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REPORT TO THE
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

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Compliance With Antidiscrimination
Provision Of Civil Rights Act
By Hospitals And Other Facilities
Under Medicare And Medicaid B.164037(4)

Department of Health, Education,
and Welfare

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

701210 [096498]

JULY 13, 1972



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

B-164031(4)

Dear Mr. Chairman:

In accordance with a request from your Subcommittee No. 4, dated June 3, 1971, we are submitting to you a report on our review of compliance with the antidiscrimination provisions (title VI) of the Civil Rights Act of 1964 by hospitals and other facilities under Medicare and Medicaid.

As authorized by the Subcommittee, we have obtained comments from the Department of Health, Education, and Welfare on a draft of this report. The Department's comments have been incorporated in the final report.

In accordance with your Subcommittee's request, we are also preparing another report, which will be sent to you separately, on our review of compliance with title VI of the Civil Rights Act of 1964 by facilities receiving assistance under the Hill-Burton Facilities Construction and Modernization Program.

We plan to make no further distribution of this report unless copies are specifically requested, and then copies will be distributed only after your approval has been obtained or public announcement has been made by you concerning the contents of this report.

Sincerely yours,

Comptroller General
of the United States

CI + R
The Honorable Emanuel Celler
Chairman, Committee on the Judiciary
House of Representatives

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ABBREVIATIONS

ECFs	Extended-care facilities
HEW	Department of Health, Education, and Welfare
OCR	Office for Civil Rights
OEHO	Office of Equal Health Opportunity

COMPTROLLER GENERAL'S REPORT TO
THE COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

COMPLIANCE WITH ANTIDISCRIMINATION
PROVISION OF CIVIL RIGHTS ACT BY
HOSPITALS AND OTHER FACILITIES UNDER
MEDICARE AND MEDICAID

1 / Department of Health, Education,
and Welfare B-164031(4) *22*

D I G E S T

WHY THE REVIEW WAS MADE

At the request of the Chairman, House Committee on the Judiciary, the General Accounting Office (GAO) examined whether hospitals, extended-care facilities (ECFs), and nursing homes participating in Medicare or Medicaid were complying with title VI of the Civil Rights Act. Title VI provides that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program receiving Federal financial assistance.

GAO evaluated the policies and procedures used by the Department of Health, Education, and Welfare (HEW), to ensure that medical institutions participating in these programs did not discriminate. GAO's review included visits to medical facilities in four metropolitan areas--Atlanta, Georgia; Birmingham, Alabama; Wayne County (including Detroit), Michigan; and Los Angeles County, California.

FINDINGS AND CONCLUSIONS

Shortly after Medicare and Medicaid were enacted, HEW made extensive efforts to enforce title VI compliance; since then it has significantly reduced its activities in this area.

HEW now makes relatively few onsite visits to hospitals, ECFs, or nursing homes. HEW officials advised GAO that during 1971 its Office for Civil Rights (OCR) made 950 reviews of hospitals and ECFs to determine their compliance status; slightly over 300 of these visits were onsite reviews.

Instead, HEW relies more on information reported by institutions participating in Medicare and Medicaid; on compliance reviews by State and local agencies; and on complaints by beneficiaries, physicians, and others to identify institutions which may require enforcement action. HEW officials advised GAO that in 1971 OCR made over 1,700 visits to State and local agencies to monitor their civil rights compliance activities, including these agencies' reviews of the compliance status of hospitals and nursing homes under the Medicaid program. (See pp. 14 to 27.)

HEW officials have told GAO that the type of discrimination existing today is substantially different from that existing when title VI was first enacted. The law was aimed at remedying overt discrimination which had existed in some States. Discrimination in health facilities today is not overt and is therefore difficult to detect or to prove. (See p. 12.)

In gaining access to the health system, discrimination against the poor is prevalent but cannot be dealt with by HEW under title VI. HEW officials believe that past racial discrimination in such areas as employment and housing have placed members of minority groups in an economically disadvantaged position and, as a consequence, in a poorer state of general health. (See p. 67.)

Disproportionate use of
government-owned hospitals

Most hospitals, ECFs, and nursing homes under Medicare and Medicaid in the four metropolitan areas were integrated, and all were considered to be in compliance with title VI. This does not mean that discrimination was completely nonexistent but only that it did not exist in an overt form subject to objective analysis and detection.

However, a disproportionate share of minority-group patients received their health care from government-owned hospitals (State, county, or city). These hospitals attracted minority-group patients because they

- provided medical care at little or no cost to indigent patients,
- were easily accessible,
- had traditionally been used, and
- had made special efforts to accommodate minority groups.

At most private hospitals patients can be admitted only by a physician having admitting privileges. Because there are relatively few physicians in many areas where minority groups live, these people often must rely on out-patient clinics at government-owned hospitals for their general medical needs. When hospitalization is necessary, they are then admitted to these institutions. (See pp. 39, 43, and 61.)

In two of the four metropolitan areas visited by GAO, minority-group patients were unaware that their Medicare or Medicaid coverage entitled them to use private hospitals as alternatives to the traditionally used government-owned hospitals. Actions to increase such awareness might result in greater use of private hospitals. HEW officials advised GAO that one of its component organizations had developed a proposal to increase the awareness of Medicaid recipients of benefits and services available to them. (See pp. 10, 35, 43, 46, and 66 to 68.)

Other reasons for clustering of
minority-group patients

Many hospitals, ECFs, and nursing homes were treating only patients of one race--or had few patients of other races--even though the facilities published open admission policies. Clustering of minority-group patients in certain

facilities is very likely not the result of current discriminatory policies or practices but is more likely the result of

- personal preferences by patients and their physicians,
- convenience of the institutions to the minority-group communities, and
- familiarity of the minority-group communities with the institutions from prior associations. (See pp. 32, 35, 46, 50, and 67.)

Most of these facilities were in areas heavily dominated by one racial group. Also some of these facilities were established to serve special religious or ethnic groups or had established policies which restricted admission to people with substantial financial resources. Although their policies did not preclude admission on the basis of race, color, or national origin, they did effectively limit the numbers of patients of races, colors, or national origins not common to the religious, ethnic, or economic character of these facilities. (See pp. 48, 59, and 60.)

Civil rights groups and HEW officials attributed patterns of predominantly black or white ECFs and nursing homes partially to the practices of State and local health and welfare departments in referring patients to these facilities. HEW officials told GAO that the referral practices in each State would be investigated beginning in July 1972. (See pp. 11, 15, 42, and 43.)

According to HEW statistics, nonwhite beneficiaries were not using extended-care facilities under the Medicare program to the same extent as white beneficiaries. On the other hand, nonwhites had substantially increased the lengths of their hospital stays after Medicare was enacted.

Some black physicians have told GAO that blacks--more frequently than others--care for ill members of their families at home and do not use ECFs or nursing homes for convalescent care after discharge from hospitals. These factors--increased hospital stays and home convalescent care--possibly may account for the disproportionate use of ECFs. (See pp. 15, 16, and 38.)

Comments of HEW officials and representatives
of civil rights groups

HEW officials believe that title VI has helped to remedy overt discrimination in health care. However, these officials, as well as representatives of civil rights organizations, believe that title VI may not be adequate to deal with the more complex forms of discrimination--such as the general attitudes of whites toward nonwhites or the lack of understanding by white hospital staff of the cultural or economic backgrounds of minority-group patients. (See pp. 12 and 52.)

According to HEW officials, to deal with the subtle forms of discrimination existing today, it may be necessary to modify the law so that instances such as a disproportionate number of minority patients in a hospital compared

with the number in the community population are considered sufficient evidence for HEW to compel a facility to take action to increase the number of its minority patients or demonstrate why more minority patients are not served. (See p. 67.)

HEW has developed a form for regional office use to determine the extent to which States are enforcing compliance with title VI in skilled nursing homes participating in the Medicaid program. HEW is also promoting the establishment of ombudsman units in each State government to review and follow up complaints made by, or on behalf of, nursing-home patients. This should provide another source for the receipt of civil rights complaints. (See p. 13.)

CHAPTER 1

INTRODUCTION

At the request of the Chairman, Committee on the Judiciary, House of Representatives, we examined whether hospitals, extended-care facilities (ECFs), and nursing homes participating in the Medicare and Medicaid programs were complying with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d-2000d-6). Medicare and Medicaid are two of the major health programs which receive Federal financial assistance and which are subject to the provisions of title VI of the Civil Rights Act.

Title VI of the Civil Rights Act of 1964 provides that:

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

The Department of Health, Education, and Welfare (HEW) regulations implementing title VI provide that all federally assisted activities provide assurance that their programs or institutions are operated without discrimination. Before being approved by HEW for Medicare or Medicaid, medical institutions are required to execute an "assurance of compliance" statement which certifies that they will comply immediately and fully with title VI and HEW regulations.

We evaluated the policies and procedures used by HEW in its attempts to obtain compliance with title VI by hospitals, ECFs, and nursing homes participating in the Medicare or Medicaid programs. We also analyzed data in four major metropolitan areas--Atlanta, Georgia; Birmingham, Alabama; Wayne County (including Detroit), Michigan; and Los Angeles County, California--to determine whether minority groups had been given an equal opportunity to obtain medical services.

DESCRIPTION OF MEDICARE PROGRAM

The Medicare program, established by the Social Security Amendments of 1965 (42 U.S.C. 1395-1395 11), is administered by the Social Security Administration in HEW. Eligible persons aged 65 and over are provided with two basic forms of protection against most of the costs of health care.

One form, designated as Hospital Insurance Benefits for the Aged (part A), covers care provided (1) by hospitals during acute stages of illness and (2) by ECFs when skilled nursing care is required on a continuous basis for a condition previously treated more intensively in a hospital. Part A benefits are financed primarily by special social security taxes collected from employees, employers, and self-employed persons. Over 20 million persons have part A coverage.

The second form of protection is a voluntary program, designated as Supplementary Medical Insurance Benefits for the Aged (part B), and covers physicians services and a number of other medical and health benefits, including outpatient hospital services and certain home care. Part B is financed by premiums collected from each eligible beneficiary who has elected to be covered by the program and by matching amounts appropriated from the general revenues of the Federal Government. Over 19 million persons have part B coverage.

Although the Social Security Administration has primary responsibility for administering the Medicare program, HEW has contracted with (1) private organizations called fiscal intermediaries and carriers to assist in reviewing and paying benefit claims and (2) the States to determine the eligibility of facilities to participate in the program.

