suffering from rat bites and injuries inflicted by a blood-stained two-by-four found in her room. In August of 1979 the hospital suggested immediate nursing home placement for Ms. Tobes. Shelby County's Department of Human Services took no action to so place her, and all other efforts have failed as well. Thus, she is forced to continue to reside in an inappropriate placement.

C. Another such example is John Hickman, a 74 year old partially blind black man who resides at Greater Community Boarding Home in Memphis. His physician has determined that he needs nursing home care, but he has been unable to secure such a placement for himself and unable to obtain the assistance of Shelby County's Department of Human Services in his efforts.

(Source: *Hickman, et al., v. Fowinkle, et al.*, W.D. Tenn. Civil No. 80-2014, filed by Don Donati, Memphis Legal Services, 46 N. 3rd St., Memphis, TN 38103, (901)526-5132.)

3. CALIFORNIA - HISPANICS

A. The Welfare Education and Legal Assistance Center (WELAC) is a Community Service Funded Agency offering advocacy and training to the poor people of Santa Cruz County. Its main office is located at 3410 Ocean St., Santa Cruz, California 95060, (408) 427-1322.

Watsonville Community Hospital is a Hill-Burton hospital offering services to the persons in the Watsonville, California area. It has received over $1,000,000 in Hill-Burton funds, and has an annual compliance obligation of approximately $100,000.

Frances Caballo, a WELAC advocate, made the following notes from a Health Services Planning meeting she attended in the Spring of 1978:

> "Recently I attended a Health Services Family Planning meeting. Mr. Walser, an administrator at Watsonville Community Hospital, was the guest speaker. I asked him what the hospital was doing to advertise the Hill-Burton Program...he quite proudly stated that they were not encouraging advertising of this program... His feelings were very clearly expressed: he doesn't want his hospital to be providing services to the Mexican segment ("illegal" or with MICAs) of the population--only to those that "merit our services". His overt anti-Mexican prejudice was proudly displayed."

Watsonville Community Hospital requires proof of legal residency as a condition of admission of Brown and Spanish speaking people. Persons unable to produce the proper papers are routinely denied services.

Frances Caballo reports as follows about a spring time admission for a client named "Jovita":

> "I recently had a case in which the woman involved was 28, Mexican, pregnant and without a MICA (papers had been filed with INS and she was awaiting her "cita") She was discontinued by her Ob-Gyn because she couldn't afford the fees....When I requested a Hill-Burton application a few days before Jovita delivered, a supervisor was immediately sent out to speak to me. Seeing that her surname was Spanish, her first question was, "Is she illegal?"

Another example of discrimination according to national origin occurred on October 29, 1978. On that date the Watsonville Community Hospital turned away a 15 year old Latina girl, Guadalupe Quintana, because she was "illegal". In the words of the girl:

> "They would not take care of me. The woman in the white dress told me that I couldn't get help because I was illegal and that the immigration department would come and get me if they served me."

Fortunately for this girl, she and her mother immediately contacted Juana Magellan, an outreach worker at a Community Service Agency in Watsonville (La Coalician). This worker was able to arrange admission into the hospital. The girl's appendix was removed the same day.

(Source: Hill-Burton complaint filed with the State of California, pursuant to 22 Cal. Admin. Code §91157, on December 21, 1978, by Jonathan McCurdy, Esq., WELAC.)

B. On March 4, 1979, Octavio Verduzco was taken to Queen of Angels Hospital in Los Angeles for treatment of stab wounds suffered in an attack. He arrived at the emergency ward at about 7:00 p.m. and was at that point conscious and talking. Upon arrival there were no doctors to treat him, only nurses, and a doctor didn't arrive until about 8:30. During this time Octavio began yelling for his wife Maria, but she was not allowed to go to him.

Upon arriving the doctor asked Maria if he had insurance or Medi-cal, which he did not. The doctor, instead of treating Octavio, began to ask his wife if he was in the country legally and if he had papers to prove he was "legal". The doctor continued to interrogate Maria a total of three times as to why they didn't speak English "well", what nationality they were, how long they were in the country, etc. Not only did Maria have to endure this, but even worse, Octavio was left unattended.

By 9:45 p.m., close to three hours after arriving and still inadequately treated, Octavio Verduzco died. He was a U.S. citizen.

(Source: Women Hold Up Half the Sky, a grass root's newsletter, November 1979, vol. 1, no. 1, Los Angeles, California, available from Dorothy Lang, National Health Law Program, 2401 Main St., Santa Monica, CA 90405, (213) 392-4811.)

4. TEXAS - HISPANICS AND BLACKS

A. Juanita E. Valdez, a 29 year-old Mexican-American woman, and her baby died of a ruptured uterus on March 8, 1979. They had been turned away from two hospitals, Aransas Hospital and Lyman Roberts Hospital, while attempting to seek care the the eight months pregnant woman in Aransas Pass, TX. Ruben Bonilla, attorney for the League of United Latin-American Citizens in San Antonio, requested an investigation by the Texas Attorney-General's office.

(Source: Dallas Times Herald, Saturday, March 10, 1979, p. 1).

B. Isidro Aguinagas, eleven months old, died on December 8, 1978 after being deined admission to Plains Memorial Hospital in Dimmitt, Texas, a Hill-Burton hospital. Mr. and Mrs. Aguinaga took Isidro to Dr. Murphy, a Dimmitt physician who was then acting Chief of Staff at the hospital.

Dr. Murphy examined the baby and informed the Aguinagas that their child was very seriously ill and should be admitted at once to the Hospital for treatment. He sent them directly to the Plains Memorial Hospital, and telephoned ahead to notify the Hospital of the situation and give his instructions.

When the Aguinagas arrived they were informed by the receptionist that a $450.00 deposit would have to be paid before the child could be admitted.

The Aguinagas' made clear to both the receptionist and to the administrator, Jack Newsom, that Dr. Murphy had sent them, that the baby required emergency care, that they were indigent, and that they did not have the money to pay the requested prior deposit.

Despite the Aguinagas' explanation of the situation, and their urgent offers to either pay the bill in installments, or to borrow the money from friends and relatives, the administrator refused to admit their son unless a sizeable prior deposit was made.

Because of this refusal to admit their child, the Aguinagas left the hospital to seek, uncessessfully, other sources of medical assistance. As a direct result of this refusal to provide medical care and treatment, the baby endured great pain and suffering, and died late that afternoon.

C. In the winter of 1977, Ollie Mae Baker, a black woman, went to the emergency room of Plains Memorial Hospital. She was suffering from Kidney problems. She was informed that in order to be seen on an outpatient basis she would have to deposit $40.00, an amount she could ill afford out of her fixed income. She offered her Medicaid card but this was not accepted. She then paid the $40.00 and was admitted.

D. On January 4, 1977, the Navarros' eleven year old son Oscar, suffered an appendicitus attack. The family took the boy to Dr. Lee, a local physician on the staff of Plains Memorial Hospital. Dr. Lee referred the child to the hospital for immediate treatment.

At Plains Memorial, the boy was refused admission, pending payment of a $700.00 deposit, a sum of money that the Navarros did not have, as they explained. The requirement was not waived, so the family immediately began arranging a loan at a nearby bank. Although the arrangements were quickly made and the deposit paid, the child's appendix ruptured during the period of delay, almost causing his death.

(Source: Aguinagas, et al., v. Castro County Hospital District, et al., Civil Action No. CA 279205, N.D. Texas 12-10-79, filed by Jennifer K. Harbury, Esq., Texas Rural Legal Aid, P.O. Box 2223, Hereford, Texas 79045, (806) 364-3961.)

5. SOUTH DAKOTA AND NEBRASKA - NATIVE AMERICANS

An Indian woman who began hemorrhaging approximately six months into a pregnancy went to her local Indian Health Services Hospital in South Dakota. She was told that her problem was too complicated for the IHS Hospital to handle and was referred to another hospital nearby, which refused to accept her. She then began an approximately 250 mile journey in search of a hospital that would accept her. After a number of rejections in both South Dakota and Nebraska, a hospital in the latter state accepted her. She lost her baby and her uterus and narrowly escaped losing her life.

Source: Ron Blevins, M.D., forensic pathologist, Denver General Hospital, Denver, Colorado.)

In sum, what our clients are experiencing all over the country are denials of hospital access, usually in extreme emergency situations, because of their race, ethnicity and low income status. In most instances the hospitals turning our clients away were private facilities. Where a public hospital existed some alternative was available. Where no public facility was available, frequently serious injury or death was the consequence. (See Texas, Aguinagas complaint above).

These incidents also reflect disparate treatment on the basis of race or ethnicity where admission has been secured. (See e.g., Arizona - Diane Ramirez, above).

Finally these incidents reflect total ignorance or disregard for local and federal requirements that residents be treated regardless of citizenship status, in areas with large Spanish speaking populations (See California, WELAC and Verduzco complaints above).

The above examples are only a few instances from a handful of states documenting racial discrimination in the provision of health care. I hope that this information will help to delineate the critical need for publicly-provided, non-discriminatory health care for this nation's indigent minorities.

Very truly yours,

Dorothy T. Lang

Dorothy T. Lang
Staff Attorney

DTL:jc

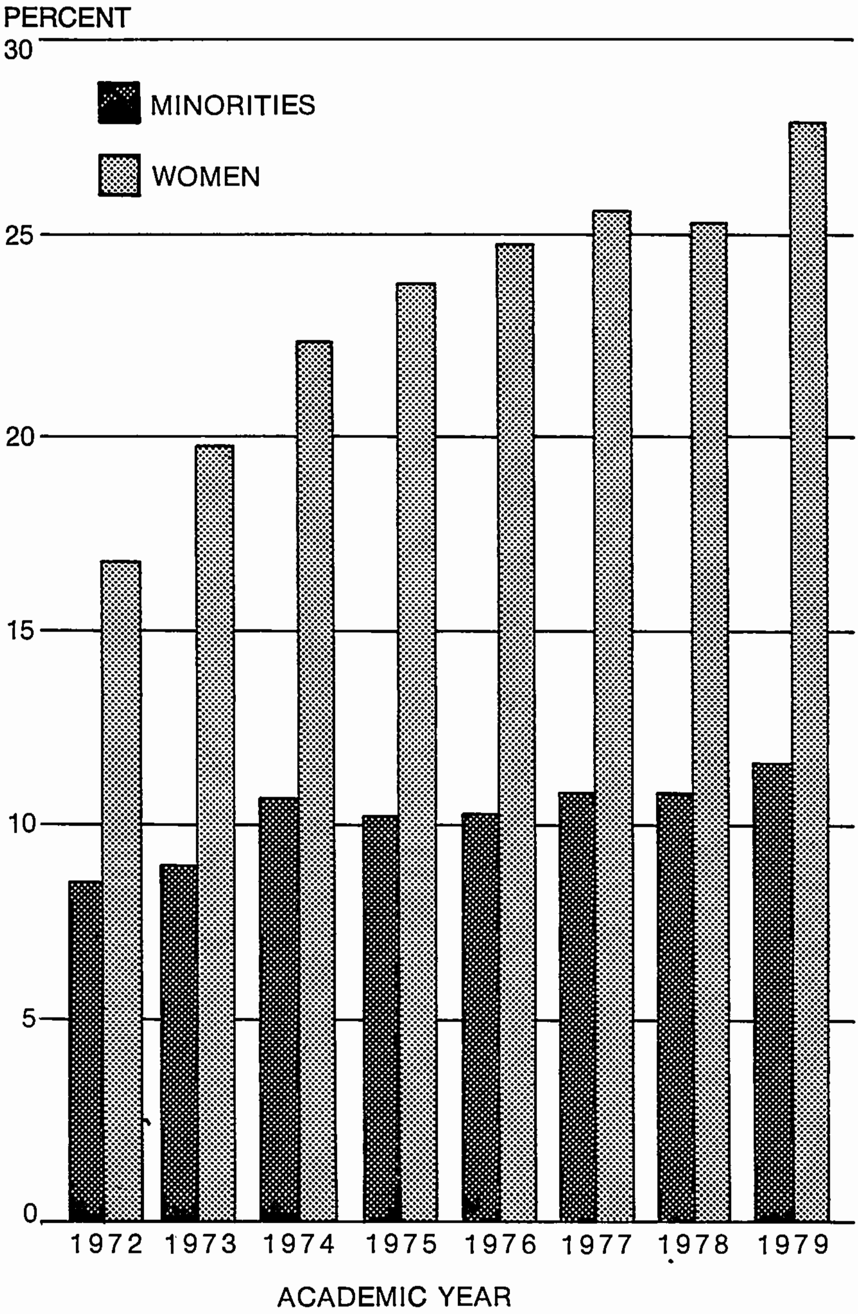
Exhibit 17

Percent Distribution For Underrepresented Minorities and For Women Among First Year Enrollees in U.S. Medical Schools:

Academic Years 1972 to Present

Academic Year	Total Underrepresented Minorities	Total Women
1972-73	8.6	16.8
1973-74	9.2	19.7
1974-75	10.7	22.2
1975-76	10.2	23.8
1976-77	10.2	24.7
1977-78	10.9	25.6
1978-79	10.7	25.2
1979-80	11.6	27.8

Percent Distribution for underrepresented minorities and for women among first year enrollees in U.S. medical schools: Academic Years 1972-Present



The total number of Black college freshmen has shown interrupted growth since 1968. The number of these freshmen wanting to become Doctors initially showed a proportionate increase, but has begun to decrease.

From 1968-69 to 1972-73, the proportion of Black students who did not follow their Freshman inclination to apply to medical school increased. Since that time, this negative trend has been blunted.

Although interest was apparently generated to influence increasing numbers of these freshmen to desire careers as Doctors, some factors are still influencing significant numbers not to follow through in applying to medical school four years later.

Table 13
Total Number of Blacks Entering Undergraduate College from 1968 Through 1976, the Estimated Number Interested in Medicine, and the Number Applying to Medical School Four Years Later

				No. Black Applicants to Medical School Four Years Later	
Academic Year (1)	No. Black Freshmen (2)	Percent of All Freshmen Interested in Medicine (3)	Estimated No. of Blacks Interested In Medicine* (4)	Medical School First-Year Class (5)	No. Blacks Applying (6)
1968-69	85,430	3.7	3,161	1972-73	2,168
1969-70	98,270	3.4	3,341	1973-74	2,227
1970-71	147,176	3.9	5,740	1974-75	2,423
1971-72	102,952	4.4	4,530	1975-76	2,288
1972-73	135,504	5.5	7,453	1976-77	2,523
1973-74	128,619	5.9	7,588	1977-78	2,487
1974-75	123,812	5.3	6,562	1978-79	2,564
1975-76	158,445	5.1	8,081	1979-80	2,599
1976-77	149,678	4.8	7,185		

SOURCES: Data on undergraduate college freshmen were derived from percentages appearing in the American Council on Education's annual issues of *The American Freshman: National Norms.* The numbers of black applicants to medical school were taken from *Medical School Applicants: Supplementary Tables,* published annually since 1972-73 as part of the AAMC's *DSS Report* series.

*Assumes that for the total number of black freshmen given in column 2, the percentage interested in medicine is the same as that for all freshmen given in column 3.