All hospitals and other facilities participating in the Medicare program are subject to the provisions of title VI of the Civil Rights Act of 1964. If a facility fails to comply with title VI, it becomes ineligible to receive Medicare payments except for hospital services provided in emergency situations.

HEW regulations state that services provided by physicians and other medical suppliers under part B of Medicare are not subject to the provisions of title VI because the Government's contractual agreement under part B is with the beneficiary not the supplier of medical services.

Medicare payments for care provided by hospitals under parts A and B and ECFs under part A amounted to \$4.8 billion in fiscal year 1970.

DESCRIPTION OF MEDICAID PROGRAM

The Medicaid program, established by the Social Security Amendments of 1965 (42 U.S.C. 1396), is administered by the Social and Rehabilitation Service in HEW. Medicaid is a grant-in-aid program under which the Federal Government participates in costs incurred by the States in providing medical assistance to persons, regardless of age, who are unable to pay for such care.

State Medicaid programs are required by law to provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing-home services, physicians services, home health services, and early and periodic screening and treatment to eligible persons. Additional items, such as dental care and prescribed drugs, may be included if a State so chooses.

All persons and institutions providing services under the Medicaid programs are subject to the provisions of title VI of the Civil Rights Act of 1964.

The Federal Government pays for 50 to 83 percent (depending on the per capita income in the States) of the costs incurred by States in providing medical services under their Medicaid programs. For fiscal year 1970, these State programs reported expenditures for hospital and skilled nursing-home care of about \$3.3 billion, of which about \$1.7 billion represented the Federal share.

ADMINISTRATION OF TITLE VI

In December 1965 the Secretary, HEW, delegated to the Public Health Service the responsibility to see that all

hospitals and other medical facilities receiving Federal funds complied with title VI.

In February 1966 the Office of Equal Health Opportunity (OEHO) was established within the Public Health Service to administer title VI on medical facilities. In November 1967 the Secretary, HEW, transferred title VI enforcement responsibilities for hospitals and other medical facilities from OEHO to the Office for Civil Rights (OCR). The primary responsibility for securing title VI compliance rests with the regional civil rights director in each of HEW's 10 regional offices.

The Health and Social Services Division of OCR, with a staff of about 50 civil rights specialists, administers title VI policies with respect to all health and social service (welfare) programs. In the health-care area, OCR is responsible for (1) seeing that hospitals and other medical facilities are complying with title VI before they participate in Medicare or Medicaid, (2) ensuring that these institutions continue to comply with title VI, and (3) investigating complaints of title VI violations by these institutions.

In a public information booklet, OCR states that any person who believes that discrimination exists in any program aided by HEW should notify OCR. Internal procedures for handling complaints specify that OCR will (1) advise the person or facility against which a complaint is filed of the nature of the complaint and request a written reply, (2) interview the complainant, and (3) conduct an onsite investigation. Title VI requires that when a facility appears to be in noncompliance, the administering agency should attempt to secure voluntary compliance.

Before OCR certifies that a hospital or an ECF is complying with title VI--and is therefore eligible to participate in Medicare--each institution is required to complete (1) an assurance-of-compliance statement in which it agrees to comply with title VI and (2) a compliance report--a two-page questionnaire pertaining to the nondiscriminatory policies and practices of the institution.

OCR officials advised us that compliance reports must be submitted by all hospitals and ECFs applying to enter Medicare and by those institutions already under Medicare that have changed ownership. OCR officials said that the factors they considered in analyzing the reports included

- the reported ethnic composition of the population in the surrounding geographic area of the facilities compared with those of the patients served,
- the policies of the facilities in advising the communities that they did not discriminate,
- the composition of the hospitals' medical staffs, and
- the sources of patient referrals to ECFs and nursing homes.

States participate in many programs with the Federal Government and share the costs involved in providing services to recipients of those programs. With the enactment of title VI of the Civil Rights Act, it became the responsibility of State and Federal agencies to ensure that no beneficiary of a federally assisted program is subjected to discrimination because of race, color, or national origin. A 1966 HEW instruction specified that the States were to be responsible for ensuring that onsite compliance reviews of all nursing homes in the Medicaid program are made at least annually.

State reviews are a major portion of OCR's compliance program in health and social services. When hospitals and ECFs participate in State Medicaid or other grant-in-aid programs and these same facilities are under Medicare, a dual compliance responsibility exists. OCR, however, has final responsibility for ensuring compliance of facilities receiving Federal funds and monitors the State's reviews to ensure their validity.

CHAPTER 2

CONCLUSIONS ON REVIEW OF COMPLIANCE WITH TITLE VI BY HOSPITALS AND OTHER FACILITIES UNDER MEDICARE AND MEDICAID

We believe that most hospitals, ECFs, and nursing homes--under Medicare and Medicaid in the four major metropolitan areas where our review was made--were in compliance with title VI. This is not to say that discrimination in providing health services to minorities was totally absent. The types of discrimination that were reported to us, however, were indirect and subtle and did not involve overt denial by medical institutions of staff privileges to minority-group physicians or of admissions or services to minority-group patients.

DISPROPORTIONATE USE OF GOVERNMENT- OWNED HOSPITALS

Although most hospitals participating in Medicare and Medicaid in these four metropolitan areas were integrated, a disproportionately large share of minority patients received their health care at government-owned hospitals (State, county, or city). Minority-group patients were reported to be drawn to these hospitals because they (1) provided medical care at little or no cost to indigent patients, (2) were easily accessible to minority-group communities, (3) had traditionally been used by members of minority groups, and (4) had made special efforts to accommodate minority groups.

At most private hospitals patients can be admitted only by a physician having admitting privileges. Because physicians are in short supply in many areas where minority groups live, persons in such groups often must rely on outpatient clinics at government-owned hospitals for their general medical needs. When hospitalization is necessary, they are then admitted to these institutions as inpatients.

In two of the four metropolitan areas visited by us, minority-group patients were often unaware that their Medicare or Medicaid coverage entitled them to use private

hospitals as alternatives to the traditionally used government-owned hospitals. Measures to increase such awareness by minority-group patients might result in their greater use of private hospitals. HEW officials advised us that one of its components--the Medical Services Administration of the Social and Rehabilitation Service--had developed a proposal for consumer education to help ensure that each Medicaid recipient is informed of all Medicaid benefits and services available in his State.

OTHER REASONS FOR CLUSTERING
OF MINORITY-GROUP PATIENTS

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

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

Civil rights groups and HEW officials have reported that patterns of predominantly black or white ECFs and nursing homes are partially caused by the practices of State and local health and welfare departments in referring patients to ECFs or nursing homes. HEW officials advised us that regional office personnel from OCR and the Medical Services

Administration would investigate the referral process and would perform a number of onsite visits to skilled nursing homes in each State beginning on July 1, 1972.

According to HEW statistics, nonwhite beneficiaries were not using their proportionate share of ECF days under Medicare compared with white beneficiaries. On the other hand, nonwhites had substantially increased the lengths of their hospital stays after the passage of Medicare. Some black physicians have told us that blacks--more frequently than others--care for ill members of their families at home and do not use ECFs or nursing homes for convalescent care after discharge from hospitals. It is possible that these factors--increased hospital stays and home convalescent care--may account for the disproportionately low use of ECFs by nonwhites.

COMPLIANCE ACTIVITIES OF HEW

Shortly after the Medicare and Medicaid programs were enacted, HEW made extensive efforts to enforce title VI compliance; since then it has significantly reduced its activities in this area. HEW now makes relatively few onsite visits to hospitals, ECFs, or nursing homes. Instead, HEW relies more on information reported by institutions participating in the Medicare and Medicaid programs; on compliance reviews by State and local agencies; and on complaints by beneficiaries, physicians, and others to highlight those institutions which may require enforcement action.

COMMENTS OF HEW OFFICIALS AND REPRESENTATIVES OF CIVIL RIGHTS GROUPS

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

HEW officials have advised us that, within the health system, discrimination against the poor is more prevalent than discrimination on the basis of race, color, or national origin.

It appears that, on the basis of discussions with HEW officials and representatives of organizations interested in civil rights matters and our reviews at hospitals, ECFs, and nursing homes, title VI has done much to remedy the forms of overt discrimination that existed in the past in the health-care area. However, these officials and representatives have told us that title VI may not be adequate to deal with today's more complex forms of discrimination--such as the general attitudes of whites toward nonwhites or the lack of understanding by white hospital staff of the cultural or economic backgrounds of minority-group patients. According to HEW officials, to deal with the subtle forms of discrimination existing today, it may be necessary to modify the law so that instances such as gross underrepresentation of minority-group patients in a hospital compared with community population are considered prima facie evidence sufficient for HEW to compel a facility to take affirmative action to increase the number of its minority patients or demonstrate why more minority patients are not served.

HEW officials advised us that its Medical Services Administration had developed a detailed reporting form for regional office use in cooperation with OCR regional offices to monitor compliance with title VI in skilled nursing homes under Medicaid. The form was designed to determine the extent to which States are enforcing compliance with title VI.

Under HEW's current efforts to enforce nursing-home standards, it is promoting the establishment of investigative ombudsman units in each State government to review and follow up complaints made by, or on behalf of, nursing-home patients. The ombudsman units should provide another avenue available to people in local communities for lodging civil rights complaints, according to HEW officials. The Health Services and Mental Health Administration is sponsoring demonstrations in five States to develop model ombudsman units.

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The results of our work (1) at OCR headquarters in Washington, D.C., (2) at OCR regional offices in Atlanta, Georgia; Chicago, Illinois; and San Francisco, California, and (3) in four metropolitan areas, which served as the basis for our overall conclusions, are discussed in the following chapters.

CHAPTER 3

ACTIVITIES OF HEW TO ENSURE

COMPLIANCE WITH CIVIL RIGHTS LEGISLATION

BY HEALTH-CARE FACILITIES

Access of members of minority groups to hospitals, ECFs, and nursing homes has increased significantly since enactment of title VI of the Civil Rights Act of 1964. In all parts of the country, but particularly in Southern and border States, many hospitals have admitted and treated black patients for the first time. Also, at many hospitals black physicians have been allowed to practice for the first time and to admit and care for their own patients instead of having to refer them to a white doctor who has staff privileges. We believe that these changes have occurred largely because of HEW's efforts to enforce compliance with title VI by hospitals, ECFs, and nursing homes participating in Medicare and Medicaid.

Most of the changes occurred during the early days of the programs (especially 1966 and 1967) when hospitals, ECFs, and nursing homes were being approved by HEW. Since then HEW has significantly reduced its title VI compliance staff to the point where the staff's principal duties are to prevent hospitals, ECFs, and nursing homes from reverting to previous overt discriminatory policies and practices. OCR efforts in this area consist mostly of reviewing States' activities; ensuring title VI compliance by health-care institutions participating in federally assisted programs; and investigating complaints by beneficiaries, physicians, and others to highlight institutions which may require enforcement action.

In recent years OCR has not made annual onsite reviews to all facilities under Medicare and Medicaid programs to ensure that they comply with title VI. Rather, it has relied more on information reported by the facilities, complaints from the public, and State agency reviews to alert it to violations.

HEW STUDIES ON USE OF
THESE FACILITIES BY MINORITY GROUPS

In 1969 all hospitals and ECFs participating in Medicare or receiving other types of Federal financial assistance were requested to send compliance reports to OCR. Compliance reports had previously been obtained from most hospitals and ECFs during 1966 and 1967, shortly after they were initially certified to participate in Medicare. The 1969 reports were requested so that OCR could (1) assess the compliance of each hospital and ECF to identify any facility needing further investigation, onsite review, or consultation to bring them into compliance with title VI and (2) compare the 1969 reports with those reports submitted in 1966 and 1967 to measure the changes which had taken place in minority groups' access to hospitals and ECFs. Comparative statistics generally showed improvements in minority groups' access to hospitals and ECFs.

From 1966 to 1969, the number of hospitals serving minority-group patients increased 24 percent and the number of minority patients in hospitals increased 30 percent. Also the number of hospitals having minority-group physicians and dentists on their staffs increased 61 percent. Because of these increases, OCR concluded that access to hospitals by minority patients was no longer a major or a widespread problem.

The utilization of ECFs by members of minority groups, however, gave OCR concern. The number of ECFs serving minority-group patients increased by 82 percent from 1967, and the number of minority-group patients in ECFs increased 75 percent. However, the 1969 compliance reports showed that members of minority groups still represented only a small percentage (5.2 percent) of all patients in ECFs and OCR's analysis of the reports showed that many ECFs in racially mixed areas were treating only patients of one race even though the facilities published open admission policies.

In a May 1970 memorandum to OCR regional offices, a headquarters official pointed out that the racial imbalance of ECFs and nursing homes has been a major problem. Of

33 States in which OCR has completed reviews, he said, all but two had patterns of all-white and all-black ECFs and nursing homes. This OCR official believed that the patterns were caused partially by the referral practices of State and local health and welfare departments. The OCR official directed that each State agency that refers persons to nursing homes under federally assisted programs ensure not only that the homes do not practice discrimination but also that persons are not referred to these homes on a discriminatory basis.

A research study performed for the Social Security Administration showed that the number of days of hospital care per year for each 100 black persons over age 65 increased from 237 days in 1965 (prior to Medicare) to 351 days in 1967 (after Medicare). For each 100 white persons of the same age group, the number of days of hospital care per year increased from 320 in 1965 to 396 in 1967. Thus, the difference in 1965 of 83 days of hospital care per year between white and black persons (320 minus 237) had been reduced to 45 days in 1967 (396 minus 351). The increase in days of hospital care for black persons has been due to longer lengths of stay per admission. Between 1965 and 1967 the number of admissions per 100 black persons actually decreased. The increase in days of hospital care for white persons was due primarily to an increase in the number of admissions for each 100 white persons.

The research study also produced evidence that the Medicare program had "enhanced the dignity" of the Nation's elderly, particularly the black elderly, by providing payments for much of their care. Hospital days per 100 blacks aged 65 and over for which charges were imposed rose from 96 per year in 1965 to 234 per year in 1967.

Other data compiled by the Social Security Administration showed that on July 1, 1967, nonwhites represented 7.7 percent of all persons enrolled in part A of the Medicare program. During 1967, however, nonwhites represented only 5.7 percent of Medicare beneficiaries treated in hospitals and only 2.8 percent of Medicare beneficiaries treated in ECFs.

TITLE VI COMPLIANCE ACTIVITIES OF HEW
DURING EARLY DAYS OF MEDICARE

In February 1966 OEHO was established within the Public Health Service to administer title VI with respect to medical institutions. With enactment of the Medicare program in 1965, HEW needed to approve many hospitals and other facilities for participation in Medicare in a short period of time. OEHO made a crash effort to approve applications of all hospitals by July 1, 1966, and all ECFs by January 1, 1967, the dates these institutions could begin participating in the Medicare program under provisions of the act. OEHO hired about 60 consultants to assist a staff of about 500 persons who were temporarily assigned to them from the Social Security Administration, the Public Health Service, the Welfare Administration,¹ and other organizations within HEW.

At the outset, OEHO decided that the best leverage for enforcement of title VI compliance was for HEW to adopt a policy that no hospital or ECF would be certified for Medicare until OEHO had assurance that the facility was in compliance with title VI. To assist in making this determination, a questionnaire was sent to hospitals requesting background data and information--such as patient admission policies, patient censuses, and the nondiscriminatory practices followed by the facility--which would indicate whether a hospital was discriminating on the basis of race, color, or national origin. Because of the large workload that developed when the Medicare program was enacted, OEHO visited only about 2,700 of the 6,600 hospitals that initially applied to participate in the program.

Many hospitals were cleared on the basis of statements of assurance of compliance and background data submitted to OEHO by representatives of the institutions. Because of this compliance procedure, OEHO worked mainly to develop a non-discriminatory policy and a public announcement of that policy by each hospital.

¹The program activities of the Welfare Administration were assigned to the newly established Social and Rehabilitation Service in August 1967.

OEHO found that, by July 1966, about 6,400 of the 6,600 hospitals complied with title VI. OEHO efforts were directed at the remaining 200 hospitals until October 1966. By that time about 150 of the 200 hospitals had complied. OEHO was then able to direct its compliance activities toward ECFs.

A questionnaire, similar to the one sent to hospitals, was sent to ECFs seeking to participate in the Medicare program. Because OEHO's staff had been reduced by this time, few onsite visits were made to ECFs. Most ECFs were cleared on the basis of data submitted to OEHO by representatives of the institutions, and OEHO's main emphasis was on the development and public announcement of a nondiscriminatory policy by each ECF.

An HEW official told us that OEHO intended to make followup inspections of hospitals and ECFs to ensure their continuing compliance with title VI. In November 1967--before OEHO could begin reviewing these institutions--the Secretary, HEW, transferred title VI enforcement responsibilities from OEHO to OCR.

From November 1966 through November 1968, HEW cited 54 medical institutions for not complying with title VI despite HEW's efforts to get the institutions to voluntarily correct the problems. HEW advised the institutions that administrative proceedings were being initiated to terminate their participation in all federally assisted programs. Notices were sent to 42 institutions during the period November 1966 through February 1967 and to the remaining 12 institutions during the period October 1967 through November 1968. As of January 1972 proceedings had not been initiated against any additional institutions.

The results of the actions taken against the 54 institutions were, as follows:

--During calendar years 1967 through 1969, HEW terminated 16 institutions' participation in federally assisted programs. Subsequently 14 of the institutions corrected the civil rights deficiencies, reapplied, and were approved to participate in federally assisted programs. The two remaining institutions closed (one in 1969 and the other in 1971).

- Proceedings against 25 institutions were dropped during calendar years 1967 through 1969, because the institutions took corrective actions to end discrimination after receiving HEW's notices rather than have their participation in federally assisted programs terminated.
- Seven institutions voluntarily withdrew their Medicare applications during the period January through April 1967, rather than submit to Federal nondiscrimination requirements. After determining that these seven institutions were not in other federally assisted programs, HEW dropped proceedings against them. Later, all seven of these institutions corrected their civil rights deficiencies, reapplied, and were accepted for Medicare.
- Proceedings were dropped against three State mental health institutions (one in 1969 and two in 1971) after the institutions took corrective actions ordered by the U.S. district court to end discrimination. After investigating the three institutions, HEW initiated formal administrative compliance proceedings in January 1967. A hearing was held in April 1967, and the hearing examiner rendered his initial decision in October 1967 that the State and its three mental institutions were violating title VI and the applicable regulations. In November 1967 a civil complaint was filed in the district court by the State against HEW. About the same time, a class action was filed in the district court by patients of the institutions who sought an injunction against discrimination in the operations of mental health facilities by the State. The two cases were consolidated in the district court. In February 1969 the State was found guilty of discrimination and ordered to desegregate the three facilities within 12 months. During the time of the district court proceedings, HEW's administrative proceedings were deferred. Action on applications by the State for new assistance to the three institutions was also deferred, but Federal assistance continued on applications which had previously been approved.

--Formal administrative proceedings against three mental health institutions in another State were incomplete as of January 31, 1972. Proceedings were initiated against these institutions in December 1967. Two of the institutions were integrated early in 1968, and a plan was established for gradually integrating the third. Accomplishment of the plan was contingent, in part, on the repair and renovation of several buildings. Construction delays and other problems delayed completion of the work on these buildings. As of January 1972, six of the seven patient dormitories had been renovated and integrated. Renovation of the seventh building and total integration of the institution were expected to be completed by April 1972. OCR officials could not explain to us why they did not require integration of the seven buildings at once. Records maintained by OCR and by HEW's General Counsel's office also did not show why the decision was made to allow gradual integration of the one institution. Since December 1967, when HEW initiated administrative proceedings, all three institutions have been allowed to participate in federally assisted programs.

RECENT COMPLIANCE ACTIVITIES BY
OFFICE FOR CIVIL RIGHTS

HEW regulations require OCR to periodically review the practices being followed by recipients of Federal funds to determine whether they are complying with title VI. OCR's Health and Social Services Division, which is responsible for enforcing title VI compliance by health and welfare facilities and agencies, had nine civil rights specialists in its Washington headquarters in July 1971. An OCR official informed us that the work of the headquarters staff consisted mainly of developing and disseminating civil rights policies and monitoring the activities of the regional offices.

OCR regulations do not provide specific time intervals in which it must make compliance reviews. An OCR official advised us that regional civil rights specialists made on-site inspections of medical institutions when considered necessary on the basis of (1) desk reviews of compliance reports submitted by the institutions, (2) complaints, and (3) the degree of reliance it believed could be placed on State reviews of civil rights activities of medical institutions. The official stated that, with only about 50 civil rights specialists nationwide, the Health and Social Services Division could not possibly make annual onsite compliance reviews of the thousands of suppliers of health and welfare services. Therefore OCR must rely heavily on reviews made by State and local review agencies, he said.