Figure 3 Total Number of Blacks Entering Undergraduate College from 1968 Through 1976, the Estimated Number Interested in Medicine, and the Number Applying to Medical School Four Years Later

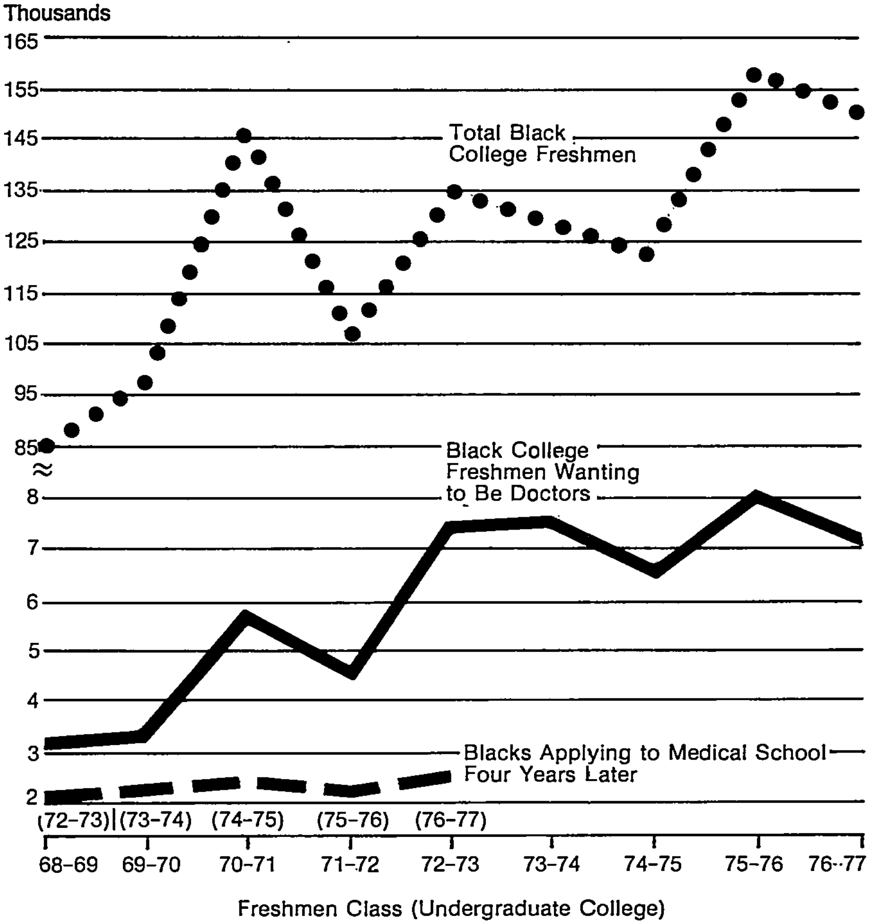


Table Distribution of Medical School Applicants, by Minority Group; 1970-79

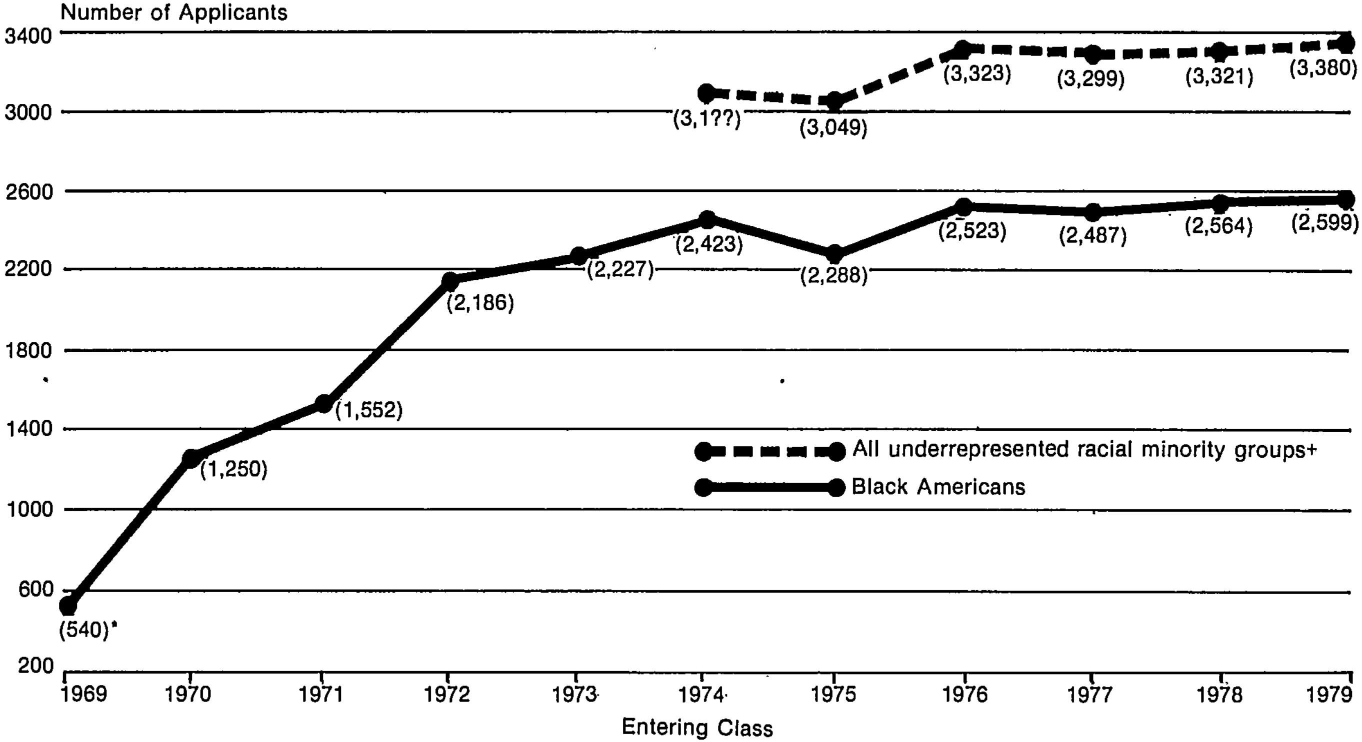
ACADEMIC YEAR	1970-1971		1971-1972		1972-1973		1973-1974		1974-1975	
MINORITY GROUP	N	%	N	%	N	%	N	%	N	%
A. Total Applicants	24,987	100.0	29,172	100.0	36,135	100.0	40,506	100.0	42,624	100.0
B. Non-Minority	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	37,457	92.5	39,518	92.7
C. Combined Minority	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	3,049	7.5	3,106	7.3
D. Black	1,250	5.0	1,552	5.3	2,382	6.6	2,227	5,5	2,368	5.6
E. Mexican American	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	349	0.9	437	1.0
F. American Indian	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	240	0.6	131	0.3
G. Puerto Rican—Mainland	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	233	0.6	170	0.4

ACADEMIC YEAR	1975-1976		1976-1977		1977-1978		1978-1979		1979-1980	
MINORITY GROUP	N	%	N	%	N	%	N	%	N	%
A. Total Applicants	42,303	100.0	42,155	100.0	45,569	100.0	36,617	100.0	36,137	100.0
B. Non-Minority	39,254	92.8	38,832	92.1	42,270	92.7	33,296	90.9	32,757	90.6
C. Combined Minority	3,049	7.2	3,323	7.9	3,299	7.9	3,321	9.1	3,380	9.4
D. Black	2,888	5.4	2,523	6.0	2,487	5.5	2,564	7.0	2,599	7.2
E. Mexican American	427	1.0	460	1.1	487	1.1	433	1.2	457	1.3
F. American Indian	132	0.3	128	0.3	122	.3	133	.4	151	.4
G. Puerto Rican—Mainland	202	0.5	212	0.5	203	.5	191	.5	173	.5

Source: AAMC, Division of Student Studies, December 5, 1975, W.F. Dube, "Datagram, U.S. Medical Student Enrollment, 1970-71 through 1979-80."
Journal of Medical Education, 50:303-305, 1975: *Ibid.,* 1977.

Applications (as well as enrollments) have also "stabilized" or leveled off in the mid-to-late 1970's.

Figure 1 Racial Minority Group Applicants to U.S. Medical Schools, 1969 to 1979



*Estimated +Includes Black Americans, American Indians, Mexican Americans, and Mainland Puerto Ricans.

The number of racial minorities applying to U.S. medical schools increased between the years 1967–1974. Since the mid-1970's this number has remained fairly constant varying between 3,000 to 3,400. Blacks constitute the largest minority group.

While the percent of total medical school applicants who were accepted has increased from 35.0% to 47.0% between the 1974-75 and 1979-80 academic years, the percent of underrepresented minority applicants who were subsequently accepted has decreased from 44.0% to 41.0%. This decrease can be attributed primarily to decreases in the percent of Black applicants accepted despite an increase in absolute number of applicants. This decrease was not apparently offset by increases in the percent of Mexican American or Mainland Puerto Rican applicants who were accepted.

Applications and Acceptees to the 1974 Through 1979 Entering Classes by Underrepresented Racial Minority Groups

ALL APPLICANTS TO MEDICAL SCHOOLS

Entering Year	Applicants	Acceptees	Percent Accepted
1974-75	42,624	15,066	35
1975-76	42,090	15,258	36
1976-77	42,155	15,774	37
1977-78	40,569	15,977	39
1978-79	36,617	16,499	45
1979-80	36,137	16,880	47
All Underrepresented Minorities			
1974-75	3,174	1,406	44
1975-76	3,049	1,308	43
1976-77	3,323	1,313	40
1977-78	3,299	1,329	40
1978-79	3,321	1,317	40
1979-80	3,380	1,389	41
Black American			
1974-75	2,423	1,049	43
1975-76	2,288	945	41
1976-77	2,523	966	38
1977-78	2,487	966	39
1978-79	2,564	938	37
1979-80	2,599	981	38
American Indian			
1974-75	134	64	48
1975-76	132	57	43
1976-77	128	39	30
1977-78	122	43	35
1978-79	133	51	38
1979-80	151	59	39
Mexican American			
1974-75	440	217	49
1975-76	427	220	52
1976-77	460	223	48
1977-78	487	227	47
1978-79	433	237	55
1979-80	457	258	56
Mainland Puerto Rican			
1974-75	177	76	43
1975-76	202	86	43
1976-77	212	85	40
1977-78	203	93	46
1978-79	191	91	48
1979-80	173	91	53

First-Year U.S. Medical School: Enrollment by Racial/Ethnic Group 1968-69 Through 1979-80

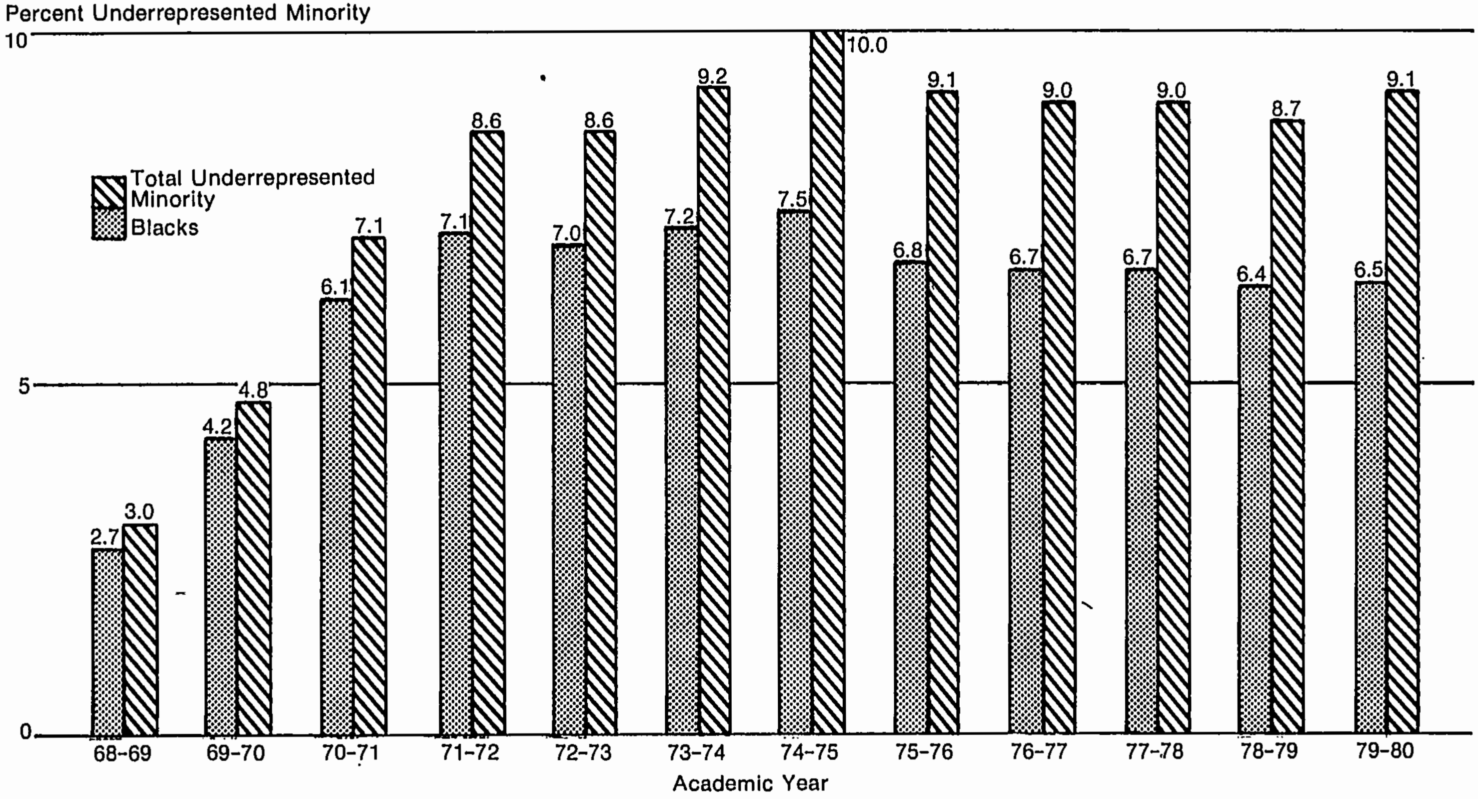
Academic Year	Total	Under-Represented Minority		Black		Indian		Mexican		Puerto Rican	
		No.	%	No.	%	No.	%	No.	%	No.	%
1968-69	9,863	292	3.0	266	2.7	3	*	20	0.2	3	*
1969-70	10,422	501	4.8	440	4.2	7	0.1	44	0.4	10	0.1
1970-71	11,348	808	7.1	697	6.1	11	0.1	73	0.6	27	0.2
1971-72	12,361	1,063	8.6	882	7.1	23	0.2	118	1.0	40	0.3
1972-73	13,677	1,172	8.6	957	7.0	34	0.2	137	1.0	44	0.3
1973-74	14,159	1,301	9.2	1,027	7.2	44	0.3	174	1.2	56	0.4
1974-75	14,763	1,473	10.0	1,106	7.5	71	0.5	227	1.5	69	0.5
1975-76	15,295	1,391	9.1	1,036	6.8	60	0.4	224	1.5	71	0.5
1976-77	15,613	1,400	9.0	1,040	6.7	43	0.3	245	1.6	72	0.5
1977-78	16,136	1,450	9.0	1,085	6.7	51	0.3	246	1.5	68	0.4
1978-79	16,501	1,443	8.7	1,061	6.4	47	0.3	260	1.6	75	0.5
1979-80	16,930	1,547	9.1	1,108	6.5	63	0.4	290	1.7	86	0.5

The percent of underrepresented minorities in the first year class of U.S. medical schools reached a peak in the 1974-75 academic year. This proportion has decreased since that time with the exception of the 1979-80 academic year which showed a marginal increase from the previous year (from 8.7% to 9.1%). Similar trends are observed in total minority enrollment in U.S. medical schools.

Source: Med. Sch. Adm. Reg. 1980-81
Table 7-B & 7-C;
Press Release (1979-80 date)

*Less than 0.05 percent

Proportion of Minority Students Entering Medical School for Academic Years 1968-69 Through 1979-80



Total U.S. Medical School Enrollment by Racial/Ethnic Group 1968-69 Through 1979-80

Academic Year	Total	Under-Represented Minority		Black		Indian		Mexican		Puerto Rican	
		No.	%	No.	%	No.	%	No.	%	No.	%
1968-69	35,833	854	2.4	783	2.2	9	*	59	0.2	3	*
1969-70	37,690	1,178	3.1	1,042	2.8	18	*	92	0.2	26	0.1
1970-71	40,238	1,723	4.3	1,509	3.8	18	*	148	0.4	48	0.1
1971-72	43,650	2,425	5.6	2,055	4.7	42	0.1	252	0.6	76	0.2
1972-73	47,366	3,102	6.5	2,582	5.5	69	0.1	361	0.8	90	0.2
1973-74	50,751	3,765	7.4	3,049	6.0	97	0.2	496	1.0	123	0.2
1974-75	53,554	4,324	8.1	3,355	6.3	159	0.3	638	1.2	172	0.3
1975-76	55,818	4,524	8.1	3,456	6.2	172	0.3	699	1.3	197	0.4
1976-77	57,765	4,715	8.2	3,517	6.1	186	0.3	780	1.4	232	0.4
1977-78	60,039	4,880	8.1	3,587	6.0	201	0.3	831	1.4	261	0.4
1978-79	62,213	4,898	7.9	3,537	5.7	202	0.3	882	1.4	277	0.4
1979-80	63,800	5,086	8.0	3,627	5.7	212	0.3	964	1.5	283	0.4

Source: Med. Sch. Adm. Reg. 1980-81
Table 7-B & 7-C;
Press Release (1979-80 date)

*Less than 0.05 percent

Percent Distribution of Underrepresented Minority Students Among Total Medical School Enrollments for Academic Years 1968-69 Through 1979-80

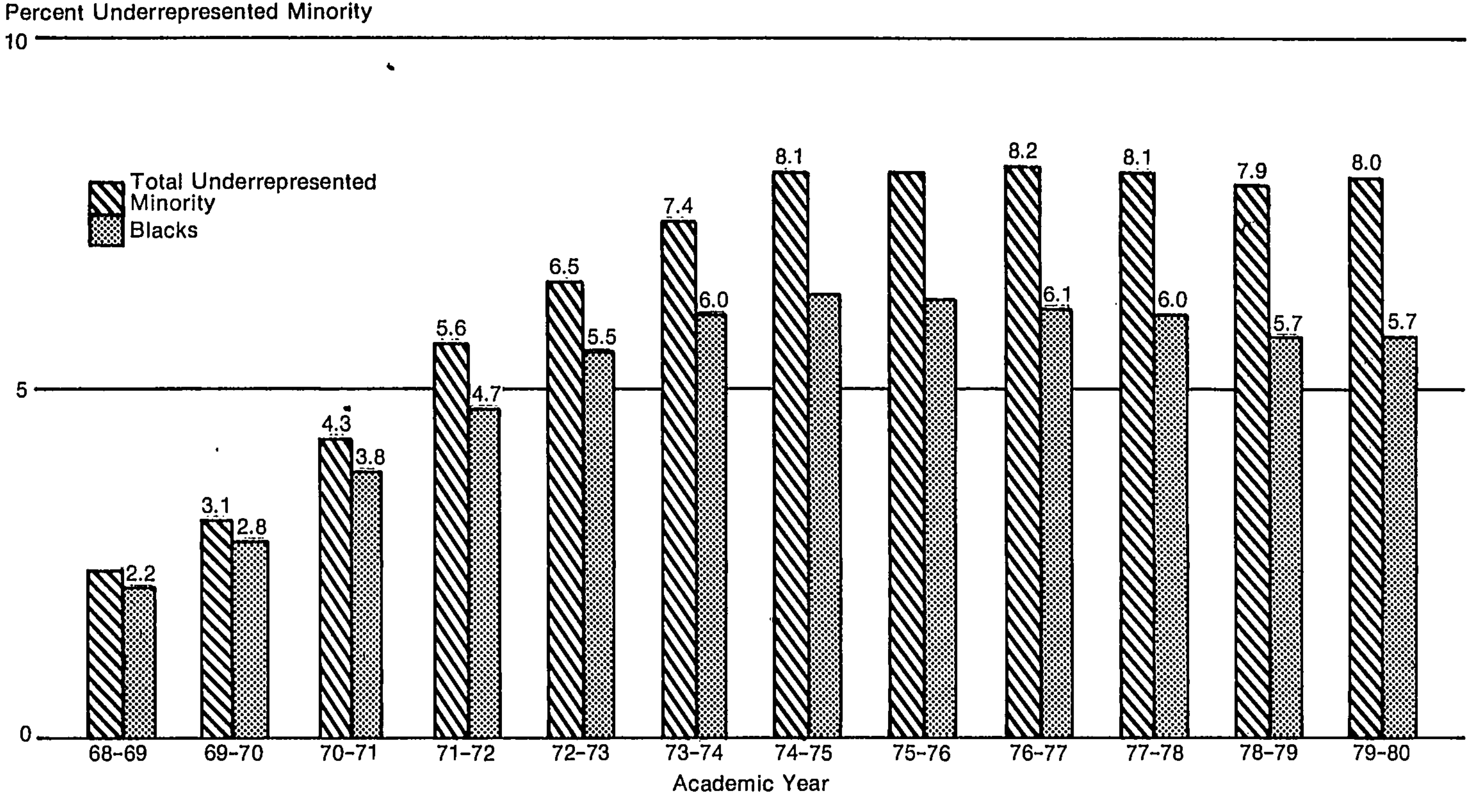


Table 4
Three Year Retention by Race of Students Entering U.S. Medical Schools in 1971, 1972 and 1973

Racial Group	Admitted 1971-72	Retained June 1974		Admitted 1972-73	Retained June 1975		Admitted 1973-74	Retained June 1976	
	No.	No.	Percent	No.	No.	Percent	No.	No.	Percent
Black Americans	758	649	86	838	729	87	935	817	87
American Indians	21	21	100	30	27	90	38	34	89
Mexican Americans	117	110	94	40	134	96	174	153	88
Mainland Puerto Ricans	33	30	91	37	35	95	51	50	98
Subtotal	929	810	87	1,045	925	89	1,198	1,054	88
All Students	10,962	10,500	96	12,045	11,751	98	12,633	12,272	97

Source: Liaison Committee on Medical Education Questionnaire.

This table illustrates that the retention rate of minority medical students entering U.S. medical schools in 1971, 1972, and 1973 has remained stable, through significantly lower than the retention rate for all students. However, the rate for Mexican Americans has decreased (and is the only group for which a decrease is noted) despite a sizeable increase in the number of students admitted.

U.S. Medical School Graduates by Underrepresented Racial Minority Group, 1968-69 Through 1977-78

Year	Black American		American Indian		Mexican American		Mainland Puerto Rican		Total Graduates
	No.	Percent of All Graduates	No.	Percent of All Graduates	No.	Percent of All Graduates	No.	Percent of All Graduates	
1968-69	142	1.8	NA+	NA	10	0.1	NA	NA	8,059
1969-70	165	2.0	4	—	NA	NA	9	0.1	8,367
1970-71	180	2.0	NA	NA	NA	NA	NA	NA	8,974
1971-72	229	2.4	NA	NA	NA	NA	NA	NA	9,551
1972-73	341	3.3	8	0.1	39	0.4	10	0.1	10,391
1973-74	511	4.5	3	—	79	0.7	19	0.2	11,613
1974-75	638	5.0	22	0.2	110	0.9	28	0.2	12,714
1975-76	743	5.5	27	0.2	130	0.9	29	0.2	13,561
1976-77	752	5.5	29	0.2	144	1.1	38	0.3	13,607
1977-78	793	5.5	47	0.3	172	1.2	176[1]	1.2	14,393

[1] The only data available include both mainland Puerto Ricans and those from the Island.
+NA = Information not available.
- Less than 0.05 percent.
Source: Liaison Committee on Medical Education Questionnaire.
Underrepresented minorities comprise approximately 8.0% of U.S. medical school graduates, with Blacks being the largest group.

Exhibit 18

CHAPTER I

Elderly People: The Population 65 Years and Over[a]

Americans are living longer today than ever before in history. Mortality rates among the elderly have been declining during the past several years. Even without further reductions in mortality, persons currently reaching their 65th birthday will, on the average, live 16 more years.

It would be a mistake to think of the elderly as a homogeneous population. As a group they are more likely than younger people to suffer from multiple, chronic, often permanent conditions that may be disabling. Despite that, the majority are living active lives and are able to remain in their own households. The proportion of the population with health problems increases with age and a minor health problem that might be quickly alleviated at younger ages tends to linger, but the range in health status is just as great in this group as in any other.

Aging is a process that continues over the entire lifespan at differing rates among different people. The rate of aging varies among populations and among individuals in the same population. It varies even within an individual because different body systems do not age at the same rate.

There are, therefore, no biological reasons for defining the "elderly" in terms of a specified calendar age. The reasons for using age 65 to mark the beginning of old age are mostly social and legislative. Private retirement plans, Social Security, and many other programs that affect a person's way of life take effect at age 65. This may change in the future in response to social pressures. At present, however, 65 years and over is generally accepted for use in programs relating to aging and is used to define the elderly population in this chapter.

Interest in how older people fare has grown in recent years, partly because of their rapid increase both in absolute numbers and in their proportion of the total population. Also, interest in their utilization of health services has mounted because of the escalating costs of medical care and the growing proportion of these costs paid out of public funds. As a result, awareness of their health status, needs for health care, and utilization of services has intensified.

POPULATION CHARACTERISTICS

Planning for the health needs of a large number of older people is a relatively recent concern that will remain with us in the foreseeable future. In 1900 there were only 3.1 million people

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[a] Prepared by Mary Grace Kovar, Division of Analysis, National Center for Health Statistics.

NOTE: Unless otherwise noted, data in this chapter are from the ongoing data-collection systems of the National Center for Health Statistics (NCHS). This is the first publication of many recent statistics from NCHS; other data have been published in the *Vital and Health Statistics* series. Bibliographic citations are given for all publications which do not originate from NCHS.

65 years and over in the United States. By 1940 the number had tripled to 9.0 million, and in the next 25 years it doubled. In 1965, just before Medicare was instituted, there were 18.5 million people 65 years and over in the United States, and by 1975 there were 22.4 million elderly people. According to the most recent population projections, there will be about 31.8 million elderly people by the year 2000, and by 2030, as the last of the post-World War II baby boom population attains age 65, there will be 55.0 million (Census Bureau, 1977). These projections may be underestimates. Since mortality rates are currently declining at all ages, the number of people surviving into old age could be greater.

Within the age group 65 years and over, the proportion of people aged 65-74 is getting smaller, while the proportion 75 years and over is getting larger. This trend is expected to continue at least until the end of the century. In 1900 the proportion of the elderly who were 75 years and over was 29 percent; by 1970 it was 38 percent. By the year 2000 it is expected that about 45 percent of the population 65 years and over will be 75 years and over (Census Bureau, 1977). The proportion of the elderly who are 75 years and over is tremendously important in evaluating health status and estimating needs for health care. The prevalence of chronic diseases and impairments and the utilization of medical services which increase with age increase more rapidly beginning at about age 75. Thus as a group the people 75 years and over need more medical care and home services if they are to continue to lead active lives.

The sex ratio (i.e., number of men per 100 women) is very low in the elderly population because death rates at every age are higher for men. For every 100 women, 105 men are born. Among people 65 years and over, however, there are only 69 men per 100 women. The ratio decreases from 77 men per 100 women at ages 65-74 to only 48 men per 100 women at 85 years and over.

The sex ratio among the elderly has changed radically within the last few decades. In 1960 the sex ratio for people 65 years and over was 83 men per 100 women (Census Bureau, 1976a). Since then, however, people who were part of the great immigration waves before World War I, in which the proportion of men relative to women was large, have mostly died. Additionally, the increase in life expectancy over the past decades has been greater for women than for men. The difference between the sexes in life expectancy at birth was only 2.0 years in 1900 but 7.8 years in 1975.

Many people in this age group rely on long-term institutional care at some point. According to the 1970 census, 5 percent of the people 65 years and over were residents of institutions, and by 85 years and over, 19 percent were residing in institutions at any given time (Census Bureau, 1973). The risk of being institutionalized at some point is high.

Still, at any given time the vast majority (95 percent) of the elderly are not in institutions. Most remain in their homes. In fact, in the past decade the proportion of the elderly maintaining their own household has increased and the proportion classified as living with "other relative" (i.e., residing in families of which they are neither the head nor the wife of the head) has decreased. Of the 21.3 million elderly not in institutions in 1975, some 5.8 million lived alone, 11.4 million were married and living with a spouse, and 4.1 million lived with other relatives or nonrelatives. The most common marital status among elderly men was to be married with the wife present (77 percent). The most common marital status among women was widowhood (51 percent); only 38 percent of elderly women were married with the husband present.

Elderly women were far more likely than elderly men to be living alone. Thirty-six percent of women 65 years and over and 41 percent of women 75 years and over were living alone in 1975, in contrast to 14 percent of men 65 years and over and 18 percent of men 75 years and over (Census Bureau, 1976a).

Financial difficulties also may beset elderly people. In 1974, men 65 years and over had a median income of about $4,500, which was nearly double the $2,400 median income of women the same age. Elderly people living alone or with nonrelatives had very low incomes; the median was $3,400 for men and $2,900 for women (Census Bureau, 1976b). Thus maintaining a household rather than moving in with relatives is often financially difficult even with Social Security benefits, the major source of cash for about 7 out of 10 elderly beneficiaries living alone. Maintenance of a household is especially difficult for elderly women since they often have little income and are more likely than elderly men to live alone.

Finally, older people, like younger ones, are likely to be living in metropolitan areas. Two-thirds (68 percent) of the 21.3 million noninstitutionalized elderly live in counties classified as metropolitan. Another 11 percent live in urbanized counties, and 21 percent live in counties which have an urban population of less than 20,000 people. The relative distribution is the same for those aged 65-74 and those 75 years and over.

This chapter focuses on three of the demographic characteristics discussed above—age, sex, and geographic distribution. Where needed, occasional references are made to other characteristics, such as income, but the Medicare and Medicaid programs along with coverage under private health insurance plans have decreased the financial barriers to many kinds of medical services. For those services, income no longer determines utilization. The change in utilization is documented where data are available.

Age and sex are biological characteristics associated with an individual's health, need for medical care, and utilization of services. Geographic area is associated with patterns of health care delivery and the availability of medical resources. Thus focusing on these three variables may throw some light on how characteristics of the individual and of the medical care system determine the older population's use of medical care.

TRENDS IN HEALTH

Mortality

Mortality rates, the oldest and still most widely available measure of health, have declined considerably for older people. From 1950 to 1975 the death rate for people 65 years and over declined by 13 percent. Most of this decline has been recent; the rate has decreased by 11 percent since 1965 (table A). In 1965 there were 6,118 deaths per 100,000 people 65 years and over; in 1975 there were 5,432.

The decline in death rates over the 25 years has actually been much greater for each 10-year age group. From 1950 to 1975 death rates for each age group declined by more than 20 percent. From 1965 to 1975 rates declined by 16 percent for people aged 65-74, by 10 percent for those aged 75-84, and by 25 percent for those 85 years and over. All of the decline in death rates for the oldest group has occurred since 1965.

Death rates have been consistently higher among elderly men than women, and the mortality differential is widening. At the turn of the century the death rate for men 65 years and over was 6 percent higher than that for women (Linder and Grove, 1943). By 1950 the death rate for elderly men was 27 percent higher than that for women. It was 41 percent higher by 1965 and 47 percent higher by 1975.

Life expectancy at age 65 increased more between 1950 and 1975 than during the first 50 years of this century. In 1900 people age 65 could expect to live 11.9 years longer; in 1950 they could expect to live 13.8 years longer. Expectation of life at age 65 increased by 0.8 years from 1950 to 1965 and by an additional 1.4 years from 1965 to 1975. Thus by 1975 a person could look forward to 16.0 more years of life after a 65th birthday.

The gain is not distributed equally; most of it is among women. Between 1965 and 1975 white women age 65 gained 1.8 years and other women 2.0 years. White men gained only 0.8 years and other men 1.1. In 1975 white women age 65 could expect to survive for another 18.1 years and other women for 17.5 years, but men, regardless of color, for only 13.7 more years.

Substantial declines in two of the three leading causes of death, heart disease and cerebrovascular disease, account for most of the decrease in mortality of the elderly (table B). The 1975 death rate for heart disease, the leading cause of death, was 84 percent of the rate 25 years before. The death rate for cerebrovascular disease was 79 percent of the 1950 rate. The decline in the death rate for heart disease alone accounted for 55 percent of the overall decline in mortality among the elderly from 1950 to 1975 and 61 percent of the decline from 1965 to 1975.

In contrast, the death rate for cancer, the second leading cause of death, has increased slowly over the years. In 1975 about 961 in every 100,000 people 65 years and over died from cancer. Ten years earlier the rate had been

Table A. Death rates for persons 65 years and over by sex, color, and age, and expectation of life at age 65 by sex and color: United States, 1950, 1965, and 1975

(Data are based on the National Vital Registration System)

Sex, color, and age	1950	1965	1975
	Deaths per 100,000 population 65 years and over		
Both sexes			
Total, 65 years and over	6,270.3	6,118.3	5,432.4
65-74 years	4,104.3	3,790.3	3,189.2
75-84 years	9,331.1	8,192.7	7,359.2
85 years and over	20,196.9	20,199.7	15,187.9
White, 65 years and over	6,260.1	6,106.8	5,442.7
65-74 years	4,023.1	3,667.1	3,107.2
75-84 years	9,416.5	8,287.0	7,384.0
85 years and over	20,678.6	20,982.5	15,707.5
All other, 65 years and over	6,414.6	6,261.0	5,323.6
65-74 years	5,205.0	5,257.0	3,970.7
75-84 years	8,039.7	7,019.5	7,076.1
85 years and over	14,473.6	12,345.3	10,102.9
Male			
Total, 65 years and over	7,053.3	7,316.1	6,702.7
65-74 years	4,931.4	5,046.4	4,414.5
75-84 years	10,426.0	9,823.2	9,519.4
85 years and over	21,636.0	21,278.9	17,572.6
White, 65 years and over	7,052.3	7,316.2	6,735.3
65-74 years	4,864.9	4,929.5	4,355.8
75-84 years	10,526.3	9,974.6	9,608.1
85 years and over	22,116.3	22,243.4	18,257.9
All other, 65 years and over	7,066.3	7,326.5	6,399.4
65-74 years	5,794.9	6,382.7	4,970.8
75-84 years	9,029.6	8,132.8	8,604.9
85 years and over	16,022.1	13,070.7	11,693.8
Female			
Total, 65 years and over	5,568.7	5,189.8	4,550.9
65-74 years	3,333.2	2,768.9	2,247.0
75-84 years	8,399.6	6,998.5	6,030.4
85 years and over	19,194.7	19,526.4	14,031.4
White, 65 years and over	5,554.9	5,175.4	4,554.6
65-74 years	3,242.8	2,644.3	2,152.8
75-84 years	8,481.5	7,064.7	6,034.7
85 years and over	19,679.5	20,213.2	14,494.1
All other, 65 years and over	5,769.1	5,362.2	4,511.3
65-74 years	4,610.7	4,291.0	3,172.0
75-84 years	7,064.7	6,092.5	5,978.5
85 years and over	13,366.8	11,794.4	9,177.3
	Expectation of life at age 65		
Total	13.8	14.6	16.0
White male	12.8	12.9	13.7
All other male	12.8	12.6	13.7
White female	15.0	16.3	18.1
All other female	14.5	15.5	17.5

SOURCES: National Center for Health Statistics: Vital Statistics of the United States, Vol. II, for data years 1950 and 1965, Washington, U.S. Government Printing Office; and for 1975, Health Resources Administration, DHEW, Rockville, Md., to be published.

Table B. Death rates for the 10 leading causes of death among persons 65 years and over, by 1975 rank order for both sexes, and by sex for 1975: United States, 1950, 1965, and 1975

(Data are based on the National Vital Registration System)

Cause of death and ICDA code		1950	1965	1975		
				Both sexes	Male	Female
		Deaths per 100,000 resident population 65 years and over				
All causes		6,270.3	6,118.3	5,432.4	6,702.7	4,550.9
Diseases of heart	390-398, 402, 404, 410-429	2,860.9	2,823.9	2,403.9	2,933.0	2,036.7
Malignant neoplasms	140-209	856.5	901.4	961.1	1,301.1	725.2
Cerebrovascular diseases	430-438	923.8	901.0	729.7	740.5	722.1
Influenza and pneumonia	470-474, 480-486	191.3	213.7	187.1	239.2	150.9
Arteriosclerosis	440	—	—	123.0	119.8	125.2
Diabetes mellitus	250	121.1	122.9	112.9	102.8	119.9
Accidents	E800-E949	210.8	155.0	109.6	140.6	88.1
Motor vehicle accidents	E810-E823	43.1	38.9	25.3	38.7	16.0
All other accidents	E800-E807, E825-E949	167.7	116.1	84.3	101.9	72.1
Bronchitis, emphysema, and asthma	490-493	—	—	80.5	152.5	30.5
Cirrhosis of liver	571	34.9	34.5	36.6	58.1	21.6
Nephritis and nephrosis	580-584	—	—	23.2	...	...
Suicide	E950-E959	30.0	22.8	...	36.8	...
Hernia and intestinal obstruction	550-553, 560	37.6	35.6	...	...	20.5
All other causes		—	—	664.9	878.4	510.1

NOTE: Cause-of-death titles and numbers are based on the Eighth Revision International Classification of Diseases, Adapted for Use in the United States. Because of decennial revisions in the classification and changes in rules of cause-of-death coding, there is lack of comparability for some causes from one revision to the next. In some instances data are omitted for earlier years because the appropriate subcategories are not available. Data for influenza and pneumonia should not be interpreted for trends since they are influenced by epidemics which cause large fluctuations in data for a single year.