HEW officials advised us that, during the 12-month period ended December 31, 1971, OCR made slightly over 1,700 visits to State and local agencies to monitor their compliance activities, including these agencies' reviews of the compliance status of hospitals and nursing homes used in the Medicaid program. During this same period, OCR made 950 reviews of hospitals and ECFs to determine their compliance status and slightly over 300 of these were onsite reviews.

OCR activities in Atlanta and Birmingham

The Atlanta regional office of OCR is responsible for ensuring title VI compliance in Alabama, Florida, Georgia,

Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. Its Health and Social Services Branch--responsible for enforcement of title VI in health and welfare facilities and agencies--employed 10 civil rights specialists in July 1971. The number of specialists had been increased from five to 10 in mid-1971 so that each State could be covered by at least one specialist.

During fiscal years 1970 and 1971, the OCR regional office approved three hospitals and eight ECFs in the Atlanta and Birmingham areas--that either had applied for the first time or had applied because of a change in ownership--for Medicare. OCR officials visited the three hospitals and two of the ECFs to examine admission practices, waiting room arrangements, bed-assignment practices, etc. OCR approved the remaining six ECFs without making a visit, relying on reviews conducted by the State or on data submitted by the ECFs.

In the Atlanta and Birmingham areas, OCR makes all initial reviews to approve hospitals and ECFs for participation in the Medicare program. OCR also makes periodic followup reviews of hospitals; however, OCR has arranged to have the Georgia and Alabama Departments of Health make followup reviews of ECFs.

Of the 24 hospitals in Medicare at the time our fieldwork was completed in these areas, 23 had been visited by OCR--20 before they were approved for Medicare and three shortly after they were approved for Medicare. OCR approved four hospitals for the program, without visiting them, on the basis of reviews of data furnished by the hospitals at the time of initial application. One hospital had not yet been visited at the time our fieldwork was completed. After approval, one-time followup visits were made to 15 of the 23 hospitals which had initially been visited; eight were routine visits and seven were related to specific complaints of discrimination.

At the time our fieldwork was completed, 20 ECFs (nine in Atlanta and 11 in Birmingham) were under Medicare. None had been visited by OCR at the time of initial approval; only half have been visited since then. All 20, however, had been reviewed by the State agencies to ensure continued

civil rights compliance. OCR visited 10 ECFs in the Birmingham area to test the adequacy of the State agency's review procedures. At the time we completed our fieldwork, OCR had not visited any ECFs in the Atlanta area to test the State agency review procedures.

In August 1971 OCR was negotiating agreements with both the Alabama and Georgia Departments of Health to make periodic title VI reviews of hospitals participating in Medicare and Medicaid. OCR was also negotiating with Alabama to improve the scope of the State's reviews of ECFs. We examined the review procedures to be incorporated into these agreements, and we believe that, if properly implemented, they should assist in determining compliance by these facilities.

Each of the 20 ECFs had been visited at least once by representatives of the State Departments of Health during fiscal years 1970 or 1971. State agency reviews disclosed only minor problems which, according to the related reports, had been quickly resolved.

According to an OCR regional official, not all institutions were visited at the time of their applications to participate in Medicare because of the large workload that developed when the Medicare program began. Also decisions concerning participation had to be made quickly and consequently many institutions--especially ECFs--had been cleared on the basis of background data furnished by the institutions and assurances of compliance executed by the institutions. Subsequently many of these facilities were not visited because the civil rights specialists were busy reviewing the civil rights activities of State agencies and approving title VI compliance reports for additional facilities applying to participate in federally assisted health and welfare programs.

OCR records covering the period July 1966 to June 1971 contained 39 charges of discrimination against hospitals participating in the Medicare program in the Atlanta and Birmingham areas. No such complaints had been received against the ECFs participating in Medicare. The charges were directed against 14 hospitals, and most of them involved discrimination by the hospitals against patients or

minority-group physicians. Examples included (1) refusal to admit patients for treatment, (2) segregating minority-group patients from others after admission, (3) inability of minority-group physicians to obtain staff privileges, and (4) unequal treatment given to minority-group professional members by hospital administrative officials.

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

Concerning the 34 resolved complaints, the charges of discrimination either could not be substantiated or were substantiated and corrective action was promised by the hospitals. None of the hospitals were removed from participation in the Medicare program.

OCR activities in Wayne County

The Chicago regional office of OCR is responsible for ensuring title VI compliance in Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Its Health and Social Services Branch employed six civil rights specialists in July 1971.

During fiscal year 1970 and 1971, the OCR regional office approved 12 ECFs and two hospitals in Wayne County for Medicare. OCR officials did not visit any of the institutions before approving them. According to an OCR official, the institutions were approved on the basis of OCR's review of the compliance reports submitted by the hospitals or ECFs and, in some instances, on the basis of additional information requested by OCR.

In September 1970 the OCR regional office completed a review of civil rights compliance activities in Michigan. OCR found that Michigan was not making title VI compliance reviews of hospitals but that the county departments of social services made annual compliance reviews of nursing homes and ECFs. The data obtained by the counties is sent to the Michigan Department of Social Services.

An OCR official advised us that, because the State had not visited hospitals and relied entirely on the counties to make title VI compliance reviews of nursing homes and ECFs, a number of such institutions were visited by OCR to test compliance. OCR selected 11 hospitals and 15 ECFs or nursing homes in Wayne County. As a result of its review of State activities and visits to hospitals, ECFs, and nursing homes, OCR--in its September 1970 report--made several recommendations to State officials for improving Michigan's civil rights activities, including

- designating someone to coordinate all State agency activities related to compliance with title VI and giving him the authority needed to effectively implement the State's plan for title VI compliance and
- establishing procedures for annual onsite reviews of all hospitals for title VI compliance.

OCR records covering the period July 1966 to June 1971 contained no charges of discrimination against medical institutions in Wayne County in admitting or caring for patients or in granting staff privileges to physicians.

OCR activities in Los Angeles County

The San Francisco regional office of OCR is responsible for ensuring title VI compliance in California, Arizona, Hawaii, and Nevada. Its Health and Social Services Branch employed four civil rights specialists in July 1971.

During fiscal years 1970 and 1971, the OCR regional office approved 29 hospitals and 151 ECFs in Los Angeles County for Medicare. OCR did not visit any of these institutions before it approved them.

According to a regional OCR official, an experienced secretary is responsible for reviewing all compliance reports and attempting to resolve any issues with representatives of the institutions. If these issues cannot be resolved by the secretary, the case is given to a civil rights specialist. In Los Angeles County all issues are resolved by telephone or through official correspondence with the

institutions. Because California reviews all medical institutions annually to ensure compliance with licensing requirements and with all Federal requirements under the Medicare and Medicaid programs--including title VI, this OCR official told us that it relied on the State to conduct onsite reviews unless a complaint had been received about an institution. He said that one exception to this in Los Angeles County occurred in 1969 when OCR regional officials visited six selected ECFs.

In California the State Department of Health Care Services is responsible for ensuring title VI compliance of all Medicaid providers which are also often Medicare providers. Through interagency agreements, onsite reviews of facilities were made by the State Department of Public Health. For Los Angeles County the State Department of Public Health has contracted with the County Health Department to inspect hospitals, ECFs, and nursing homes.

According to a Los Angeles County Health Department official, title VI compliance reviews are made as part of the county's annual onsite review effort to ensure compliance by hospitals, ECFs, and nursing homes with State licensing requirements and with all Federal requirements under the Medicare and Medicaid programs. Because of numerous other factors evaluated during these onsite reviews--such as sanitation, safety conditions, and adequacy of nursing services--title VI compliance has not been emphasized. The county has not instituted any specific procedures to ensure title VI compliance. No violations of title VI requirements have ever been identified during onsite inspections in Los Angeles County.

In letters dated July 14, 1971, OCR advised the Directors of the State Departments of Health Care Services and of Public Health that OCR had found that (1) no one had been assigned specific responsibility for coordinating the implementation of title VI within each of these State departments, (2) the Department of Health Care Services did not have a system for evaluating the compliance work of the Department of Public Health, and (3) in turn, the Department of Public Health did not have a system for ensuring that local health departments, hospitals, ECFs, and other providers of medical services were complying with title VI. OCR requested both departments to implement corrective actions by September 12, 1971.

In their replies, both State departments agreed to take corrective actions. An OCR official told us that, as of January 31, 1972, few corrective actions had been implemented and that OCR planned to work closely with both State departments to obtain satisfactory results.

OCR records showed that, from July 1966 to June 1971, it had received charges of discrimination against six hospitals and two ECFs in Los Angeles County in the granting of staff privileges to minority-group physicians or in admitting and treating minority-group patients. Six of the complaints could not be substantiated. For the remaining two complaints, OCR substantiated the charge and was able to persuade the institution to correct the situation so that neither institution was denied participation in federally assisted programs.

One case involved an ECF--which had no black patients--denying admission to a black woman on the basis of her race. After discussion and correspondence between OCR and the owners of the ECF during the period February to August 1970, the administrator was replaced and the ECF agreed to actively seek out minority-group patients. Starting August 1970, the ECF was required to submit monthly reports of the race, color, and national origin of all patients referred and admitted. Reports were still being required by OCR in January 1972.

In the other case OCR concluded that a community mental health center was insensitive and unresponsive to the needs of minority groups. As a result of OCR's efforts, the center took action to (1) obtain representation of minority groups on its board of trustees, (2) recruit minority-group medical and paramedical staff, and (3) initiate outreach activities for minority patients. In addition, OCR required the center to submit reports on the progress in these areas every 4 months from July 1971 through July 1972. In February 1972 an OCR official advised us that reports from the center had been received on schedule and that he was satisfied with the reported results.

CONTROLS OVER PAYMENTS FOR EMERGENCY SERVICES PROVIDED BY HOSPITALS THAT DO NOT PARTICIPATE FULLY IN MEDICARE

Some hospitals participate in Medicare only when providing care to patients in emergency situations when no other hospital is conveniently available. These are referred to as "emergency hospitals."

An "emergency hospital" is defined by the Medicare legislation as an institution which (1) is licensed if its State or local law provides for licensing of hospitals, (2) furnishes care by or under the supervision of a physician, and (3) provides 24-hour licensed nursing service under the supervision of a full-time registered nurse. Emergency hospitals, however, need not comply with other conditions established by Medicare for hospitals or with the provisions of title VI.

During the early stages of Medicare, concern was expressed by health-care leaders that a large concentration of claims for emergency services in some areas of the South was an indication that some hospitals--which were not in compliance with title VI--were securing reimbursement for routine services provided to Medicare beneficiaries under the guise of emergency services.

We reviewed the procedures followed by the Social Security Administration to control reimbursements for services provided by emergency hospitals within the jurisdiction of HEW's regional office in Atlanta, Georgia. This region covers eight of the Southern States, and these States account for 23 percent of the Nation's emergency hospitals. The Social Security Administration's procedures seemed adequate to ensure that reimbursement for emergency services was made only when a bona fide medical emergency existed and use of a fully participating hospital was not feasible because of the circumstances of the case.

The procedures for payment provide that the Social Security Administration district office located nearest the emergency hospital determine whether a fully participating hospital was as near or nearer than the emergency hospital and whether space and needed services were available in that hospital at

the time the emergency occurred. This information--together with the claim file--is forwarded for review to the HEW regional office. The procedures provide that, if the claim is approved on the basis that space or needed service was not available in a fully participating hospital, a Public Health Service physician will then examine the clinical records accompanying the claim to determine whether a bona fide medical emergency existed. The claims are then sent to the Medicare part A intermediary where (1) approved claims are paid and (2) rejected claims are subject to reconsideration.

Those having rejected claims are advised of the reasons and the procedures to follow if the patient wants the claim to be reconsidered. If a reconsideration is requested, the claim file and any additional medical information furnished by the hospital or the physician are forwarded to the Social Security Administration's Bureau of Hearings and Appeals in Rockville, Maryland, where a final decision is made on the case.

We examined 140 claims for emergency Medicare services provided by six emergency hospitals. OCR records showed that five of these six hospitals were not in compliance with title VI and could not be accepted as fully participating hospitals in Medicare. No information was available in OCR records to indicate whether the sixth hospital was complying with title VI.

Our examination of these 140 claims shows that

- 68 claims were approved for payment after review by the Social Security Administration district office and the HEW regional office;
- seven claims were initially rejected but approved upon reconsideration;
- 51 claims were rejected in total because (1) space or needed service was available in an accessible and fully participating hospital at the time the emergency occurred or (2) after examining the patients' clinical records, Public Health Service physicians determined that an emergency requiring hospitalization did not exist; and

--14 claims were rejected, in part, because Public Health Service physicians determined that the emergency condition had subsided to a point where the patients could have been moved to other hospitals. HEW rejected those parts of the claims covering services provided after this point.

CHAPTER 4

ACCESS TO MEDICAL SERVICES BY BLACKS IN THE ATLANTA AND BIRMINGHAM AREAS

OCR and State agency reviews in the Atlanta and Birmingham areas revealed little evidence of discrimination on the basis of race, color, or national origin in the admission or care of patients or in the granting of staff privileges to physicians by the 24 hospitals and 20 ECFs participating in the Medicare and Medicaid programs. In these areas our interviews with black and white persons--including physicians, nurses, patients, and administrative personnel at these institutions, plus representatives of local medical societies and various community service organizations--produced no new evidence of overt discrimination.

Hospitals and ECFs under Medicare and Medicaid have policies to admit all patients regardless of race, color, or national origin, and most of them have admitted black and white patients at one time or another. Nevertheless, black patients were clustered in a few hospitals and ECFs.

A patient census taken for us by the hospitals and ECFs in the Atlanta and Birmingham areas in 1971¹ showed a definite pattern of usage of certain medical institutions by black patients. From this pattern it seems reasonable to conclude that a dual system of medical facilities existed even if not intended--one group for white patients and another group for black patients.

¹A patient census was taken for us by each of the 24 hospitals for each day of the period July 19 to 26, 1971. From this we determined an average daily census. Each of the 20 ECFs took a patient census for us on July 19, 1971. When we visited the hospitals and ECFs to pick up the data, we also toured them to confirm the reasonableness of the census data furnished.

Reasons given to us in interviews in these two areas for the concentration of black patients in certain hospitals were that

- the black patients preferred to use these hospitals for convenience and because of their familiarity with the hospital from prior association,
- the patients' physicians preferred to use these hospitals,
- the hospitals were located in areas heavily populated by blacks, and
- many black patients did not have their own physicians so they had to use the outpatient clinics of the State- or county-owned hospitals to gain admission to these hospitals.

Listings of physicians having staff privileges obtained from each of the 24 hospitals show that black physicians have been able to obtain staff privileges at most hospitals in the Atlanta and Birmingham areas, but at many hospitals--particularly those treating predominantly white patients--few black physicians had staff privileges.

The small numbers of black physicians at some hospitals may have been due to the following reasons.

- In July 1971 only 78 black physicians were practicing at hospitals in the Atlanta area which had a population of about 1.4 million, including over 300,000 black persons (or one black physician for every 3,846 black persons); only 15 black physicians were practicing at hospitals in Birmingham which had a population of over 300,000, including over 125,000 blacks (or one black physician for every 8,333 black persons).
- Black physicians having staff privileges at hospitals treating predominantly white patients advised us that they seldom used these privileges because of (1) loyalty to predominantly black-patient hospitals where they also had staff privileges, (2) the desire to have

their patients near their offices, or (3) the time and expense of making rounds at several hospitals.

--Black physicians with staff privileges at only those hospitals treating predominantly black patients advised us that they were not interested in obtaining staff privileges at predominantly white-patient hospitals for the same reasons mentioned above. Several of these physicians said that they had applied for staff privileges at white-patient hospitals years ago, were rejected, and were no longer interested in practicing at those hospitals.

The persons whom we interviewed generally agreed that little difference existed between the quality of medical care or services provided to blacks and whites.

CONCENTRATION OF BLACK PATIENTS
IN CERTAIN HOSPITALS AND ECFs

The patient census taken for us at the 24 hospitals and 20 ECFs that were participating in Medicare in the Atlanta and Birmingham areas showed that 67 percent of the black patients had been treated at five institutions. One hospital and six ECFs had no black patients. In addition, as shown below, another four hospitals and nine ECFs had five or fewer black patients.

	Number of patients		
	<u>White</u>	<u>Black</u>	<u>Total</u>
Atlanta area institutions:			
A (hospital)	210	4	214
B "	35	2	37
C "	19	1	20
D (ECF)	182	2	184
E "	164	2	166
F "	90	4	94
G "	67	1	68
H "	25	1	26
Birmingham area institutions:			
I (hospital)	146	5	151
J (ECF)	65	4	69
K "	38	1	39
L "	35	1	36
M "	14	3	17
Total	<u>1,090</u>	<u>31</u>	<u>1,121</u>

Three of the 15 hospitals in the Atlanta area were treating 81 percent of all black patients. One hospital (having 20 patients) had no black patients. At the remaining 11 hospitals, from 2 to 13 percent of all patients being treated were black patients.

One hospital with an average daily census of 117 patients had no white patients. The hospital was constructed under a Hill-Burton¹ grant in 1949 to serve black patients with the ability to pay for their care. The hospital has been a concern of HEW at various times since passage of the 1964 Civil Rights Act. HEW officials have advised us, however, that they have been unable to prove that the hospital practices any form of discrimination.

Of the nine ECFs in the Atlanta area, one was treating 75 percent of the black patients. This ECF had 116 patients and only one was white. On the other hand, one religiously affiliated ECF had 101 patients and none were black.

Of the nine participating hospitals in the Birmingham area, one (a State-owned hospital) was treating 49 percent of the black patients. Another hospital, with an average daily census of 43, had all black patients. At the remaining seven hospitals, 3 to 21 percent of all patients being treated were black patients.

Of the black patients in ECFs in the Birmingham area, 91 percent were being treated in two of the 11 ECFs. One of these ECFs had 43 black patients and no white patients; the other had 46 black patients and one white patient. Five of the ECFs--providing care to 400 patients--had no black patients.

¹The Hill-Burton program provides Federal grants or loans and loan guarantees with interest subsidies for the construction or modernization of hospitals and other health-care facilities.

REASONS FOR BLACK PATIENTS' BEING
CLUSTERED IN CERTAIN HOSPITALS AND ECFs

We interviewed physicians; patients; hospital and ECF officials; and representatives of civil rights organizations, medical societies, and welfare organizations to obtain reasons for the heavy concentration of black patients in certain hospitals and ECFs. The disproportionate number of black patients being treated by only a few of the hospitals and ECFs, they believe, is not the result of current discriminatory policies or practices but is the result of (1) personal preference by black patients and their physicians, (2) convenience of the institutions to the black community, and (3) traditional use of State- or county-owned hospitals by black patients without personal physicians.

Preferences of black patients
and their physicians

The most frequent reasons given by black patients we interviewed for being in a particular hospital or ECF were (1) it was convenient to them or had been used previously, (2) their physician had selected it, and (3) it had provided free medical care to them before they became eligible for Medicare or Medicaid benefits. Most patients said that the institutions in which they were confined were selected with full knowledge that, under the Medicare and Medicaid programs, they could have selected any medical facility of their choice.

Physicians have told us that it is a general practice in their profession for the patient to select a physician and for the physician to select the medical facility. Black physicians have told us that they generally confine their use of staff privileges to hospitals where the patient loads have been totally or predominantly black. This was done principally, they said, for their convenience to limit their hospital rounds to a few hospitals.

Black physicians with staff privileges at several hospitals--including hospitals where the patients treated were predominantly white--admit almost all of their patients to hospitals treating predominantly black persons, they said. In Birmingham, for example, of the 15 black physicians who

had staff privileges at Medicare-approved hospitals, 14 had privileges at the one hospital where only black patients were being treated at the time of the patient census. Of these 14 physicians, four also had staff privileges at hospitals where predominantly white patients were being treated, including one physician who had patient admission privileges at seven hospitals in the city. These four physicians said they rarely admitted patients to any hospital other than the one where the patient load was totally black.

Some black physicians in the Atlanta and Birmingham areas practiced at hospitals which had traditionally served a greater number of black patients, even though other hospitals at which the physicians had staff privileges were more conveniently located. They preferred to practice, they said, at the predominantly black-patient hospitals for a variety of reasons--including tradition, loyalty, and preference of their patients to use those hospitals. In Birmingham, for example, the hospital occupied totally by black patients was the only one where black physicians could practice prior to passage of the 1964 Civil Rights Act. Two black physicians told us that they preferred to continue to practice at this hospital out of loyalty and because the hospital was experiencing financial problems and needed patients.