SOURCES: National Center for Health Statistics: Vital Statistics of the United States, Vol. II, for data years 1950 and 1965, Washington, U.S. Government Printing Office; and for 1975, Health Resources Administration, DHEW, Rockville, Md., to be published.

901, and 25 years earlier it had been 857 per 100,000 people 65 years and over.

The death rate for accidents (excluding motor vehicle accidents) deserves mention, if only to point out the remarkable decline; the rate in 1975 was half the rate 25 years earlier. For those 85 years and over the rate was one-third the rate in 1950, about 293 in contrast with 928 deaths per 100,000 people.

Disability

Data on morbidity and disability are unfortunately not available for as many years as mortality data. It is possible to look at trends for only the past 10 years (1965-75), and then only for the noninstitutionalized population. The proportion of the elderly population in institutions increased somewhat over the 10 years, and the health characteristics of those in institutions may not be the same in 1975 as in 1965. Changes in the reason for institutionalizing elderly people would affect comparisons over time of disability and illness in the noninstitutionalized population.

Short-term disability is usually measured by the number of days during the year that people have to modify their usual behavior because of illness. Three measures are commonly used: days of restricted activity, days in bed, and days lost from work. There has been no change in the level of two of these measures over the 10 years. In 1965 the average number of days of restricted activity per year per elderly person was 39; in 1975 it was 38. The average number of days in bed was 14 in 1965 and 13 in 1975.

In contrast, the number of days lost from work by employed elderly decreased considerably over the past 10 years. Employed people 65 years and over lost about 8 days from work per person in 1965 and about 4 days in 1975. The proportion of people 65 years and over in the labor force decreased during that time from 16 to 12 percent (Bureau of Labor Statistics, 1974; Bureau of Labor Statistics, 1976; Census Bureau, 1974). The concurrent decreases could mean that older people in relatively poor health are able to retire earlier as retirement benefits improve while those in better health continue to work.

Long-term disability can be measured by the proportion of people who are limited in amount or kind of usual activity or in mobility because of chronic conditions or impairments. The proportion of elderly people limited in activity appears to have increased very slowly from about 42 percent in 1965 to 47 percent in 1975 but all of the increase is due to the aging of the population; the age-specific rates are unchanged. That is, the larger proportion of the people 65 years and over was limited in activity in 1975 than in 1965 simply because a higher proportion was 75 years and over and thus more likely to be limited.

There was no change in the proportion of the elderly limited in mobility due to chronic conditions for the 2 years for which data are available, 1966 and 1972. In both years limitation of mobility was reported for about 20 percent of the elderly.

It has been suggested that prolonging the lives of older people will produce a dependent, badly impaired elderly population. However, death rates for people 65 years and over certainly declined from 1965 through 1975, but the limited data available do not indicate any increase in disability among noninstitutionalized elderly people. No more definitive evaluation can be made without information on the proportion of the elderly population residing in institutions and their levels of disability (information which is lacking, especially for the early years).

CURRENT MEASURES OF HEALTH

Mortality

The majority of deaths in the United States are deaths of elderly people. Of the 1.9 million people who died in 1975, 1.2 million (64 percent) died after their 65th birthday, 0.8 million (41 percent) after their 75th birthday, and 0.3 million (15 percent) after their 85th birthday.

If the 1975 mortality rates continued to prevail during their lifetimes, three-quarters of the babies born in the United States that year would reach their 65th birthday. Over half (53 percent) would reach their 75th birthday, and a quarter their 85th (table C).

Even though death rates are high among older people, a large proportion survive any 5-year period, at least until age 85. Of the people reaching their 65th birthday, 88 percent can expect to survive to their 70th if mortality rates remain at the 1975 level; 82 percent of those celebrating a 70th birthday can expect to celebrate their 75th.

The chances of surviving until a relatively late age are not the same for everyone. White women, by far, have the best chance. Their mortality rates are relatively low throughout life and remain low. If the 1975 rates were to prevail, over half (52 percent) of the white girl babies born in 1975 would survive until age 80. Three-quarters (78 percent) of the white women reaching their 75th birthday would survive until age 80. Other women also have low mortality rates although higher than white women.

Men have higher mortality rates than women throughout life and a much poorer chance of living to old age. Two-thirds (68 percent) of the boys born in 1975 would survive to age 65 if the 1975 rates prevailed and just over a quarter (28 percent) would reach their 80th birthday. White men have lower death rates than other men at young ages and thus a better chance of reaching age 65. For those who do reach retirement age, however, the chances of living to old age are close to the same.

The leading cause of death among the elderly is heart disease, which is responsible for 44 percent of the deaths of people 65 years and over. Malignant neoplasms account for another 18 percent of the deaths (19 percent for men and 16 percent for women). The third leading cause is cerebrovascular disease, which accounts for 13 percent of the deaths (11 percent for men and 16 percent for women). Together, these three account for 75 percent of all deaths of elderly people.

The fact that these three causes account for

Table C. Percent of all persons reaching specified age and percent surviving 5 years after specified age, by selected ages 65 years and over, sex, and color: United States, 1975

(Data are based on the National Vital Registration System)

Sex and color	Age in years				
	65	70	75	80	85
	Percent of all persons reaching specified age				
Both sexes					
Total	74.6	65.5	53.4	39.0	24.5
White	76.2	67.2	55.1	40.4	25.2
All other	63.0	53.9	40.8	28.8	19.9
Male					
Total	67.5	56.2	42.5	28.0	15.5
White	69.4	57.9	43.9	28.9	15.8
All other	54.3	44.4	31.9	21.0	13.2
Female					
Total	81.7	74.9	64.6	50.4	34.1
White	83.2	76.5	66.5	52.1	35.0
All other	71.5	63.6	50.2	37.4	27.4
	Percent surviving 5 years after specified age				
Both sexes					
Total	87.8	81.5	73.0	62.9	—
White	88.1	82.1	73.2	62.4	—
All other	85.6	75.7	70.7	69.0	—
Male					
Total	83.3	75.5	65.8	55.4	—
White	83.4	75.9	65.8	54.7	—
All other	81.6	71.8	65.9	63.0	—
Female					
Total	91.7	86.2	78.1	67.6	—
White	92.0	86.8	78.4	67.2	—
All other	89.0	78.9	74.5	73.2	—

SOURCE: National Center for Health Statistics: Vital Statistics of the United States, Vol. II, 1975. Health Resources Administration, DHEW, Rockville, Md., to be published.

so many of the deaths of the elderly is not surprising. They also accounted for 53 percent of the deaths of people under 65 years in the United States in 1975. In childhood and early adulthood external events (accidents, suicides, and homicides) cause most of the deaths, with malignant neoplasms second. By ages 35-44 heart disease replaces malignant neoplasms as the second cause, and by ages 45-54 heart disease ranks first with malignant neoplasms second. They account for 32 and 28 percent of the deaths, respectively, while accidents account for only 12 percent. By ages 55-64 heart disease accounts for 38 percent of all deaths, malignant neoplasms for 29 percent, and cerebrovascular diseases for 6 percent. The high proportion of the deaths of elderly people due to these three causes is a continuation of trends begun much earlier.

Influenza and pneumonia, the fourth leading cause, account for 3 percent of the deaths of elderly men and women. For men, the fifth leading cause is a cluster of conditions grouped under bronchitis, emphysema, and asthma; accidents rank sixth. Arteriosclerosis is fifth for women, while diabetes is sixth.

Most of the deaths of elderly people result from disease conditions which have existed for many years or from personal habits or environmental conditions which may go back many years. Although good medical care for the elderly can delay death (and ameliorate suffering), preventing such deaths must start early in life.

A small proportion of the deaths, such as those from accidents, may be prevented at any age regardless of early life history by modifying living conditions and assuring prompt medical care if an accident occurs.

Chronic Conditions

At the beginning of 1974, 4 percent of the elderly people were in nursing homes. They were, on the average, older than elderly people living in the community; 83 percent were 75 years and over in contrast with 36 percent of the noninstitutionalized elderly.

In general, these elderly residents of nursing homes suffered from multiple chronic conditions and functional impairments. Almost two-thirds (63 percent) were senile, 36 percent had heart trouble, and 14 percent had diabetes. Orthopedic problems due to a variety of disease conditions were common. About a third (31 percent) were bedfast or chairfast and about a third (35 percent) were incontinent. Almost half (49 percent) of the elderly in nursing homes could not see well enough to read an ordinary newspaper regardless of whether they wore glasses; one-third (35 percent) could not hear a conversation on an ordinary telephone; and one-fourth (24 percent) had impaired speech.

The most common primary diagnoses were hardening of the arteries, senility, stroke, and mental disorders, all diagnoses likely to give rise to functional impairments.

Other elderly people are in psychiatric or other chronic disease hospitals, Veterans Administration hospitals, and other long-term care facilities. Data are not available on the prevalence of all the chronic conditions or impairments afflicting residents of these facilities, but it is reasonable to assume that they too have multiple chronic conditions and impairments.

The prevalence of chronic conditions among the elderly living in the community is higher than among younger people but far lower than among people in nursing homes. Some of the most frequently reported chronic conditions and impairments for elderly people living in the community are arthritis, vision and hearing impairments, heart conditions, and hypertension. The reported prevalence rate for each of these is 20 percent or higher; 38 percent have arthritis. Some of the people have more than one condition although multiple conditions are less common among community residents than among nursing home residents. Prevalence rates for all of these conditions are higher in nonmetropolitan than in metropolitan areas and higher in the South than in other regions.

Elderly women, who are on the average older than elderly men, have higher rates than men for arthritis, diabetes, hypertension, back impairments, and vision impairments. Men have higher rates of asthma and chronic bronchitis, hernias, ulcers, and hearing impairments.

A high prevalence of chronic conditions, however, does not necessarily mean a high prevalence of disabling conditions. The impact of chronic conditions varies markedly. For example, approximately equal numbers of elderly people were reported to have heart conditions and hypertensive disease without heart involvement. Yet 4 times as many people were limited in activity, 8 times as many had been hospitalized, and 9 times as many had more than 2 weeks of bed disability during the year because of heart conditions than because of hypertensive disease without heart involvement.

Loss of sensory ability frequently accompanies aging. It is well known that many elderly people have lost some of their ability to see or hear. About 92 percent of the elderly people living in the community wear glasses, and 5 percent wear hearing aids (Dickson, 1976). Much less widely known is that taste, smell, and adaptation to darkness also are altered by age (Busse, 1977). Complaints from older people that all food tastes bitter or sour may be due not to imagination but to physical loss of the ability to taste and smell. Thus older people may not enjoy food and may not fulfill their nutritional requirements. Loss of ability to adapt to light changes may lead to accidents.

Only 14 percent of the noninstitutionalized people 65 years and over have no chronic disease that they are aware of. However, some of them may have conditions that they do not know about. Laboratory findings have indicated significant pathology for many elderly people who were not aware that they had diabetes, hypertensive heart disease, or coronary heart disease (Lawrence, 1973).

Thus the prevalence of some chronic diseases must be higher than the estimates given here.

Prevalence estimates for other conditions such as rheumatoid arthritis and for many impairments appear to be reasonably accurate.

Long-Term Disability

The presence of a chronic condition is often not as important to people as the inability to carry out their usual activities. It is only when a condition causes interference with or restriction of activities that people feel impaired. In that context, people were asked whether they were limited in activity, that is, limited in ability to work or keep house because of a chronic condition. About 47 percent of the noninstitutionalized elderly people in 1975 were limited in activity due to chronic conditions. Six percent were limited but not in their major activity, 23 percent were limited in the amount or kind of major activity, and 17 percent were unable to carry on their major activity.

The proportions of elderly people with activity limitation differed with a number of demographic variables. Age was most important; only 42 percent of people aged 65-74 were limited, in contrast with 56 percent of those 75 years and over. Women were less likely to be limited than men (44 percent and 50 percent, respectively). Activity limitation was less common among elderly whites (46 percent) than among all other elderly people (55 percent). Limitation was reported less frequently as income or years of education increased. Those living alone or with their spouses were less likely to be limited (45 percent) than those living with nonrelatives or relatives other than their spouses (54 percent). Elderly people in the Northeast Region or in urban counties were less likely to be limited than those in the South Region or in less urbanized counties.

Two chronic conditions caused almost half the limitation. About 24 percent of the elderly who were limited in activity in 1974 were restricted by heart disease, and another 23 percent were limited by arthritis or rheumatism.

Other conditions reported as causing limitation of activity in the elderly population were orthopedic impairments (10 percent of those limited), visual impairments (10 percent), and hypertension (9 percent). Emphysema was reported as a cause for 8 percent of the men limited in activity but for only 2 percent of the women. The fact that over twice as many men 65 years and over as women of that age were current or former cigarette smokers may account for part of this difference.

A more rigorous measure of the impact of chronic conditions is whether the person is limited in mobility (i.e., the ability to move about freely). In 1972 about one-fifth (18 percent) of the elderly had some degree of mobility limitation due to chronic conditions or impairments. Five percent were confined to the house, 7 percent needed help in getting around, and 6 percent could get around alone but had trouble. If one assumes that residents of nursing homes are also limited in mobility, then 22 percent of the total elderly population were to some degree limited in mobility, and 16 percent were unable to get around alone.

Short-Term Disability

Elderly people, whether or not they were limited in activity or mobility by chronic conditions, were forced to restrict their usual activities an average of 5½ weeks per person in 1975. Approximately two-thirds of the days of restricted activity were accounted for by chronic conditions and one-third by acute illnesses or injuries.

Older people, like younger ones, have colds, flu, and other illnesses of short duration. They also suffer accidental injuries which, while not indicators of health *per se*, do cause short-term restriction of activity and require medical care. Injuries also may cause permanent limitation of activity or mobility and are one of the leading causes of death.

Accidential injuries were responsible for 101 million days of restricted activity, including 25 million days in bed, for elderly people living in the community in 1975. Older women were particularly susceptible. They had, on the average, almost twice as many injuries as men. People 75 years and over were more likely to suffer such injuries (0.26 per person per year) than those aged 65-74 (0.18 per person per year). About 40 percent of all injuries to the elderly were the result of falls and about two-thirds (68 percent) of all injuries occurred at home; 80 percent of the injuries to people 75 years and over were at home.

Self-Assessment of Health

Good health for people of any age does not necessarily imply the complete absence of impairments or disease conditions, but only that the conditions present do not significantly interfere with physical and social functioning. Illness is a social as well as a physical phenomenon, and the existence of a morbid condition does not predetermine a universal pattern of behavior. The individual's self-assessment of health may be as important as his actual medical status in predicting general emotional state and behavior (Maddox and Douglass, 1973).

The high prevalence of chronic conditions and impairments and the high levels of limitation of activity and mobility may give the impression that most elderly people view themselves as being in poor health and unable to function. Instead, the majority assess themselves as being in good health compared to other people their own age.

Two-thirds (69 percent) of the elderly noninstitutionalized people rated their health as good or excellent in 1975; poor health was reported for only 9 percent (table D). Poor health was somewhat more common among men than women and among those 75 years and over than among those aged 65-74 but the differences were not significant. However, the proportion assessing their health as poor was twice as large among elderly members of minority groups (16 percent) as among the elderly whites (8 percent). Poor health was reported more frequently

Table D. Percent distribution of assessment of health status as reported in health interviews for persons 65 years and over, according to selected demographic characteristics: United States, 1975

(Data are based on household interviews of the civilian noninstitutionalized population)

Demographic characteristic	Health status				
	All health statuses[1]	Excellent	Good	Fair	Poor
	Percent distribution				
Total	100.0	28.6	40.3	21.5	8.6
Sex and age					
Male	100.0	28.1	40.0	21.4	9.4
65-74 years	100.0	28.5	39.8	21.5	9.3
75 years and over	100.0	27.5	40.3	21.3	9.8
Female	100.0	28.9	40.6	21.6	8.0
65-74 years	100.0	29.2	41.4	21.5	7.2
75 years and over	100.0	28.6	39.3	21.8	9.4
Color					
White	100.0	29.4	40.8	21.0	7.8
All other	100.0	20.6	35.5	26.7	16.3
Region					
Northeast	100.0	27.3	44.4	21.2	6.2
North Central	100.0	27.1	43.2	21.6	7.1
South	100.0	27.6	35.4	23.5	12.4
West	100.0	35.3	38.4	18.0	7.5
Residence					
Metropolitan	100.0	30.6	40.5	20.1	7.8
Nonmetropolitan	100.0	24.4	40.0	24.7	10.3
Family income[2]					
Less than $5,000	100.0	23.3	38.7	24.9	12.2
$5,000-$9,999	100.0	29.8	41.3	21.4	6.8
$10,000-$14,999	100.0	31.6	42.7	19.9	5.1
$15,000 or more	100.0	38.7	40.3	13.9	5.8

[1] Includes unknown health status.

[2] Excludes unknown family income.

SOURCE: Division of Health Interview Statistics, National Center for Health Statistics.

among elderly residents of nonmetropolitan areas than among those in the cities, and the proportion of the elderly with reported poor health increased as income diminished.

Self-assessment of health status by elderly people has been found to correspond with the results of medical examinations in about 70 percent of the cases (Maddox, 1964). Self-addressed health status also has been found to correlate highly with other measures of health status and utilization of health services. People who rate their health as poorer than others their age are more likely to suffer from activity-limiting chronic conditions and comparatively frequent acute conditions or disability days than those who rate their health as good or excellent. They also utilize more medical services (Kovar and Wilson, 1975).

Ninety percent of elderly people reported to be in poor health were limited in their major activity, in contrast to 15 percent of those in excellent health. People in poor health had twice as many acute conditions per person, 14 times as many days of restricted activity, and 27 times as many days in bed per person as those reporting excellent health.

UTILIZATION OF MEDICAL SERVICES

Levels of Health and Use of Medical Services

The relationship between morbidity or level of health and the utilization of medical services is complex. The presence of an impairment, a chronic condition, a limitation, or a self-assessment of poor health does not necessarily indicate a need for medical care. Medical care may not be able to change the situation. On the other hand, improvement may be possible but the individual, believing that nothing can be done, may fail to seek medical care.

In general, elderly people with chronic conditions are more likely to utilize medical services than those without; however, wide variations exist in the amount of medical care utilized for specific chronic conditions. For example, only two-fifths (43 percent) of the elderly reported to have arthritis had seen a doctor about this condition within a year. In contrast, four-fifths (81-82 percent) of those reported to have diabetes, a heart condition, or hypertensive disease without heart involvement had seen a doctor about the condition within a year.

The perception of poor health is also related to utilization of medical services. In 1975 noninstitutionalized elderly people in reported poor health were more than 3 times as likely to have been hospitalized during the preceding year as those in excellent health. They were 5 times as likely to have had 10 or more physician visits during the year. At the other end of the scale, 28 percent of those in excellent health did not visit a physician at all during the year, in contrast with 6 percent of those in poor health.

In 1974 less than half (46 percent) of the people 65 years and over were reported to have any degree of activity limitation due to chronic conditions. Yet this 46 percent of the elderly accounted for 63 percent of all physician visits, 72 percent of all short-stay hospital episodes, and 78 percent of all days in short-stay hospitals utilized by elderly people.

Similarly, Medicare data reveal that enrollees who are limited utilize more services than those who are not. Enrollees who were confined to bed had 79 physician services per person in 1973, while those with no limitation had 25. Enrollees who perceived their health as "worse than others" had 58 services, while those who perceived their health as "better than others" had 20. Only 7 percent of the enrollees were confined to bed or house, yet they utilized 14 percent of the physician services. Only 12 percent of the enrollees had health "worse than others," yet they utilized 22 percent of the services (Coulter, 1976).

With rising costs of medical care and concern about the possibility of overutilization, it is essential to recognize that medical services are being utilized to a greater extent by people in poor health than by those in relatively good health and that even people in good health require preventive care and care for acute illnesses. It is also important to remember that many elderly people have one or more chronic conditions and as a group utilize medical services at a higher rate than younger adults.

Elderly people in poor health were less likely to have seen a dentist, however, than those in good health. Forty-four percent of those in excellent health but only 32 percent of those in poor health had seen a dentist during the previous 2 years. Dental services are usually more discretionary than medical services. Thus the higher utilization by those in excellent health may be associated with greater ability to pay for the care, greater mobility, or higher motivation to maintain their good health.

Trends

Despite the implementation of Medicare, there was no increase in the rate of utilization of physicians by older people from 1965 through 1975. The average number of physician contacts by persons 65 years and over living in the community (excluding contacts while a patient in a hospital) remained at approximately 6.6 visits per person during the 10 years. Medicare data confirm this. The percentage of Medicare enrollees using services covered by supplementary medical insurance and the average number of services per person showed no consistent increase from 1968 through 1974 (Gornick, 1976).

The lack of change for the entire elderly population hides shifts which appear to have taken place within the population. The number of physician contacts per person per year increased for the elderly poor and decreased for the nonpoor. (The poor are defined as persons with family income of under $3,000 in 1963 or under $6,000 in 1974.) The proportion who had not seen a physician for 2 years or more decreased for both groups (Wilson and White, 1977). Thus differences in the rate of physician utilization by the poor and the nonpoor elderly have been narrowed or eliminated with programs designed to reduce financial barriers to medical care.

The proportion of elderly people with no dental visits within 2 years also decreased a bit, especially among the nonpoor, and the number of visits increased somewhat from 0.8 to 1.2 visits per person per year. No change occurred in the general pattern of the elderly poor receiving less dental care than the nonpoor. Unlike medical care, dental care is seldom financed by public programs or private health insurance. Comparatively few programs have been designed to remove the financial barriers to dental care.

Utilization of short-stay hospitals by the elderly increased in the 10 years from 1965 to 1975 even though utilization by people under 65 years remained relatively constant and even declined in some age groups. In 1965 there were 264 discharges from short-stay hospitals for every 1,000 noninstitutionalized elderly people; in 1975 there were 359 discharges, an increase of 36 percent. In 1965 there were 3,447 days of care in short-stay hospitals per 1,000 elderly people; in 1975 there were 4,166 days, an increase of 21 percent. During the 10 years the average length of stay declined from 13.1 to 11.6 days per discharge. Thus the discharge rate increased more than the rate for days of care. Elderly people were more likely to be hospitalized in 1975 than 10 years earlier, but once in the hospital they did not stay as long.

The great increase in hospital utilization was during the year that Medicare was implemented. It is estimated that between the year before Medicare and the first year of Medicare, the hospital discharge rate increased by 4.6-7.4 percent, average length of stay by 4.1-7.8 percent, and days of care per 1,000 elderly people by 8.9-16.0 percent (Pettengill, 1972). Since then, the increase in the discharge rate and the decrease in the average length of stay have tended to cancel one another so that the number of days of care per 1,000 elderly people has not increased substantially.

The increase in short-stay utilization was greater among the elderly poor than the nonpoor. From 1964 to 1975 discharge rates increased by 47 percent for the poor and by 18 percent for the nonpoor elderly (Wilson and White, 1977). Financial barriers appear to have been lifted for poor people who were unable to pay for inpatient hospital care before public programs were implemented.

The rate of surgery in hospitals also increased. In 1965 there were 7,554 operations for every 100,000 people 65 years and over; in 1975 there were 15,482 operations, an increase of 105 percent. Cataract surgery more than doubled, from 525 to 1,115 operations per 100,000 elderly people. Arthroplasty increased from 49 to 145 operations per 100,000 elderly people.

Change in the use of other technical innovations for treatment of the elderly in hospitals is not as well documented as change in surgery rates. Presumably, however, the new procedures, techniques, and facilities introduced in hospitals over the 10 years are being used to treat elderly people as well as younger ones.

Changes in utilization of long-term care are much more difficult to document than trends in either ambulatory physician care or short-stay hospital care. The ongoing household surveys do not include residents of institutions. As a result, good estimates of the total number of elderly residents, the number in each kind of facility, and descriptions of the health characteristics of residents are not available over time.

Chronic disease hospitals, old people's homes, Veterans Administration hospitals, nursing homes, State and county mental hospitals, and private hospitals all provide long-term care of one kind or another. Whether the proportion of elderly people in these facilities has changed over the years is not known with any degree of certainty. There have not been State or national reporting systems which collect uniform data from all of these facilities, some of which are not even licensed as medical care facilities. Among the medical facilities which do report, methods of counting residents, patient days, and lengths of stay vary, and age is frequently not reported at all. The mechanisms to collect data, which should have been implemented 15 years ago if we were to have answers to today's questions, were not developed. As a result, the only trend data are those from the decennial censuses.

According to the 1960 census, about 4 percent of people 65 years and over resided in institutions; according to the 1970 census, 5 percent lived in such facilities. The definitions of facilities used in the two censuses may not be comparable, and facilities may have changed names over the period without changing in any other way. However, data from the two censuses make it clear that there were shifts in the type of institutions housing elderly people during that decade. In 1960, 29 percent of elderly residents of institutions were in mental hospitals and 63 percent were in homes for the aged and dependent. In 1970 the comparable figures were 12 percent and 83 percent, respectively.

Data which substantiate this shift from mental hospitals to nursing homes are available for State and county mental hospitals over a 20-year period and for nursing homes at three recent points in time. The number of elderly residents of State and county mental hospitals decreased from 773 per 100,000 people 65 years and over in 1965 (National Institute of Mental Health, 1975) to 242 in 1975 (National Institute of Mental Health, 1977). The number of elderly residents of nursing homes increased from 2,535 per 100,000 in 1964 to 4,454 per 100,000 at the beginning of 1974.

Part of the decline in the resident population of State and county mental hospitals is due to new methods of treatment, especially the introduction of psychotropic drugs, which freed people from the back wards. Part of the decline is due to the transfer of elderly people to nursing homes. In 1969, 37.7 percent of the 37,062 elderly patients released from State and county mental hospitals (29.1 percent of the men and 48.7 percent of the women) were released to nursing homes or homes for the aged. At the beginning of 1974, 5.5 percent of the elderly people then residents of nursing homes had been in a mental or other specialty hospital immediately before entering their current nursing home. The data are fragmentary but it is clear that some elderly people were transferred from one kind of facility to another. It is also likely that a proportion of the people in nursing homes would have been placed in mental hospitals if nursing homes had not been available.

CURRENT MEASURES OF UTILIZATION OF MEDICAL SERVICES

Ambulatory Care

In 1975 noninstitutionalized elderly people had a physician contact (other than visits to hospital inpatients) on an average of 6.6 times a year, in contrast to an average of 5.6 times for persons aged 45-64. About 79 percent had had a physician contact within the preceding year and 69 percent within 6 months. About 7 percent reportedly had not seen a physician for 5 years or more.

People 75 years and over were more likely to have had at least one physician contact within the year than those aged 65-74. However, people in both groups had the same number of visits per person per year. Women were more likely than men to have had a physician contact and they had more contacts during the year than men of the same age.

The proportion of elderly people who had at least one physician contact during the year was high regardless of degree of urbanization. However, elderly residents of urban areas had, on the average, more contacts per year than residents of counties which are thinly populated or have at most a small town. For each age group and sex, residents of metropolitan counties had more physician contacts per person in 1975 than residents of counties with only a small town.

Elderly people in thinly populated counties made as many visits per person per year to a doctor's office as those in metropolitan counties. The higher number of contacts in metropolitan counties was entirely due to contacts outside a physician's office. Telephone calls, home visits, and visits to emergency rooms, clinics, and group practices accounted for 26 percent of physician contacts in metropolitan counties, in contrast to 17 percent in counties with at most one small town. Nine percent of contacts elderly people in metropolitan counties had with physicians were by phone in contrast with only 5 percent for elderly people in lightly populated counties.

When physicians in office-based practice themselves reported on visits of the elderly in 1975, it was apparent that these office visits were mostly for ongoing care; 92 percent of the visits were for patients who had been seen before. Almost half (46 percent) of the visits were for routine care of a chronic condition; another 16 percent were for flareups of chronic conditions. Almost three-quarters (70 percent) of the patients were given a definite return appointment. Very few visits resulted in referral to another physician or admission to a hospital. Thus the bulk of ambulatory care for the elderly was for followup and continuing care.

Forty-six percent of the visits were to physicians in general or family practice, and another 19 percent were to internists. One-quarter (26 percent) of the visits, regardless of the physician's specialty, were for diseases of the circulatory system. About 9 percent were for musculoskeletal conditions, and 9 percent for diseases of the nervous system and sense organs. The rest were for a wide variety of other diagnoses.

Dental Care

Dental care is an aspect on the health care of older people which is frequently overlooked. To many people dental care is something which can be postponed. It is not regarded as a necessity.

The elderly are less likely than younger adults to visit a dentist. In 1975 only 30 percent of people 65 years and over living in the community had visited a dentist within a year (about 35 percent of those aged 65-74 and 23 percent of those 75 years and over).

Unlike the proportion of the elderly visiting a physician, which by 1975 displayed little relationship with either family income or place of residence, the proportion seeing a dentist within a year was strongly correlated with both. In 1975 only 20 percent of the elderly with annual family incomes under $5,000 had visited a dentist within the year in contrast with 50 percent of those with incomes of $15,000 or more. Approximately 22 percent of elderly residents of thinly populated counties or those with only small towns had visited a dentist within the year in contrast with 30 percent of residents of metropolitan counties.

This lack of dental care is serious. Half of the elderly have no natural teeth. In 1971 about 6 percent of the edentulous elderly had no false teeth, 4 percent had an incomplete set, and 14 percent had a set but did not use it all the time. Even among those with false teeth who used them all the time, 28 percent reported that their dentures needed refitting or replacement. Thus 44 percent of the edentulous elderly had an obvious need of dental care in order to have properly fitting, useful dentures.

In 1960-62 a sizable proportion of persons aged 65-79 who were not edentulous (59 percent of the men and 36 percent of the women) had destructive periodontal disease and they had an average of 18.0 teeth missing. Dental services could improve the ability of the elderly to socialize as well as improve their nutritional levels by making it possible for them to eat a wider variety of foods.

Care in Short-Stay Hospitals

There were more than 4,000 days in non-Federal short-stay hospitals in 1975 for every

1,000 people 65 years and over. On the average, people 75 years and over were more likely to be hospitalized and to remain in the hospital longer than those aged 65-74. Men were more likely than women to be hospitalized and had more days of hospital care per person despite their somewhat shorter stays per hospitalization.

During the working years, men are less likely to be in the hospital than women, even when hospitalization for pregnancy and childbirth is excluded. Only early and late in life are males more likely to be in the hospital. No reason is immediately apparent for the relatively greater hospitalization of men beginning around age 55 and continuing through the older years. It is not due to higher death rates, as death rates are higher for men at every age. It does not appear to be due to increased medical contacts, as men make fewer physician visits than women at every age. And it does not appear to be due to delaying hospital care until after retirement, as the hospitalization rate for men is still higher 10 years after the usual retirement age.

However, the death rates for heart disease are 44 percent higher and for malignant neoplasms 79 percent higher among men than among women. Almost everyone dying of cancer and the majority of people dying of heart disease are hospitalized at some time during the last year of life; many people dying of cancer have multiple hospitalizations. Thus the higher hospitalization rate of older men may be due to their higher likelihood of having diseases for which the standard treatment is in hospitals.

Heart disease accounted for a fifth (18 percent) of the days that elderly people spent in the hospital. Chronic ischemic heart disease and acute myocardial infarction together accounted for 12 percent (485 days per 1,000 people 65 years and over).

Malignant neoplasms, the second leading cause of death, were responsible for 12 percent of the hospital days. Cerebrovascular disease, the third leading cause, accounted for an additional 7 percent (275 days per 1,000 elderly population). Both of these diagnoses accounted for a far larger proportion of the hospital care of the elderly than of their ambulatory care. Other diagnoses responsible for sizable amounts of hospital care of the elderly were diseases of the digestive system (510 days), accidental injuries (406 days), and diseases of the respiratory system (388 days per 1,000 persons 65 years and over).

The ranges of diagnoses, lengths of stay associated with them, and types of care were wide. Some hospital episodes were for cataract surgery and repair of fractures, procedures which may enable elderly people to return to active lives. Some were for illnesses which may strike at any age and from which people usually recover. Pneumonia and acute myocardial infarctions, for example, are serious but not necessarily fatal diseases among people 65 years and over. Conditions which may eventually be fatal accounted for another part of care, but this care might give the person a longer life. Such care may be very expensive regardless of the patient's age. Malignant neoplasms, for example, may be treated with surgery, radioactive or drug therapy, or other methods which often require multiple hospital episodes. Some of the hospital care was for terminal illnesses. The amount of hospital care is great in the last few months of life.

Discharge rates, average lengths of stay, and rates of days of care all vary enormously from region to region and State to State. They even vary from hospital to hospital and among areas within a State (Office of Research and Statistics, 1977). Some of the variation among hospitals and even some of the variation among small geographic areas is due to the patient mix. Hospitals with highly sophisticated technology or a staff specializing in certain kinds of care may draw seriously ill patients from outside the local area, while hospitals with lower levels of technology and less specialized staff may furnish care primarily to people within their own area. Variation among larger areas will be relatively uninfluenced by patient mix.

In an analysis of Medicare data from 1967 and 1973, the variation among the 4 geographic regions of the United States was striking and was the same in both 1967 and 1973. In both years discharge rates were lowest in the Northeast, but the average length of stay and the number of days of care per 1,000 enrollees were lowest in the West. In both years discharge rates were highest in the South, average length of stay longest in the Northeast, and rate of days of care highest in the North Central Region (Gornick, 1976). In 1973, for example, the number of days of care per 1,000 enrollees was 36 percent higher in the North Central Region than in the

West. There is no reason to believe that elderly people in the North Central Region are sicker and require more hospital care than elderly people in the West. In fact, mortality rates are relatively low in the North Central Region and have been for years. The persistent regional differences are due to patterns of providing care rather than biological needs for care. The North Central Region, for example, has a relatively high ratio of hospital beds to population and a relatively low ratio of physicians to population.

Although there is considerable variation among the States within each region, States within a region are more like one another than like States in other regions. For example, in 1974 the average length of stay in the Northeast Region ranged from 10.4 days in Maine to 15.1 days in New York. In the West, the range was from 7.6 days in Washington to 10.1 days in Arizona. There was no overlap. In the South Region patients in States in the South Atlantic Division tended to have stays longer than the regional average, similar to those in the Northeast, while those in the West South Central Division tended to have shorter stays, similar to those in the West (Office of Research and Statistics).