Of the 11 black physicians we interviewed who had staff privileges at only those hospitals treating predominantly black patients, 10 told us they were not interested in obtaining staff privileges at predominantly white-patient hospitals. The other physician said that he has applied at two predominantly white-patient hospitals over the past few years. Also, from 1968 to 1970 he submitted three applications to one hospital but was told by hospital staff that they had never received any of his applications. He told us that he applied at the other hospital in 1969 but was told in 1971 that the hospital had not yet acted on his application. This physician believes that he may have been discriminated against.

Three of the 10 black physicians--who told us they were not interested in obtaining staff privileges at hospitals treating predominantly white patients--said that they had applied for staff privileges at white-patient hospitals

several years ago but were told by the hospitals that (1) the hospital was already overcrowded and could not handle the additional patient load which would be generated by granting admitting privileges to additional physicians or (2) the hospitals had no need for additional general practitioners. Two of these black physicians believed that they had been refused admission privileges because of their race.

A black physician told us about a particular case where two black and three white physicians had applied for staff privileges in 1970 at a hospital where the patient load had traditionally been predominantly white. All five applications had been deferred because of overcrowded conditions, and none of the applicants had been granted staff privileges at the time of our fieldwork. We interviewed one of the black physicians who had applied; his application was still pending, he said, and he did not consider the hospital's action to be discriminatory.

At hospitals where few black patients were treated, administrators told us that physicians having staff privileges had few black patients. Others said few black patients lived in the areas served by the hospitals.

Because the selection of a hospital is often based on the desire of the attending physician rather than on the desire of the patient, black physicians in the Atlanta and Birmingham areas may be contributing to the existing patterns of hospital use by black patients (1) by not persisting in their efforts to obtain staff privileges at hospitals treating predominantly white patients and (2) by seldom using their staff privileges at white-patient hospitals when they have such privileges.

People generally use institutions near where they live

Those institutions in areas containing high concentrations of the black population generally received the highest usage by black patients. The same relationship exists in predominantly white population areas.

Atlanta area

The three hospitals treating 81 percent of the black hospital patients in the Atlanta area during the patient census made for us are in census tracts¹ where black persons represent more than 90 percent of the population. The hospital with no black patients and the three hospitals with five or fewer black patients (see A, B, and C on p. 33) are in census tracts where less than 5 percent of the population is black.

The ECF treating 75 percent of the black patients is in a census tract where black persons represent over 93 percent of the population. The ECF with no black patients and four of the five ECFs with five or fewer black patients (see D, E, G, and H on p. 33) are in census tracts where less than 5 percent of the population is black. The other ECF with five or fewer black patients (see F on p. 33) is on the border of two census tracts--one having a black population of 1 percent and the other having a black population of 49 percent.

Birmingham area

The hospital treating only black patients during the patient census conducted for us in the Birmingham area is in a census tract where black persons represent 97 percent of the population. The State-owned hospital treating 49 percent of Birmingham's black patients is in a census tract having a black population of 28 percent. The remaining seven hospitals in Birmingham were located in census tracts where black persons represented from 0 to 22 percent of the population. The hospital with five or less black patients (see I on p. 33) is in a census tract where only one black person lives.

The patient census data for ECFs in Birmingham did not conform to the mix of black and white persons in the census

¹Information gathered by the U.S. Census Bureau is reported by tracts to permit small-area analysis. These are called census tracts. The population information for these census tracts came from the 1970 census.

tracts where the ECFs are located. The two ECFs treating 91 percent of black ECF patients are in census tracts where only 10 to 12 percent of the populations are black. On the other hand one ECF with no black patients and two with fewer than five black patients (see J and M on p. 33) are in a census tract where 22 percent of the population is black. Another ECF with no black patients and one with fewer than five black patients (see K on p. 33) are in census tracts where about 10 to 12 percent of the populations are black.

The major reason two ECFs were treating most of the black patients, in our opinion, was that they were black owned. At one ECF all patients had to be admitted by the black staff physician. At the other ECF patients are attended by a black physician who visits there 1 day a week and is on call at any time.

Several black physicians in Birmingham advised us that blacks--more so than whites--had not yet accepted the nursing home or ECF as a means of obtaining care less intensive than that provided in hospitals and often viewed such facilities as places to set aside unwanted elderly people. According to these physicians, blacks often prefer to care for members of their families at home for illnesses not requiring confinement to a hospital and those who do seek nursing-home or ECF care generally cluster in certain facilities by choice to be in the company of other black persons.

Black patients without personal physicians
have traditionally used State- or
county-owned hospitals

Officials of civil rights organizations advised us that many poor black persons did not have their own physicians. Consequently they have used outpatient clinics of State- or county-owned hospitals to receive needed medical treatment. When further care has been found necessary--by the examining intern or resident physician--the patients have been admitted to these hospitals. Other reasons given for the heavier use by black persons of government-owned hospitals over other hospitals were that they (1) provided medical care at little or no cost to low-income patients and that much of the local black population was in this category, (2) had been the hospitals generally used by the aged and indigent before the

Medicare and Medicaid programs were established, (3) were in or near predominantly black communities.

The county-owned hospital in Atlanta provides medical care at little or no cost to indigent patients, and all patients are admitted through its outpatient clinic and emergency room. The hospital is a teaching hospital,¹ and all patients are admitted by staff physicians and interns. None of the staff physicians have private medical practices.

During 1 day of the 1-week census period, 1,798 patients--of which 1,378, or about 77 percent, were black--visited the hospital's outpatient clinic and emergency room. During this 1-week period, 58 percent of all black patients hospitalized in the Atlanta area were confined in this one hospital.

In this connection, we noted that, under a Model Cities grant,² an agency of the city operates a bus in one of the large black communities and the bus passes this hospital. The bus fare is 10 cents compared with 40 cents for the regular bus fare in Atlanta. Therefore it is convenient and economical for black patients to use this hospital for needed medical services.

In Birmingham, black patients extensively used the one State-owned hospital that provided medical care at little or

¹The term "teaching hospital" has been defined by the Association of American Medical Colleges as any hospital having a program of graduate medical education (one which trains residents and interns) whether or not the hospital is related directly to a medical school.

²Established under title I of the Demonstration Cities and Metropolitan Development Act of 1966, the Model Cities Program was designed to demonstrate how the living environment and general welfare of people living in slum and blighted neighborhoods could be substantially improved in cities of all sizes through a comprehensive attack on the social, economic, and physical problems by a concentrated and coordinated Federal, State, and local effort.

no cost to indigent patients. This hospital is also a teaching hospital, and all patients are admitted by staff physicians through its outpatient clinics and emergency room. According to the hospital administrator, poor persons and persons who do not have their own private physicians come to the State-owned hospital for medical treatment because they are not able to obtain it elsewhere.

During the 1-week census period, this hospital accounted for 49 percent of all black patients in hospitals in Birmingham. On 1 day, this hospital received 386 patients in its outpatient clinic and emergency room and 256 of them, or about 66 percent, were black.

Other than the two government-owned hospitals in Atlanta and Birmingham, patients could be admitted to a hospital only by a physician having staff privileges at that hospital.

CHAPTER 5

ACCESS TO MEDICAL SERVICES BY

NONWHITES IN WAYNE COUNTY

In reviews of hospitals in Wayne County, OCR has found no evidence of discrimination. OCR and State agency reviews have also shown nursing homes and ECFs under Medicare or Medicaid in Wayne County to be in compliance with title VI. Our interviews in Wayne County with administrators, 10 black physicians, and 20 black patients at 12 hospitals and five ECFs or nursing homes and with officials of local civil rights organizations, State and local social service organizations, and medical societies substantiated that compliance with title VI was being attained.

In a 1966 study of 19 hospitals in the Detroit area,¹ the Michigan Civil Rights Commission found little overt racial discrimination and concluded that of most significance was the extent of change and improvement that had taken place in hospitals over the period of a few years. The study pointed out that (1) most hospital administrators were aware of their responsibilities in promoting equality of opportunity and (2) administrators had shown a willingness to consider community expectations and adopt aggressive and affirmative programs designed to help overcome past inequities.

In a 1966 study of 16 licensed nursing homes in Wayne County, however, the commission found that many of these facilities seldom had black patients and some had never had a black patient referred to them. The commission concluded that the four major sources of nursing-home referrals--the county welfare department and three local government-owned hospitals--contributed to an extreme racial imbalance of patients in many nursing homes.

¹The population of Detroit represents about 57 percent of Wayne County's population (1.51 million of 2.67 million). About 92 percent of Wayne County's black persons live in Detroit.

An official of the Michigan Civil Rights Commission told us in June 1971 that, during the past few years, the commission had received no charges of discrimination in providing services to patients or in granting staff privileges to physicians against medical institutions in Wayne County.

In 1970 OCR made reviews of 11 hospitals and 15 ECFs or nursing homes in Wayne County. OCR observed no discriminatory practices in hospitals. Nonwhite persons were being served commensurate with the minority population in each hospital's locale. However, many of the ECFs or nursing homes had few or no minority-group patients. OCR directed the Wayne County Department of Social Services to reexamine its referral practices to ensure that patients of minority groups were not being restricted in their access to ECFs or nursing homes.

The 12 hospitals and five ECFs or nursing homes which we visited had policies of admitting patients regardless of race, color, or national origin. Nevertheless, patient counts taken at these 17 institutions--and others throughout Wayne County--showed that some were used almost exclusively by whites and others were used almost exclusively by nonwhites.

Nonwhites have used city- and county-owned hospitals more extensively than most other nearby hospitals. Reasons given to us in interviews in Wayne County for the heavier use by nonwhites of these government-owned hospitals are:

- They are open to anyone in need of medical treatment regardless of their ability to pay and much of the black population in Wayne County has low incomes.
- Because many nonwhites do not have their own family physicians, they go to the city- or county-owned hospitals, outpatient clinics, or emergency departments for their care and when further care is found necessary, they are admitted to these hospitals.
- Nonwhite patients often are not aware that Medicare and Medicaid benefits are payable to other participating hospitals.

Many hospitals have limited numbers of black physicians on their staffs; however, the consensus of the 10 black physicians whom we interviewed is that the trend in Wayne County is toward acceptance of physicians on hospital staffs on the basis of ability, not race. There is, however, a shortage of black physicians in Wayne County and a shortage of any physicians practicing in the Detroit inner-city area which has a high percentage of black persons. Wayne County had a black population of nearly 725,000 but had only about 200 black physicians in 1971--or one black physician for each 3,625 black persons. Fewer than 60 black physicians practiced in the Detroit inner-city area. Black physicians represented only about 4 percent of the physicians on the staffs of the 12 hospitals we visited.