In summary, there is a great deal of variability in the probability of an elderly individual being hospitalized, in the amount of hospitalization, and in the treatment provided. Some of this variation is explainable by the characteristics of the individual. For example, people 75 years and over are more likely to be sick and to be hospitalized than those aged 65-74; people with cancer or heart disease are more likely to be hospitalized than those with arthritis or hypertension. This variation is to be expected.

Some of the variation, as demonstrated by the data on regional and State differences, appears to be related to patterns of medical practice and is therefore amenable to change especially since inpatient care is not always the best method of treatment. Some heart attack victims are better off at home. If the customary method of treatment in an area is 3 weeks of hospitalization, utilization rates will be high, cost of care will be high, and the patient may not benefit at all.

Reducing the amount of hospitalization where it can be done without harming the patient is critical if the cost of medical care is to be controlled. Hospital care is the largest component (45 percent) of the total amount spent for health care of the elderly.

Long-Term Care

Although the total number of elderly people in long-term institutions providing health care is unknown, there is reason to believe that the majority are in nursing homes. These are homes in which nursing care is the predominant function of the facility and excludes places which only provide living quarters and meals. Although nursing homes may accept patients of all ages, they are overwhelmingly providing care to the elderly; 89 percent of the residents at the beginning of 1974 were 65 years and over.

In 1973 there were 14,873 nursing care homes in the United States. These homes had 1,107,358 beds, or 52 beds for every 1,000 persons 65 years and over. They were relatively small; 41 percent had fewer than 50 beds, 76 percent had fewer than 100 beds. Three-quarters were proprietary homes.

At the beginning of 1974 about 961,500 people 65 years and over were in nursing homes or 44 residents for every 1,000 people 65 years and over. There were approximately 16,000 days of care per year in nursing homes for every 1,000 persons 65 years and over (4 times the number of days spent in short-stay hospitals). Utilization rates for nursing homes increased rapidly with age. There were only 12 residents of nursing homes for every 1,000 persons aged 65-74. At ages 75-84 there were 59 residents per 1,000 persons. Among people who had had their 85th birthday, 237 per 1,000 (almost a quarter) were in nursing homes. There were 86,400 days of care per year in nursing homes for every 1,000 people 85 years and over in 1973.

Almost three-quarters of the elderly nursing home residents (72 percent) were women. Elderly women are far more likely than elderly men to be living alone. Therefore, when they become seriously ill, they are less likely to have someone living with them who can care for them. Thus, of necessity, they may become residents of nursing homes.

Men aged 65-74 were almost as likely as women of the same age to be in nursing homes. By ages 75-84 there were 41 residents for every 1,000 men but 70 residents for every 1,000 women. From age 85 on, 170 out of every 1,000 men but 270 out of every 1,000 women were in nursing homes.

The best data on geographic variation in utilization come from the nursing care homes themselves. Age of the residents is not reported. Therefore, the number of residents per 1,000 persons 65 years and over is overestimated to the extent that people under 65 years are residents of nursing homes. The overestimate for the United States is about 3 residents per 1,000; there were 47 residents of nursing care homes per 1,000 persons 65 years and over according to facility reporting and 44 residents per 1,000 persons according to the survey data which were the basis for the previous discussion. If practices in individual States are such that higher or lower proportions of the residents are under 65 years, data for the States are not comparable.

However, lack of data comparability certainly does not account for all of the differences among regions and States. In 1973 there were 62 residents of nursing care homes per 1,000 persons in the North Central Region, 59 in the West, and 45 in the Northeast and the South. There were 82 residents of nursing care homes per 1,000 persons 65 years and over in Minnesota; at the other extreme, there were 16 per 1,000 in West Virginia. In 13 States there were at least 60 residents per 1,000 elderly people; in 8 States there were fewer than 30.

The consistent regional patterns found in utilization of short-stay hospitals do not exist for nursing home utilization. There is more variation within regions than among them. This is due, at least in part, to differences in State regulations. Even within a region, there is little uniformity among States in terminology, definitions, or licensure requirements. There is also little uniformity in the administration and eligibility requirements of Medicaid, which is the means of paying for a sizable portion of the care of elderly people in nursing homes.

Alternatives to Current Utilization of Medical Services

Home health programs offer one alternative to long-term institutionalization. At present, however, there are no good national estimates of the number of elderly people served by these programs nor of the number who could benefit if more programs were in operation. Certainly many residents of nursing homes need to be where care is available 24 hours a day. Others, however, could live outside the institution if they did not have to live alone or if professional help were provided regularly. Unknown numbers of the elderly now living alone could live more comfortably if they had home health care, and the lives of those living with relatives, as well as the lives of the relatives, could be eased were such care readily available.

Home health services also could help shorten the length of stay of some elderly people in hospitals. Day care services are another alternative to inpatient care for some elderly people.

Retirement, widowhood, and increasing inability to care for oneself without help are all stress-producing situations, yet admission rates to both inpatient and outpatient psychiatric facilities are lower in the age group 65 years and over than in any other group of adults. It is not known whether the elderly do not seek help or are unable to get it. It is known that admission rates to psychiatric facilities are low for the elderly, and half of the episodes reported for them are still in State or county mental hospitals. Only 4 percent of the new patients in community mental health centers in 1975 were people 65 years and over (NIMH, 1977). Easily available outpatient facilities that did not carry a stigma in the eyes of elderly people who grew up in an age when psychiatric help was less acceptable than it is now might reduce the amount of care in inpatient facilities. Such facilities might also make the lives of the elderly, and the lives of the people with whom they live, more comfortable.

EXPENDITURES FOR MEDICAL CARE

Trends

Over the decade covered by fiscal years (FY) 1966-76, years ending 6 months after the calendar years 1965-75, there have been major changes in expenditures for the medical care of elderly people. First, the amount spent has increased much more for elderly people than for younger ones. From FY 1966 to 1976, the average annual rate of increase in per capita expenditures for health care was 13 percent per year for people 65 years and over and 11 percent for people under 65. Second, the source of funds to pay for health care of the elderly changed dramatically. In FY 1966 only 30 percent of the funds were public; 10 years later 68 percent of the money came from public funds. In contrast, public funds still paid for only 29 percent of the medical care of people under 65 years in FY 1976. Third, a larger portion of the money went for inpatient care in FY 1976 than 10 years earlier. In FY 1966, 40 percent of the money went to hospitals and 15 percent to nursing homes, with these two types of facilities receiving 55 percent of all payments. By FY 1976 hospitals were receiving 45 percent and nursing homes 23 percent for a total of 68 percent of all money spent on health care of elderly people. People under 65 years seldom receive care in nursing homes, but the portion of the total bill for their care which was received by hospitals increased from 39 to 46 percent.

Over the decade the total amount spent on medical care for the elderly rose at an average annual rate of 15.5 percent from $8.2 billion in FY 1966 to $34.9 billion in FY 1976. The amount of money spent in FY 1976 was 4.2 times the amount 10 years earlier. About 50 percent of the increase was due to increases in the price of medical care, 36 percent to increases in services, and 14 percent to population increases.

At the beginning of Medicare, medical care expenditures for people 65 years and over rose rapidly, increasing by 16 percent from FY 1966 to 1967, 24 percent from FY 1967 to 1968, and 18 percent from FY 1968 to 1969. Expenditures continued to increase at 12-14 percent per year until the implementation of the Economic Stabilization Program in August 1971 slowed the rate of increase. In FY 1974, during 10 months of which prices were still controlled, the amount spent on medical care for the elderly increased by only 8 percent from the amount spent the previous year. Then, when price controls were removed and administrative procedures changed, medical care expenditures for the elderly increased by 23 percent from FY 1974 to 1975. From FY 1975 to 1976 the rate of increase again slowed to 17 percent.

Part of the increase in expenditures is due, of course, to the increasing number of elderly people; the rate of increase in per capita expenditures is always less than in aggregate expenditures. Still, per capita expenditures increased at an average annual rate of 13 percent over the decade, from $445.25 in FY 1966 to $1,521.36 in FY 1976 (table E). From FY 1974 to 1975 the per capita amount increased by 20 percent and from FY 1975 to 1976 by 14 percent.

Twice during the decade there has been a sudden and rapid increase in the amount spent on medical care for the elderly. The increase early in Medicare program operations was primarily due to increases in utilization as Medicare reduced the financial barriers to obtaining care. For example, the number of days of care in hospitals per elderly person probably increased between 9 and 16 percent in a single year. The price of medical care also rose, led by the increase in the cost of hospital care. From FY 1967 to 1968 the Consumer Price Index (CPI) for medical care services increased by 8 percent while the price of a semiprivate room in a hospital increased by 16 percent.

The recent increases in expenditures have been mainly due to price increases. The CPI for medical care services increased by 13.3 percent from FY 1974 to 1975 and by 10.6 percent from FY 1975 to 1976. The price of a semiprivate room in a hospital increased by 16.4 percent and then by another 15.2 percent. The CPI for hospital service charges, which was set at 100 in January 1972 when it was introduced, was at 147.1 at the end of FY 1976.

The amount spent on inpatient care accounted for most of the recent increase in expenditures for medical care of the elderly just as it accounted for the largest part of the increase over the decade. While per capita expenditures for hospital care increased at an average rate of 14.5 percent and expenditures for nursing home care increased at an average rate of 17.8 percent per year from FY 1966 to 1976, the average annual rate of increase for all other medical care services combined was 9.3 percent. As a result, the proportion of the total which was paid to inpatient facilities increased.

The amount spent on physicians' services for the elderly increased less over the decade but is now increasing as rapidly as hospital expenditures. From FY 1966 to 1976 per capita ex-

Table E. Estimated per capita personal health care expenditures for persons 65 years and over, by type of expenditure: United States, fiscal years 1966-76

(Data are compiled from a number of government and private sources)

Type of expenditure	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
	Expenditures per person										
Total	$445.25	$509.09	$617.72	$716.78	$790.84	$877.48	$966.92	$1,047.43	$1,109.54	$1,335.72	$1,521.36
Hospital care	177.84	197.63	258.20	313.46	340.17	378.28	416.91	451.03	485.04	605.09	688.59
Physician services	89.57	108.97	118.17	131.38	139.09	146.14	157.68	166.98	178.64	218.86	255.97
Dentist services	12.86	13.80	14.96	15.53	16.20	17.00	17.90	17.69	24.91	28.67	31.53
Other professional services	11.51	12.74	13.91	13.94	14.60	15.44	17.19	18.33	17.47	20.92	23.31
Drug and drug sundries	62.40	67.57	71.25	77.97	85.32	87.85	91.66	96.68	106.21	113.64	121.22
Eyeglasses and appliances	15.40	17.42	18.83	19.22	19.11	18.89	19.19	20.44	16.80	17.42	18.86
Nursing home care	68.39	84.94	113.56	133.18	162.76	202.39	237.79	264.38	261.53	308.54	350.61
Other health services	7.29	6.02	8.84	12.10	13.59	11.49	8.59	11.93	18.92	22.49	31.31

SOURCES: For data years 1966-72, Social Security Administration: Compendium of National Health Expenditures Data, DHEW Pub. No. (SSA) 76-11927, Social Security Administration, Washington, U.S. Government Printing Office, 1976; for data years 1973-75, Mueller, M. S., and Gibson, R. M.: Age differences in health care spending, fiscal year 1975, Social Security Bulletin, 39(6):18-31, June 1976; for data year 1976 (and revisions of previous years), Gibson, R. M., Mueller, M. S., and Fisher, C. R.: Age differences in health care spending, fiscal year 1976, Social Security Bulletin, 40(8):3-14, Aug. 1977.

penditures for physicians' services increased at an average annual rate of 11.1 percent. From FY 1974 to 1975 they increased by 23 percent and from FY 1975 to 1976 by 17 percent. Physicians' fees did not increase as much over the 10 years as hospital prices. The average annual rate of increase was 7.1 percent per year from FY 1966 to 1976 but from FY 1974 to 1975 physicians' fees rose by 12.8 percent and from FY 1975 to 1976 by 11.4 percent.

Part of the price increase has undoubtedly been due to catching up after the end of the Economic Stabilization Program which restrained the amount hospitals could charge patients without restraining the amount hospitals were charged for goods, services, and labor. Part was due to new services and newly introduced technology which are supported by everyone using the facility not just those patients using the new services or technology. That is true for services and technical equipment in a physician's office also. Equipment must be paid for by someone and the cost is passed on to all patients who have it available, not just those who use it.

One of the major shifts in expenditures has been the increased proportion of the bill paid for out of public funds. Concurrently, the proportion paid for out of the elderly individuals' own resources decreased from 53 to 27 percent. However, the actual amount paid directly increased over the 10 years from $236.72 per person in FY 1966 to $403.53 in FY 1976. The rate of increase in direct payments has been much greater in the past few years (13 percent from FY 1974 to 1975 and 15 percent from FY 1975 to 1976) than the rate of increase in the total CPI. Because this is money paid directly, people are intensely aware of it in the same way they are aware of increases in the price of food, clothing, and shelter.

Medicare

The Medicare and Medicaid programs strongly influence the manner in which medical care for the elderly is paid and the way in which services are utilized. Understanding of at least the Medicare program is essential to understanding the expenditures for medical care. In FY 1966, before the two programs went into operation, public funds financed 30 percent of medical care expenditures for the aged. In FY 1976 the public share was 68 percent; 43 percent of all medical care of the elderly was paid for by Medicare alone.

There was rapid growth in the proportion of the total bill paid out of Medicare at the beginning of the program. Then from FY 1969 to 1974 the Medicare share of the medical bill for people 65 years and over decreased from 45 percent to 41 percent for a number of reasons. The average length of hospital stay declined during much of the period 1969-1974. As a result, the patient's initial share of the hospital bill (a deductible roughly equivalent to the average cost nationally of a day of care) became a larger proportion of the total bill, and the Medicare proportion became smaller (Mueller and Gibson, 1976).

Additionally, the proportion of expenditures for outpatient hospital diagnostic and therapeutic services, which are included as hospital expenses but paid from the Medicare supplementary medical insurance trust fund, has been increasing. These expenses are reimbursed at a lower rate than those for inpatient hospital care, mainly because of the 20-percent coinsurance requirement.

Premiums paid by enrollees for supplementary medical insurance, Part B of the benefit package, also increased. When Medicare began, the monthly premium was $3.00. By July 1976 the premium was $7.20 per month.

The decline in Medicare's share of expenditures for physicians' services resulted partly from the increase in the deductible from $50 to $60 in 1973, but even more important was the decrease in the proportion of claims for which physicians accepted assignment. Physicians who do not accept assignment may bill patients for more than Medicare's "reasonable charges." In FY 1969 the net assignment rate (excluding hospital-based physicians) was 61 percent; in 1974 it was only 52 percent. As a result, a greater proportion of total charges was met through private insurance, Medicaid, or out-of-pocket payments by the patient, and a smaller proportion by Medicare (Mueller and Gibson, 1976).

Since 1974, Medicare's share of the bill for the elderly has risen again. Supplementary medical insurance benefits rose somewhat, largely because of catchup increases in physicians' fees following the end of the Economic Stabilization Program. Medicare placed a limit of 55 percent on fee increases in determining its calendar-year base for FY 1974 payments. The amounts paid physicians in FY 1975, however, were based on prevailing and customary charges derived from actual charges in calendar year 1973. Increased utilization of medical services, increased charges for outpatient services, extension of Medicare coverage to services performed by independent physical therapists, and elimination of coinsurance payments for home health visits have all contributed to the sharp rise in supplementary medical insurance benefits. Another factor was submission of bills on a more frequent, "even flow" basis by physicians accepting assignment, a practice encouraged by the carriers. Beneficiaries, probably feeling the effects of the recession and the pinch of inflation on their incomes, also submitted their bills more frequently.

The Medicare program pays for care in nursing homes only under certain conditions and does not pay for dental care, out-of-hospital prescribed drugs, or eyeglasses. Because of these program limitations, Medicare's share in the financing of total health care for the aged has not been as great as its share in financing hospital and medical services.

The role of private health insurance with respect to expenditures for the aged diminished rapidly with the advent of the Medicare program. Insurance for this group now generally only supplements or complements the Medicare benefit structure. Although the number of aged persons who carry private insurance is now even larger than it was before Medicare, insurance payments make up only about 5 percent of the elderly's total outlays, compared with about 16 percent in 1966.

The Current Situation

In FY 1976, when $34.9 billion were spent on medical care of the elderly, the largest single item on the bill was hospital care which accounted for 45 percent of all personal health care expenditures for people 65 years and over. Hospital care alone cost $15.8 billion, or an average of $688.59 for each elderly person in the United States.

The amount spent on hospital care for the elderly is bound to increase if utilization continues at its current rate and prices continue to rise. Even during FY 1976 while the CPI for all items increased by 5.9 percent, hospital service charges increased by 12.2 percent, and semiprivate room charges by 13.9 percent and prices have continued to rise, although at a slower rate in FY 1977.

Fortunately for the elderly individual who is hospitalized, almost all of the bill is paid out of public funds. In FY 1976, 91 percent of the bill for hospital care of the elderly was met out of public funds; the Medicare program alone paid for 71 percent. The 9 percent not covered by public funds, which amounted to $1.4 billion, was not covered primarily because of the deductible under Medicare. That must be paid for by the patient out of his own resources or by private health insurance.