Several black physicians have told us that black general practitioners have problems getting privileges to admit patients at many hospitals because the hospitals admit only specialists to their staffs. This practice by hospitals of limiting new staff appointments to specialists was mentioned as a problem in the 1966 Michigan Civil Rights Commission study but was reported to be of equal concern to white as well as black physicians.

The persons whom we interviewed have generally agreed that white and nonwhite patients are treated equally at medical institutions in Wayne County.

USE OF HOSPITALS BY NONWHITES

Statistics compiled by HEW in 1969 on the basis of a 1-day census at 59 hospitals participating in the Medicare program in Wayne County showed that

--nonwhites represented under 5 percent of the patients at 11 hospitals, including one that had all whites among its 237 patients, and

--whites represented under 5 percent of the patients at five hospitals, including three hospitals that had only nonwhites among their 222 patients.

We visited six hospitals--including a city-owned hospital--in the Detroit inner city where about 80 percent

of the population is black. The following table shows the racial mix of the patients at the six hospitals on the day of our visits.

<u>Hospital</u>	<u>Patient load</u>				
	<u>Total</u>	<u>White</u>		<u>Nonwhite</u>	
		<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
A (city owned)	471	71	15.1	400	84.9
B	103	39	37.9	64	62.1
C	357	164	45.9	193	54.1
D	746	481	64.5	265	35.5
E	585	409	69.9	176	30.1
F	<u>90</u>	<u>85</u>	94.4	<u>5</u>	5.6
Total	<u>2,352</u>	<u>1,249</u>	53.1	<u>1,103</u>	46.9

The city-owned hospital (A) had the highest percentage of nonwhite patients, and only hospital F had a small number of nonwhite patients. We asked an official of hospital F why the hospital had so few nonwhite patients; he said that nonwhites living in this locale were generally treated at neighborhood clinics staffed by general practitioners and that this hospital limited admissions to referrals from members of the medical staff, who were all specialists.

At the city-owned hospital, patients could be admitted only through the outpatient clinic or emergency room; usually admission was by an intern or a resident physician. Although a patient could be referred to this hospital by a private physician, the physician could not admit or treat his patient there.

We also visited six hospitals--including a county-owned hospital--in an area of suburban Wayne County where only about 5 percent of the population is black. The following table shows the racial mix of the patients at these six hospitals on the day of our visits.

<u>Hospital</u>	<u>Patient load</u>				
	<u>Total</u>	<u>White</u>		<u>Nonwhite</u>	
		<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
G (county owned)	358	261	72.9	97	27.1
H	257	210	81.7	47	18.3
I	22	21	95.5	1	4.5
J	214	207	96.7	7	3.3
K	435	431	99.1	4	.9
L	<u>204</u>	<u>204</u>	100.0	<u>0</u>	0
Total	<u>1,490</u>	<u>1,334</u>	89.5	<u>156</u>	10.5

The county-owned hospital (G) had the highest percentage of nonwhite patients. The only other hospital with a significant number of nonwhite patients in this suburban area heavily populated by whites was hospital H which is on the border of a community with a black population of 45 percent.

We asked 10 black patients at hospital A and 10 black patients at hospital G why they had selected the government-owned hospitals. Of these patients, 17 said that, because they had no family physicians, they had come to the out-patient clinics to see physicians and were then admitted to the hospitals. Most patients gave more than one reason for using the government-owned hospital; these other reasons are shown below.

<u>Other reasons given for using government-owned hospital</u>	<u>Number of patients responding</u>
Preferred hospital because of familiarity from previous use	9
Preferred hospital because it was convenient	3
Had no money and knew these hospitals would treat them	5
Brought to hospital by police or government-owned ambulance	7
Referred to hospital by someone else	5
Were not aware that Medicare or Medicaid coverage was accepted at other hospitals	11

USE OF ECFs AND NURSING HOMES BY NONWHITES

In 1969 HEW compiled statistics on 35 ECFs in Wayne County which showed that

- six ECFs with 796 patients had no nonwhite patients;
- one ECF with 486 patients had only one nonwhite patient;
- at five other ECFs, nonwhites represented less than 5 percent of the patients; and
- one ECF had only one white among its 55 patients.

In Michigan, county departments of social services make annual onsite reviews of the compliance by nursing homes and ECFs with title VI. The Michigan Department of Social Services compiles a report on the basis of the results of these reviews. Its 1971 report showed no instances of noncompliance with title VI by the 400 nursing homes and ECFs in the State.

The report showed that, of all nonwhite patients treated in nursing homes in Michigan, 84 percent were in Wayne County nursing homes. Although nonwhites represented only about 8 percent of all nursing-home patients in Michigan, they represented about 23 percent of all nursing-home patients in Wayne County. For the 112 nursing homes in Wayne County, 21 had no nonwhite patients and an additional 32 had five or fewer nonwhite patients each. These 53 nursing homes had only 87 nonwhites among 4,670 total patients--less than 2 percent--whereas 57 nursing homes in Wayne County had 2,048 nonwhites among 6,152 total patients--about 33 percent. The remaining two nursing homes had 121 patients, but the report did not show a breakdown between white and nonwhite patients for these facilities. None of the 110 nursing homes in Wayne County for which a breakdown of white and nonwhite patients was reported were treating only nonwhite patients.

To obtain reasons for concentrations in certain ECFs and nursing homes of one racial group, we visited one ECF and one nursing home in the Detroit inner-city area and two

ECFs and one nursing home in a suburban area of Wayne County. The racial mix of the patients at the five institutions on the day of our visits was, as follows:

<u>Facility</u>	<u>Patient load</u>				
	<u>Total</u>	<u>White</u>		<u>Nonwhite</u>	
		<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
Detroit inner-city area:					
A	101	97	96.0	4	4.0
B	476	470	98.7	6	1.3
Suburban Wayne County:					
C (county owned)	221	150	67.9	71	32.1
D	87	69	79.3	18	20.7
E	<u>90</u>	<u>83</u>	92.2	<u>7</u>	7.8
	<u>975</u>	<u>869</u>		<u>106</u>	

According to officials of facilities A and B, the homes are religiously affiliated and most of their patients are referred by churches or people previously treated there. Very few referrals are from the government-owned hospitals or from the county welfare department.

The administrator of facility A said that the facility had few nonwhite patients because (1) few nonwhites were referred there, (2) nonwhites preferred to stay at home with their families rather than use a nursing home, and (3) the black community had a general misunderstanding about the type of services provided by the facility.

An official of facility B told us that this facility did not discriminate although the patient mix might imply that it did. He showed us advertisements in local newspapers stating that applicants were accepted by the facility regardless of race, color, creed, national origin, or financial means but said that they received very few applications as a result of these advertisements. He attributed the virtual absence of nonwhite applicants to a belief that nonwhite people preferred to live with other nonwhites.

The three facilities in suburban Wayne County get most of their patients from the county-owned hospital and the county welfare department. Facility C is a county-owned ECF on the grounds of the county-owned hospital complex in an area with a small black population. (See G on p.46.) Most of its patients are transferred from the county-owned hospital which had nearly the same percentage of nonwhite patients. The population of the suburban community in which facility D is located has a black population of 45 percent. Facility E is in an almost all-white suburban section of Wayne County.

CHAPTER 6

ACCESS TO MEDICAL SERVICES BY MEMBERS OF

MINORITY GROUPS IN LOS ANGELES COUNTY

Hospitals and ECFs in or near the minority-group communities in which our review was concentrated in Los Angeles County were in compliance with title VI. Except for two complaints which had been substantiated and acted upon by OCR (see p.), we found no instances in which patients had been refused admittance or otherwise discriminated against or in which physicians had been refused staff privileges at hospitals because of race, color, or national origin.

Some minority-group physicians told us, however, that subtle forms of discrimination existed in the granting of hospital staff privileges but that such discrimination could not be proved. Some members of minority-group organizations and some minority-group patients told us that subtle discrimination also existed in the provision of services to minority patients.

Although not in violation of title VI, many hospitals, ECFs, and nursing homes in Los Angeles County served relatively few minority-group patients. This is apparently attributable to

- the tendency for minorities to use those institutions in or near the areas in which they reside and
- a disproportionate use of county-owned hospitals by members of minority groups.

These matters are discussed in greater detail below.

ADMISSION AND CARE OF PATIENTS

All of the 30 hospitals and 16 of the 18 ECFs we visited were treating patients of minority groups. Three of the ECFs--including the two not treating minority-group members and the one treating only members of a minority group--catered

to certain religious, ethnic, or economic groups. According to OCR, however, those ECFs were not in violation of title VI.

We toured all 48 institutions and, in the 45 which were treating both majority- and minority-group patients, we saw no indication of segregation of patients or differences in services afforded patients of minority groups. We also interviewed several admitting personnel at nine of the institutions, including three persons who were members of minority groups, and were told that they knew of no instances in which individuals had been denied access to the institutions because of race, color, or national origin.

To obtain their views regarding discrimination by health institutions, we interviewed 39 patients, 44 physicians, and 27 nurses whose ethnic characteristics were, as follows:

<u>Ethnic characteristic</u>	<u>Number of</u>		
	<u>Patients</u>	<u>Physicians</u>	<u>Nurses</u>
Black	21	19	6
Oriental	0	9	2
Spanish surname	7	8	10
White	<u>11</u>	<u>8</u>	<u>9</u>
Total	<u>39</u>	<u>44</u>	<u>27</u>

None of the 39 patients advised us of any specific instances of discrimination; however, two black patients felt that an overtone of discrimination existed in the attitude of hospital staffs. None of the physicians informed us of difficulty in having patients admitted to an institution because of race, color, or national origin. The nurses told us that they had not observed any difference in the services provided to minority patients and were unaware of any policy by any institution to exclude patients because of their race, color, or national origin.

One black physician advised us, however, of a nursing home which had segregated minorities by room. He informed the home that, if it did not end the practice, he would stop making referrals there; the nursing home corrected the situation.