Several recent analyses of Medicare data reveal wide variation from area to area in the cost of hospital care for the elderly. Gornick (1976) pointed out that in 1973 the mean charge per day ranged from $90 in the South to $129 in the West. Mean charges per enrollee, which reflect the combined effect of the discharge rate, length of stay, and charge per day, ranged from $319 in the South to $450 in the Northeast.

Another study conducted by the Social Security Administration, based on a 20-percent sample of Medicare claims in 1974, compared utilization for selected diagnoses in 65 conditional Professional Standards Review Organizations (PSRO's) (Gaus, 1976). The daily charge varied from $75 in a Mississippi PSRO to $187 in a New York PSRO; the mean was $118. The average charge per hospital stay ranged from $652 to $2,486, with a mean of $1,234.

This geographic variation in the cost of hospital care is due to differences in room and service charges, differences in rates of surgery or use of other procedures, and differences in the length of time the patient remains in the hospital. In essence, geographic differentials reflect variations in medical care practice and charges rather than differences in the health of elderly people.

The second largest item on the medical care bill for the elderly in FY 1976 was care in nursing homes which accounted for 23 percent of the total. Nursing home care cost $8.0 billion or $350.61 for each elderly person.

Over half (54 percent) of the bill for care in nursing homes was paid out of public funds. Unlike the hospital bill, however, very little (4 percent) of the nursing home bill was paid for out of Medicare. Medicaid was the primary source of public funds, providing 48 percent of the money in FY 1976.

Thus $3.7 billion were paid for out of private funds in FY 1976. This was the largest item privately paid for, and almost all of it had to be paid for out of patient or family resources since private health insurance seldom covers care in a nursing home.

Medicaid will not pay for care in a nursing home as long as the patient has resources. While some families have current income to fund long-term care in a nursing home, many do not. Much of this private spending represents depletion of assets by patients ineligible for Medicaid.

More than half (61 percent) of the elderly residents in nursing homes at the beginning of 1974 had been in the home for a year or more at that time. Although relatively few people rely on nursing homes for care, many of those who do must finance costs over a long period of time without public funding, which helps pay such a large portion of hospital costs.

The third largest item in the bill for medical care of the elderly was for physicians' services. In FY 1976 physicians' services accounted for 17 percent of the bill for a total of $5.9 billion or $255.97 for each person 65 years and over.

Over half (59 percent) of the bill for physicians' services was paid out of public funds. Like the hospital bill, the major part (55 percent) of the bill for physicians' services was paid for out of Medicare. Other public funding paid only 4 percent of the bill in FY 1976. Ninety-three percent of the bill for physicians' services was for services which were covered by Medicare but beneficiary payments for deductibles, coinsurance, and liabilities for reasonable charges reduced the actual payments by Medicare from $5.4 billion to $3.2 billion.

Hospital care, nursing home care, and physicians' services together accounted for $29.7 billion or 85 percent of the $34.9 billion spent on health care of the elderly in FY 1976. They accounted for $22.1 billion or 94 percent of all public funds and for $14.7 billion or 98 percent of the Medicare expenditures for elderly people.

Other services, including dentists' services, accounted for $2.0 billion in FY 1976 or $86.15 for each elderly person.

Almost all of the $0.7 billion spent on dental services was privately financed; Medicare paid no part of the bill and Medicaid only 4 percent. Since private health insurance very seldom covers dental services, it can be assumed that on the average elderly people spent $29.66 out of pocket on dental services.

Other professional services cost $0.5 billion in FY 1976 and all other health services $0.7 billion. About 83 percent of the $1.3 billion spent on these services came from public funds; professional services were financed mostly by Medicare and other health services by Medicaid and other public funds. Thus the private cost of these services amounted to less than $10 per elderly person ($9.47).

In addition to health care and services, medical care involves supplies. Drugs, glasses, and orthopedic appliances are needed by elderly people with chronic conditions or impairments and for episodes of acute illness. In FY 1976, $3.2 billion were spent on drugs, eyeglasses, and appliances for elderly people. Only $0.4 billion or 12 percent of the expenditure was financed by public funds.

Drugs and drug sundries alone cost $2.8 billion or $121.22 for each elderly person. Medicaid paid for 14 percent of this bill, leaving $2.4 billion or $104.09 per person to be financed privately. Again, private health insurance seldom pays for drugs; they are paid for by the individual. For the elderly person with a chronic condition requiring ongoing drug therapy, the out-of-pocket cost can be enormous.

Drugs account for only 8 percent of the total medical bill of the elderly but for 21 percent of the private bill. Drugs are the largest out-of-pocket medical expense for elderly people living in the community.

Eyeglasses and appliances cost $0.4 billion in FY 1976, almost all of which (98 percent) had to be paid for privately. These aids are a very small item on the total bill (only 1 percent), or on the privately funded bill (4 percent), but there is some evidence that expenditures for these items are low because elderly people are going without them. Costs have been rising faster than expenditures, indicating decreasing utilization.

CONCLUSION

Increased prevalence of chronic conditions and longer duration of acute conditions frequently accompany aging. Stress due to changing life conditions such as retirement, inability to live independently, or death of family members and friends may also occur more frequently as people age. Thus the needs for many kinds of care are great in old age. Care should be provided with dignity and made accessible so that elderly people can live to their capacity. Old age should not be a burden on the individual or on society.

Fortunately, research on aging is focusing on comprehensive investigations of the normal physiological changes with age; the behavioral constitution of the aged; the social, cultural, and economic environment in which the elderly live; and the means of delivering needed health services to the elderly.

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Exhibit 19

A Chronology of Major Health Legislation

According to Article I, Section 8, of the U.S. Constitution, "The Congress shall have power To . . . provide for the common defense and general welfare of the United States" and "To regulate commerce with foreign nations, and among the several States, and with the Indian tribes." Ever since 1789, when the Constitution became effective, Congress has enacted (and Presidents have signed into law) a great deal of legislation in support of the health of Americans under both the "General Welfare Clause" and the "Commerce Clause" of Section 8.

The following list of laws is by no means complete; but it should serve to illustrate how a national policy on public health has evolved over the years through legislation, influenced by science, the growth of the Nation on this continent, the increased complexity of the relationship between commerce and health, and the emergence in this century of the "politics of health." Invaluable assistance was received from the legislative offices of many Federal agencies, the staffs of the several health committees of the Congress, and the Office of the Federal Register of the National Archives and Records Service. From a mountain of possible citations we made the final choices. We accept full responsibility for any errors or omissions and promise that these will be corrected in time for the Tricentennial printing.

The Numbering System

In addition to the substance of health legislation, the numbering system of all legislation evolved during the past two centuries. Beginning on June 1, 1789, and continuing through December 14, 1901, Congress enacted public and private laws that were published as "chapters" in numbered volumes of "statutes" (*U.S. Statutes at Large*). The customary citation, however, was the page number of the statute volume, even though several chapters may

Source: U.S. Department of Health, Education, and Welfare. <u>Health in America.</u> DHEW Pub. No. (HRA) 76-616. Washington, D.C.: U.S. Government Printing Office (Stock No. 017-022-00507-7), 1976.

have appeared on a page. Thus, the Vaccination Act proposed by President Jefferson was commonly referred to as "2 Stat. 806"—it appeared on page 806 of the second volume of statutes enacted by Congress. However, that specific law was officially Chapter 37, passed during the Second Session of the Twelfth Congress. In the list below, numbers 1. through 12. are presented to show the Congress, the Session of that Congress, and the Chapter designation for each law. Thus, "2 Stat. 806" has been translated to be 12 (II)–37 for clarity, although it is not yet accepted by legal scholars.

During the first decade of this century, Congress separated the public laws and private laws, gave each category its own numbering system, but maintained the chapter designations, also. As before, the numbering began anew with the opening of each Session of the Congress. Hence, the Food and Drugs Act of 1906 was known as "Public, No. 384." But there could be more than one of these "Public, No.'s" with each Session. This changed somewhat during the Second Session of the 60th Congress; all the "Public, No.'s" were put into continuous sequence—but the chaptering started all over again with each Session.

In 1941, at the opening of the First Session of the 77th Congress, the designation "Public Law" was employed. The chaptering system was also employed, but began to fall into disuse. With the First Session of the 85th Congress, in January of 1957, Congress finally dropped the chapter designations altogether, maintained the "Public Law" title, and continued numbering each enacted statute in sequence regardless of Session. And to really clarify and simplify the designation, Congress also placed the number of that particular sitting of the Congress as a prefix. Hence the Air Quality Act is identified below as Public Law 90–148 (or PL 90–148), the 148th piece of legislation enacted by the Congress and signed by the President during the sitting of the 90th Congress. (The actual number of the law is assigned by the Office of the Federal Register of the National Archives and Register Service, upon notification that the President has indeed signed it.)

The citations below are, therefore, consistent: each one identifies the Congress and the law, as it came up for passage. Legal authorities do not use this system, so the reader is cautioned against rooting about in law libraries with our citations as his or her only beginning point. It is, nevertheless, a rational system, for which we offer no apology at all:

Year	*Citation*	*Title*	*Summary of Purpose*
1794	3 (I)–61	*Act of June 9, 1794*	Authorized appointment of a health officer for the Port of Baltimore, Md.
1796	4 (I)–31	*Act Relative to Quarantine*	Directed Revenue officers to execute health and quarantine regulations at U.S. ports of entry.
1798	5 (II)–77	*Act for the Relief of Sick & Disabled Seamen*	Imposed 20¢ tax on seamen's wages to provide funds for their health care.
1799	5 (III)–12	*Act Respecting Quarantine and Health Laws*	Placed supervision of maritime quarantine in Treasury Dept.; authorized assistance to States for their quarantine laws.
1811	11 (III)–26	*Act Establishing Navy Hospitals and a Hospital Fund*	Created fund to build naval hospitals.
1813	12 (II)–37	*Act to Encourage Vaccination*	Effort by Pres. Jefferson to encourage vaccination, especially against cowpox; created post of Vaccination Agent, with (limited) free mailing privileges.
1818	15 (I)–61	*Act Regulating the Staff of the Army*	Created a Medical Department under a Surgeon General.
1847	29 (II)–8	*Act to Raise Additional Military Force*	Gave military rank to Army medical officers.
1848	30 (I)–70	*Import Drugs Act*	The first Federal statute to insure the quality of drugs.
1862	37 (II)–166	*Act to Grant Pensions*	Provided compensation for all U.S. veterans (their dependents and survivors) for service-connected injuries, disabilities, or death; established principle of medical care and hospitalization.
1863	37 (III)–111	*Act to Incorporate the National Academy of Sciences*	Provided the Federal Government with an official yet independent advisor on questions of science and technology.
1866	39 (I)–21	*Disabled Volunteer Soldiers Act*	Authorized a National Asylum (later called a "Home") for disabled veterans of Civil War.
1870	41 (II)–169	*Act to Reorganize the Marine Hospital Service*	Authorized the Secretary of the Treasury to create the Office of Supervising Surgeon, Marine Hospital Service (forerunner of the Surgeon General, USPHS).

Year	*Citation*	*Title*	*Summary of Purpose*
1878	45 (II)–66	*Act to Enforce Quarantine on Vessels and Vehicles*	Created a "national quarantine system" to supervise efforts to control epidemic diseases.
1879	45 (III)–202	*Act to Establish a National Board of Health*	Created, for a four-year period, a Board to cooperate with State and local boards of health on "all matters affecting the public health."
1887	49 (II)–311	*Act to Establish a Hospital Corps*	Formal establishment of career opportunities for enlisted personnel in the Army Medical Dept.
1889	50 (II)–19	*Act to Regulate Appointments in the Marine Hospital Service*	Created the Commissioned Corps of the Marine Hospital Service; appointed by President, approved by Senate.
1890	51 (I)–51	*Act to Prevent Interstate Spread of Disease*	Gave the Marine Hospital Service interstate quarantine authority.
1891	51 (II)–555	*Animal Inspection Act*	Required inspection of animals for diseases before slaughter and subsequent export or interstate shipment.
1899	55 (III)–425	*Rivers and Harbors Act ("Refuse Act")*	Prohibited the dumping of wastes into navigable waters without a permit from the Corps of Engineers.
1901	56 (II)–192	*Army Reorganization Act*	Established the Nurse Corps ("female") as a permanent part of the Army's Medical Department.
1902	57 (I)–236	*Reorganization Act*	Changed name to Public Health and Marine Hospital Service with six divisions (including research at the Hygienic Laboratory).
1902	57 (I)–244	*Biologics Control Act*	Ordered the licensing and regulation of interstate sales of serums, vaccines, etc., for use in humans.
1906	59 (I)–382	*Agriculture Department Appropriations*	Called for regular inspection of meat-packing plants to combat unsanitary conditions (separated out as Meat Inspection Act of 1907).
1906	59 (I)–384	*Food and Drugs Act*	Prohibited interstate commerce in misbranded and adulterated foods, drinks, and drugs.

Year	*Citation*	*Title*	*Summary of Purpose*
1910	61 (II)–152	*Insecticide Act*	Prohibited the interstate transport of adulterated or misbranded insecticides.
1912	62–116	*Act to Establish a Children's Bureau*	First effort to establish maternal and child health care programs at the Federal level.
1912	62–265	*Reorganization Act*	Changed name to Public Health Service and authorized field investigations and studies.
1912	62–301	*The Sherley Amendment*	Prohibited the labeling of medicines with false and misleading therapeutic claims.
1914	62–223	*Harrison Narcotics Act*	Established Federal controls over narcotics users and suppliers, including physicians and hospitals.
1917	65–90	*War Risk Insurance Act*	Authorized money compensation, insurance, vocational rehabilitation, and medical and hospital care for WW I veterans.
1919	65–193	*Army Appropriations Act*	Designed to control venereal disease in the Army; also created a PHS Division of Venereal Disease.
1921	67–47	*The Sweet Act*	Established the Veterans Bureau as an independent agency with control of hospitals and outpatient services for veterans.
1921	67–97	*Sheppard-Towner Act*	Established the Board of Maternal and Infant Hygiene; led to strengthened Federal and State child health programs.
1924	68–238	*Oil Pollution Act*	Prohibited the dumping of oil into navigable waters except in dire emergencies, etc.
1926	69–254	*Air Commerce Act*	Extended quarantine regulations for travelers arriving in the United States by air.
1929	70–672	*Narcotics Act of 1929*	Authorized "narcotic farms" for addicts (later built at Lexington, Ky., and Fort Worth, Texas) and set up a Narcotics Division in PHS to administer them, and do other related work.
1930	71–251	*Act to Establish a National Institute of Health*	Reorganized the original Marine Hospital Service Hygienic Laboratory into the National Institute of Health.

Year	*Citation*	*Title*	*Summary of Purpose*
1930	71–357	*Bureau of Narcotics Act*	Created a separate Bureau of Narcotics within the Treasury Dept.; changed PHS Narcotics Division to Division of Mental Hygiene.
1930	71–536	*Veterans Affairs Consolidation Act*	Created the Veterans Administration by consolidating the Veterans Bureau, Pension Bureau, and National Home for Disabled Volunteer Soldiers.
1935	74–241	*Social Security Act*	Provided for the first time grants-in-aid to States for such public health activities as maternal and child care, aid to crippled children, blind persons, the aged, and other health-impaired persons.
1936	74–846	*Walsh-Healy Act*	Authorized Federal regulation of industrial safety in companies doing business with the government.
1937	75–244	*National Cancer Institute Act*	Established National Cancer Institute to coordinate research related to cancer.
1938	75–540	*LaFollette-Bulwinkle (VD Control Act)*	Provided grants-in-aid to States and other authorities to investigate and control venereal disease.
1938	75–717	*Federal Food, Drug, and Cosmetic Act*	Extended Federal authority to act against adulterated and misbranded food, drug, and cosmetic products.
1939	76–19	*Reorganization Act of 1939*	Transferred the PHS from Treasury to a new Federal Security Agency.
1941	77–146	*The Nurse Training Act*	Supported schools of nursing to increase their enrollments and help strengthen their facilities.
1941	77–366	*Insulin Certification Amendment of FD&C Act*	Required pre-marketing batch certification of insulin drugs.
1943	78–38	*Act to Provide for the Appointment of Female Physicians and Surgeons in the Army.*	Gave women and men equal rank, pay, allowances, and privileges in the Army Medical Corps.

Year	*Citation*	*Title*	*Summary of Purpose*
1943	78–74	*Nurse Training Act*	Provided intial funding for the Nurse Cadet Corps in the Public Health Service.
1944	78–410	*Public Health Service Act*	Consolidated all PHS authorities into a single statute (42 USC).
1945	79–139	*Antibiotic Certification Amendment*	Required pre-marketing batch certification of penicillin (other antibiotics added in later amendments).
1946	79–293	*Medical and Surgical Act*	Established a Dept. of Medicine and Surgery in VA; removed it from Civil Service control; authorized medical student residencies in VA hospitals.
1946	79–396	*National School Lunch Act*	Authorized a national school lunch program.
1946	79–487	*National Mental Health Act*	Authorized major Federal support for mental health research, diagnosis, prevention, and treatment; changed PHS Division of Mental Health to National Institute of Mental Health; established State grants-in-aid for mental health.
1946	79–725	*Hospital Survey and Construction Act*	The Hill-Burton Act to support surveys, plans, and new facilities.
1947	80–36	*Women's Medical Specialist Corps*	Established a permanent Nursing Corps in the Army and Navy; permitted dietitians and physical therapists to join a Specialist Corps.
1947	80–104	*Federal Insecticide, Fungicide, and Rodenticide Act*	Required all pesticides to be registered prior to sale and be properly labeled for use.
1948	80–655	*National Heart Act*	Authorized aid for research, training, and other programs related to heart disease; established the National Heart Institute; acknowledged a plural NIH.
1948	80–755	*National Dental Research Act*	Authorized aid for research on dental diseases and conditions; established a National Institute of Dental Research at NIH.
1948	80–845	*Water Pollution Control Act*	Authorized PHS to help States develop water pollution control programs and to aid in the planning of sewage treatment plants.

Year	*Citation*	*Title*	*Summary of Purpose*
1949	81–380	*Hospital Survey and Construction Amendments*	Increased Federal financial assistance to promote effective development and utilization of hospital services and facilities.
1949	81–439	*Agricultural Act of 1949*	Authorized donations of commodities acquired under price support programs for school lunch and for feeding the needy.
1950	81–507	*Act to Establish a National Science Foundation*	Set up an autonomous NSF and strengthened the concept of Federal support for university-based research in physical, medical, and social sciences.
1950	81–692	*National Research Institutes Act*	Expanded the National Institutes of Health to include research and training relating to arthritis, rheumatism, multiple sclerosis, cerebral palsy, epilepsy, polio, blindness, leprosy, and other diseases.
1951	82–215	*Durham-Humphrey Amendments*	Established category of prescription drugs, requiring labeling and medical supervision, as separate from nonprescription drugs.
1954	83–482	*Medical Facilities Survey and Construction Act*	Extended aid to chronic hospitals, rehabilitation facilities, and nursing homes.
1954	83–568	*Act to Transfer Indian Health Responsibility to the Public Health Service*	Placed responsibility for maintenance and operation of Indian health facilities in PHS rather than Bureau of Indian Affairs.
1955	84–159	*Air Pollution Control Act*	Provided aid to States, regions, and localities for research and control programs to protect air quality.
1955	84–182	*Mental Health Study Act*	Authorized grants to nongovernmental organizations for partial support of a national study and reevaluation of the human and economic problems of mental illness.
1955	84–377	*Polio Vaccination Assistance Act*	Provided assistance to State vaccination programs.
1956	84–569	*Dependents Medical Care Act*	Set up program of primarily inpatient medical care for dependents of military personnel (CHAMPUS).

Year	*Citation*	*Title*	*Summary of Purpose*
1956	84–652	*National Health Survey Act*	Provided for a continuing survey and special studies of sickness and disability in the U.S.
1956	84–660	*Water Pollution Control Act*	Established water pollution control programs on interstate waterways; expanded research and aid to States for sewage treatment.
1956	84–835	*Health Research Facilities Act*	Aided construction of research facilities.
1956	84–911	*Health Amendments*	Increased mental health staff and skills.
1956	84–941	*National Library of Medicine Act*	Transferred responsibility for the library to the Public Health Service.
1957	85–151	*Indian Health Assistance Act*	Provided for construction of health facilities for Indians.
1957	85–172	*Poultry Products Inspection Act*	First Federal effort at mandatory inspection of poultry products (similar to efforts in meat inspection).
1958	85–340	*Social Security Amendments*	Provided States with minimum maternal and child health grants and extended authority to Guam.
1958	85–929	*Food Additive Amendments to the FD&C Act*	Required pre-marketing clearance for new food additives; established a GRAS (generally recognized as safe) category; prohibited the approval of any additive "found to induce cancer in man or animal" (the so-called "Delaney clause").
1959	86–382	*Federal Employees Health Benefits Act*	Authorized program of prepaid health insurance for employees of Federal Executive and Legislative Branches.
1960	86–610	*International Health Research Act*	Provided for international cooperation in research, research training, and planning.
1960	86–613	*Federal Hazardous Substances Labeling Act*	Required prominent label warning on hazardous household or workplace chemical products.
1960	86–778	*Social Security Amendments (Kerr-Mills)*	Authorized grants to States for medical assistance for the aged.
1961	87–395	*Community Health Services and Facilities Act*	To improve community facilities and services for aged and others.

Year	*Citation*	*Title*	*Summary of Purpose*
1962	87–692	*Assistance to Migratory Workers Act*	Authorized Federal aid for clinics serving migratory agricultural workers and families.
1962	87–781	*Kefauver-Harris Drug Amendments*	Required improved manufacturing practices, better reporting, the assurance of efficacy as well as safety, and strengthened regulation in the drug industry.
1962	87–838	*National Institutes of Child Health and Human Development and General Medical Sciences Act*	Established an Institute to coordinate and expand research into childhood diseases and human growth and a second Institute of General Medical Sciences to coordinate inter-Institute research and handle "all other" diseases.
1962	87–868	*Vaccination Assistance Act*	Aided programs that attacked whooping cough, polio, diphtheria, and tetanus.
1963	88–129	*Health Professions Educational Assistance Act*	Aided training of physicians, dentists, public health personnel, and others.
1963	88–156	*Maternal and Child Health and Mental Retardation Planning Amendments*	Initiated program of comprehensive maternity and infant care and mental retardation prevention.
1963	88–164	*Mental Retardation Facilities and Community Mental Health Centers Construction Act*	Provided aid for the construction of these facilities and centers; became the basic law for mental health centers' staffing, programming, etc.
1963	88–206	*Clean Air Act*	Authorized direct grants to States and local governments for air pollution control; established Federal enforcement in interstate air pollution; directed major research efforts into motor vehicle exhaust, removal of sulfur from fuel, and the development of air quality criteria.
1964	88–352	*Civil Rights Act*	Title VI provided 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."

Year	*Citation*	*Title*	*Summary of Purpose*
1964	88–525	*Food Stamp Act*	Authorized food stamp program for low-income persons to buy nutritious food for balanced diet.
1964	88–581	*Nurse Training Act*	Provided special Federal effort for training professional nursing personnel.
1965	89–74	*Drug Abuse Control Amendments*	Established enforcement procedures to control depressants, stimulants, and hallucinogens.
1965	89–92	*Federal Cigarette Labeling and Advertising Act*	Informed the public of health hazards of cigarette smoking.
1965	89–97	*Social Security Amendments*	Established health insurance for aged and grants to States for medical assistance programs (Medicare and Medicaid).
1965	89–239	*Heart Disease, Cancer, and Stroke Amendments*	Established Region Medical Programs for research training and sharing of new knowledge in heart disease, cancer, and stroke.
1965	89–272	*Clean Air Act Amendments*	Directed Federal regulation of motor vehicle exhaust (Title I); established program of Federal research and grants-in-aid in solid waste disposal (Title II).
1965	89–290	*Health Professions Educational Assistance Amendments*	Aided schools of medicine, osteopathy, and dentistry; provided scholarships and loans; and aided construction.
1966	89–563	*National Traffic and Motor Vehicle Safety Act*	Provided for a coordinated national safety program and established safety standards for motor vehicles in interstate commerce.
1966	89–614	*Amendments to CHAMPUS (Military Dependents Act)*	Broadened eligibility to CHAMPUS and extended benefits beyond inpatient care.
1966	89–642	*Child Nutrition Act*	Established Federal program of research and support for child nutrition; authorized school breakfast program.
1966	89–749	*Comprehensive Health Planning and Public Health Services Amendments*	Promoted health planning and improved public health services; authorized broad research, demonstration, and training programs in Federal-State-local partnership.

Year	*Citation*	*Title*	*Summary of Purpose*
1966	89–751	*Allied Health Professions Personnel Act*	Initial effort to support the training of allied health workers; also provided student loans for health professionals.
1966	89–753	*Clean Water Restoration Act*	Expanded, strengthened, and centralized water pollution programs in the Department of the Interior; new efforts in sewage treatment, purification, ecology.
1966	89–785	*VA Assistance Act*	Permitted the VA to share, rather than replicate, specialized medical resources of other Federal, State, and local agencies.
1966	89–793	*Narcotic Addict Rehabilitation Act*	Authorized programs to deal more effectively with narcotic addiction as a public health issue.
1967	90–148	*Air Quality Act*	Established program of criteria and standards development and enforcement to control air pollution; set up air quality regions; overall strengthening of the Federal role.
1967	90–174	*Partnership for Health Amendments*	Expanded health planning and services; broadened health services research and demonstrations; and improved clinical laboratories.
1967	90–201	*Wholesale Meat Act*	Amended, updated, and expanded Meat Inspection Act of 1907; brought all meat plants in intra- as well as interstate commerce under control.
1967	90–222	*Economic Opportunity Amendments*	Authorized grants for Comprehensive Health Services and other programs for the poor.
1967	90–248	*Social Security Amendments*	Consolidated maternal and child health authorities, extended grants for family planning and dental health.
1968	90–407	*Amendments to NSF Act of 1950*	Expanded the authorities of the National Science Foundation to include major support of applied research in the sciences.
1968	90–411	*Aircraft Noise Abatement Act*	Amended Federal Aviation Act; first government effort to deal with health hazards of noise.

Year	*Citation*	*Title*	*Summary of Purpose*
1968	90–456	*Lister Hill National Center for Biomedical Communications Designation*	Designated the title for a national center for biomedical communications within the National Library of Medicine, NIH.
1968	90–490	*Health Manpower Act*	Authorized formula institutional grants for training all health professionals; added pharmacy and veterinary medicine.
1968	90–492	*Wholesome Poultry Products Act*	Amended, updated, and expanded the 1957 Poultry Act to make poultry inspection similar to updated Meat Inspection program.
1968	90–574	*Health Services Amendment*	Extended grants for RMP's and migrant health services; provided treatment facilities for alcoholics and narcotic addicts.
1968	90–602	*Radiation Control for Health and Safety Act*	Authorized setting of safe performance standards for electronic products such as x-ray machines, television sets, microwave ovens, etc.; established procedures for enforcement.
1969	91–173	*Federal Coal Mine Health and Safety Act*	Protected the health and safety of coal miners.
969	91–190	*National Environmental Policy Act*	Stated the concern of Congress for preserving the environment and to "stimulate the health and welfare of man"; created the Council on Environmental Quality to advise the President; required environmental impact statements before major Federal actions.
970	91–211	*Community Mental Health Centers Amendments*	Extended grants for community mental health centers and facilities for alcoholics and narcotic addicts and established programs for children's mental health.
970	91–222	*Public Health Cigarette Smoking Act*	Banned cigarette advertising from radio and television.
970	91–512	*Resource Recovery Act*	Shifted emphasis from solid waste disposal to overall problems of control, recovery, and recycling of wastes.

Year	*Citation*	*Title*	*Summary of Purpose*
1970	91–513	*Comprehensive Drug Abuse Prevention and Control Act*	Increased aid for research; strengthened prevention, treatment, rehabilitation programs.
1970	91–517	*Developmental Disabilities Services and Facilities Construction Amendments*	Assisted States to develop and implement plans for provision of comprehensive services to persons affected by mental retardation and other developmental disabilities.
1970	91–519	*Health Training Improvement Act*	Provided expanded aid to all allied health professions.
1970	91–572	*Family Planning Services and Population Research Act*	Expanded and coordinated services and research activities.
1970	91–596	*Occupational Safety and Health Act*	Provided Federal program of standard-setting and enforcement to assure safe and healthful conditions in the workplace.
1970	91–604	*Clean Air Act Amendments*	Strengthened and expanded air pollution control activities; placed broad regulatory responsibility in new Environmental Protection Agency, in operation as of December 2, 1970.
1970	91–616	*Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act*	Established National Institute on Alcohol Abuse and Alcoholism; provided a comprehensive aid program to States and localities.
1970	91–623	*Emergency Health Personnel Act*	Provided assistance to health manpower shortage areas through a new National Health Service Corps.
1971	91–695	*Lead-Based Paint Poisoning Prevention Act*	Authorized Federal help to communities wishing to eliminate the causes of lead-based paint poisoning.
1971	92–157	*Comprehensive Health Manpower Training Act*	Expanded and strengthened Federal programs for the development of health manpower.
1971	92–158	*Nurse Training Act*	Expanded and strengthened Federal efforts specifically directed toward nurse training.
1971	92–218	*National Cancer Act*	Expanded national effort against cancer.

Year	*Citation*	*Title*	*Summary of Purpose*
1972	92–294	*National Sickle Cell Anemia Control Act*	Provided for control of and research into sickle cell anemia.
1972	92–303	*Amendments to Federal Coal Mine H&S Act*	Provided benefits and other assistance for coal miners suffering from black lung diseases.
1972	92–414	*National Cooley's Anemia Control Act*	Provided assistance for programs of diagnosis, prevention, and treatment.
1972	92–423	*National Heart, Blood Vessel, Lung, and Blood Act*	Enlarged the National Heart and Lung Institute and authorized broad studies in blood management.
1972	92–426	*Uniformed Services Health Professions Revitalization Act*	Established a Uniformed Services University of the Health Sciences and an Armed Forces Health Professions Scholarship Program.
1972	92–433	*National School Lunch and Child Nutrition Amendments*	Added funds to support nutritious diets for pregnant and lactating women and for infants and children (the "WIC" program).
1972	92–500	*Federal Water Pollution Control Amendments*	Totally revised Federal water program; shifted efforts from the preservation of available water quality to the improvement of quality through technology; set as a goal the elimination of pollutant discharges from all navigable waters.
1972	92–513	*Motor Vehicle Information and Cost Savings Act*	Established diagnostic and demonstration projects to reduce auto-related safety and health hazards.
1972	92–516	*Federal Environmental Pesticide Control Act*	Expanded and strengthened provisions on product registration, labeling, environmental protection, registration of manufacturers, and national monitoring of pesticide residues in water and food.
1972	92–541	*VA Medical School Assistance and Health Manpower Training Act*	Authorized VA to help establish 8 State medical schools and provide grant support to existing medical schools.

Year	*Citation*	*Title*	*Summary of Purpose*
1972	92–573	*Consumer Product Safety Act*	Created the Consumer Product Safety Commission; transferred enforcement of Hazardous Substances, Flammable Fabrics, Poison Prevention Packaging Acts to CPSC; expanded and strengthened Federal effort in safety and prevention.
1972	92–574	*Noise Control Act*	Authorized broad Federal program to coordinate noise research and control activities, establish standards, and improve public information.
1972	92–603	*Social Security Amendments*	Extended health insurance benefits to the disabled and to end-stage renal disease patients; established Professional Standards Review Organization program; and expanded research and demonstrations of financing mechanisms.
1972	93–154	*Emergency Medical Services Systems Act*	Provided aid to States and localities to establish coordinated, cost-effective areawide EMS systems.
1973	93–222	*Health Maintenance Organization Act*	Assisted in the establishment and expansion of HMOs.
1974	93–247	*Child Abuse Prevention and Treatment Act*	Created a National Center on Child Abuse and Neglect; authorized research and demonstration grants to States and other public and private agencies.
1974	93–270	*Sudden Infant Death Syndrome Act*	Provided assistance for research, training, and extensive public education concerning SIDS.
1974	93–281	*Narcotic Addict Treatment Act*	Provided for registration of practitioners.
1974	93–286	*Research on Aging Act*	Established National Institute on Aging within the NIH.
1974	93–319	*Energy Supply and Coordination Act*	Directed the National Institute of Environmental Health Sciences to study the effects of chronic exposure to sulfur oxides.
1974	93–348	*National Research Act*	Established research training awards and the National Commission for the Protection of Human Subjects.

Year	*Citation*	*Title*	*Summary of Purpose*
1974	93–352	*National Cancer Amendments*	Improved the national cancer program and established a Biomedical Research Panel.
1974	93–353	*Health Services Research, Health Statistics, and Medical Libraries Act*	Revised and expanded health statistics and services research programs; established a National Center for each one; expanded aid to non-Federal medical libraries.
1974	93–354	*National Diabetes Mellitus Research and Education Act*	Expanded diabetes research and public education programs.
1974	93–523	*Safe Drinking Water Act*	Requires EPA to set national drinking water standards and to aid States and localities in enforcement.
1974	93–640	*National Arthritis Act*	Established National Commission on Arthritis and coordinated arthritis programs in NIH.
1975	93–641	*National Health Planning and Resources Development Act*	Authorized major Federal reorganization of health planning programs, including Hill-Burton; set up national designation of local Health Services Areas and governing agencies.
1975	94–63	*Health Revenue Sharing and Nurse Training Act*	Established National Center for Prevention and Control of Rape; revised and extended National Health Service Corps, Community Mental Health Centers, migrant health, family planning, and other programs; strengthened the nurse training program.
1975	94–103	*Developmentally Disabled Assistance and Bill of Rights Act*	Expanded national effort and protected rights of the developmentally disabled.
1976	94–295	*Medical Device Amendments to FD&C Act*	Authorized broad FDA regulatory power over medical devices; required premarket approval for new devices (similar to procedure for new drugs); interstate commerce is presumed for all devices to be seized as violative (*i.e.*, intrastate protection is superceded).

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Health Services and Nurse Training Act Amendments (P.L.94-63)

Council on Wage and Price Stability Act Amendments (P.L.94-78)

Developmentally Disabled Assistance and Bill of Rights Act (P.L.94-103)

National School Lunch Act and Child Nutrition Act Amendments (P.L.94-105)

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Older Americans Amendments of 1975 (P.L.94-135)

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Supplemental Security Income Payments in Lieu of Food Stamps (P.L.94-379)

Source: Washington Report on Health Legislation. Major Health Legislation: A Compendium of Health Laws Passed By the Congress Since 1974. The 94th and 95th Congresses. Washington, D.C.: Washington Health Letters of of McGraw-Hill, Inc., 1979.

National Swine Flu Immunization Program of 1976 (P.L.94-380)

Government in the Sunshine Act (P.L.94-409)

State Veterans' Homes Assistance (P.L.94-412)

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