Officials whom we interviewed--representing 34 civil rights, health, welfare, and other community organizations--had differing opinions as to whether discrimination actually existed. Views of some of the organizations whose officials believed that discrimination in admission or care of patients existed included:

- An official of a postgraduate medical school in the highest black-populated area of Los Angeles has said that a rapport often does not exist between white hospital staff and black patients because the staff does not understand the cultural or economic background of the black persons.
- Officials of a new county-owned hospital to be opened in the highest black-populated area of Los Angeles in March 1972 have advised us that, especially in southern California, discrimination is very subtle and impossible to describe in specific terms. It takes the form of general discriminatory overtones behind the actions of whites and may not necessarily be a conscious effort.
- A community organization in the section of Los Angeles most heavily populated with Spanish-surnamed individuals reported in 1970 that many health service staff members were insensitive to the problems of the Spanish-speaking patient and needed to be educated in Mexican-American culture.

HOSPITAL STAFF PRIVILEGES FOR MINORITY PHYSICIANS

According to regional OCR officials, the granting of hospital staff privileges to physicians is of major importance when considering whether hospitals discriminate in admissions or services and they found no indication that physicians had any difficulty in having minority patients admitted to hospitals once they obtained staff privileges. Also, because patients were admitted to most hospitals by their physicians, hospitals could effectively exclude or control admission of minority patients by discriminating in the granting of staff privileges. Although minorities were significantly underrepresented on hospital staffs, they

believed this was partially due to a general shortage of minority-group physicians. Minority-group physicians--especially blacks--were apt to serve patients of their own race, they said.

At 28 of the 30 hospitals visited, data was available on the ethnic breakdown of physicians having staff privileges. Each of the 28 hospitals had granted staff privileges to physicians of minority groups; the range was from 5 percent of the total physicians at two hospitals outside the large minority population areas to 68 percent of the total physicians at one hospital in the most heavily populated black area in Los Angeles County.

Oriental and Spanish-surnamed physicians we interviewed said that they had found no difficulty in obtaining staff privileges. Eight of the 19 black physicians, however, believed that subtle forms of discrimination existed in the granting of staff privileges.

According to four black physicians, complaints received by OCR reflected just a sample of existing discriminatory practices because many physicians who might have requested investigations of discrimination were interested in practicing medicine and not in pursuing civil rights issues. One of these physicians said that (1) minority-group physicians often simply avoided seeking privileges at hospitals they suspected of discrimination and (2) even when those physicians who did apply were denied staff privileges for seemingly racial reasons, they found it simpler or less humiliating to ignore the matter.

Another black physician told us that he had been dismissed from a hospital staff for not adequately maintaining his Medicare and Medicaid records but that he believed race had played a part in his dismissal. He felt that a white physician would have been given a second chance under similar circumstances. He had not referred the matter to OCR because he was attempting to be readmitted to the staff and did not want adverse attention.

OCR had received complaints from minority-group physicians who charged that three hospitals in Los Angeles County had rejected their applications for staff privileges

on the basis of race or national origin. In each case OCR found that the applications had been rejected for reasons unrelated to the applicants' race or national origin.

Officials of two of the three hospitals contended that they were already overstaffed and therefore accepted only those applicants (1) whose medical speciality was in short supply, (2) whose medical capabilities were outstanding, or (3) who were associated in a partnership or group practice with someone who already had staff privileges. The hospitals were complying with title VI, OCR concluded, because their policies were applied consistently regardless of the race, color, or national origin of the physician and some minority-group physicians had been granted privileges.

Black physicians believed such policies were discriminatory because the physicians on the staffs of these hospitals were predominantly white and they would therefore likely be associated in practice only with other white physicians. Furthermore, they maintained that blacks were less likely to have medical specialities to offer hospitals because a larger proportion of black physicians were general practitioners than were their white counterparts.

OCR officials advised us that, although such admission policies placed minority-group physicians at a disadvantage, they were not discriminatory if applied uniformly regardless of race, color, or national origin.

MEMBERS OF MINORITY GROUPS USE
INSTITUTIONS NEAR THEIR HOMES

Information extracted from compliance reports--submitted to HEW on the basis of a 1-day census in 1969 by 160 hospitals and 284 ECFs in Los Angeles County--showed that many hospitals and ECFs in Los Angeles County treated few minority-group patients, as follows:

Percent of minority-group patients	Hospitals		ECFs	
	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
0 to 9.9	53	33	213	75
10 to 49.9	88	55	61	22
50 to 89.9	13	8	6	2
90 to 100	<u>6</u>	<u>4</u>	<u>4</u>	<u>1</u>
Total	<u>160</u>	<u>100</u>	<u>284</u>	<u>100</u>

Each of the 19 hospitals in which 50 percent or more of the patients were from minority groups was in or near areas heavily populated by such groups. Four of the 141 hospitals which had reported that less than 50 percent of the patients were from minority groups were within the two largest minority-group population areas in Los Angeles County. We visited three of these four hospitals and found that the minority-group representation had changed at two of them after 1969; minority-group members represented 100 percent of the total patients at one hospital and 88 percent of the total patients at the second hospital. The third--which had 22 percent of its patients from minority groups--was established to serve employees of a large railroad company rather than the general community.

Five of the 10 ECFs in which 50 percent or more of the patients were from minority groups were within the two largest minority-group population areas in Los Angeles; the other five were in areas having minority-group populations of over 30 percent. Four of the 274 ECFs in which less than 50 percent of the patients were from minority groups were within the two largest minority-group population areas in Los Angeles County. We visited two of these four ECFs and learned that they were established to serve particular

ethnic or economic groups. (See facilities B and C on p. 57.)

Bureau of the Census statistics show that the two largest minority groups in Los Angeles County are black and Spanish-surnamed persons. These two minority groups account for 88 percent of the total minority population in the county. A Community Action Agency representative has advised us that South Los Angeles is the largest black community and that East Los Angeles is the largest Spanish-surnamed community in the county.

South Los Angeles area

According to a 1965 Bureau of the Census special report, the South Los Angeles area--which includes the neighborhoods of Central Los Angeles, Avalon, Exposition, Florence, Green Meadows, Watts, and Willowbrook--had a black population of 259,980 representing about 81 percent of the area's population of 320,830.

A 1970 report of a postgraduate medical school serving much of the area showed that the area's two major health problems were (1) a shortage of medical manpower and (2) a lack of medical institutions.

The South Los Angeles area had only nine general hospitals providing 719 beds. We visited seven of these hospitals plus four other hospitals within 1-1/2 miles of South Los Angeles. The following table shows the racial mix of the patients at these 11 hospitals on the day of our visits.

Hospital	Number of patients					Percentage of minority patients to total patients
	Total	White	Black	Spanish surnamed	Other minority	
South Los Angeles area:						
A	8	1	7	0	0	88
B	53	1	52	0	0	98
C	41	3	32	6	0	93
D	29	12	13	4	0	59
E	22	2	20	0	0	91
F	31	3	28	0	0	90
G	126	58	43	25	0	54
Adjacent areas:						
H	192	115	51	22	4	40
I	158	93	49	7	9	41
J	332	283	28	12	9	15
K	408	346	39	23	0	15
Total	<u>1,400</u>	<u>917</u>	<u>362</u>	<u>99</u>	<u>22</u>	35

The hospitals in the South Los Angeles area had a heavy minority-group patient load. The nearby hospitals which we visited, although treating minority-group patients, had predominantly white patients.

We also visited four ECFs in the South Los Angeles area and three others within 1-1/2 miles of that area. The following table shows the racial mix of the patients at these seven facilities on the day of our visits.

ECF	Number of patients					Percentage of minority patients to total patients
	Total	White	Black	Spanish surnamed	Other minority	
South Los Angeles area:						
A	94	9	83	2	0	90
B	55	15	35	4	1	73
C	78	20	58	0	0	74
D	90	8	78	2	2	91
Adjacent areas:						
E	108	102	2	4	0	6
F	98	88	4	2	4	10
G	127	121	3	2	1	5
Total	<u>650</u>	<u>363</u>	<u>263</u>	<u>16</u>	<u>8</u>	44

ECFs in the South Los Angeles area--like the hospitals--had heavy minority-group patient loads; ECFs in the adjacent areas had significantly lower percentages of minority patients.

East Los Angeles area

A 1965 Bureau of the Census special report showed that the East Los Angeles area--which includes the neighborhoods of City Terrace, East Los Angeles, and Boyle Heights--had a total population of 178,333, of which 134,870, or about 76 percent, had Spanish surnames. This minority group consisted primarily of persons of Mexican descent. Spanish is the primary language spoken by many residents of the area.

According to a 1970 Health Task Force report¹ some of the health problems in the East Los Angeles area were (1) difficulty in receiving proper medical treatment because a language barrier frequently existed between staff and patient, (2) unawareness by the population of the medical services available, (3) drug abuse, and (4) lack of medical manpower.

The East Los Angeles area had nine general hospitals with 2,932 beds; of these, 2,105 beds were in the Los Angeles County/University of Southern California Medical Center, the largest general hospital in Los Angeles County and one of the largest in the United States. We visited all nine hospitals and four others within 1-1/2 miles of the East Los Angeles area. We did not obtain a 1-day patient census at the large county/university hospital; however, for fiscal year 1970 members of minority groups represented 54 percent of that hospital's total inpatients.

The following table shows the racial mix of the patients at the other 12 hospitals on the day of our visits.

<u>Hospital</u>	<u>Number of patients</u>					<u>Percentage of minority patients to total patients</u>
	<u>Total</u>	<u>White</u>	<u>Black</u>	<u>Spanish surnamed</u>	<u>Other minority</u>	
East Los Angeles area:						
A	25	1	15	9	0	96
B	34	6	1	27	0	82
C	86	10	3	73	0	88
D	80	5	0	75	0	94
E	26	1	0	25	0	96
F	104	81	9	14	0	22
G	5	0	0	5	0	100
H	242	85	36	85	36	65
Adjacent area:						
I	153	93	0	59	1	39
J	6	1	0	5	0	83
K	40	5	0	9	26	88
L	<u>53</u>	<u>17</u>	<u>3</u>	<u>28</u>	<u>5</u>	68
Total	<u>854</u>	<u>305</u>	<u>67</u>	<u>414</u>	<u>68</u>	64

¹The study was funded primarily under a grant from HEW.

Seven of the eight hospitals in the East Los Angeles area had heavy minority-group patient loads. The other hospital--with a 22-percent minority-group patient load--was the one established to serve employees of a large railroad company. (See p. 55.) The nearby hospitals which we visited also had high percentages of minority-group patients.

We also visited four ECFs in the East Los Angeles area and one ECF within 1-1/2 miles of the area. A table showing the racial mix of the patients at these facilities on the day of our visits follows.

ECF	Number of patients					Percentage of minority patients to total patients
	Total	White	Black	Spanish surnamed	Other minority	
East Los Angeles area:						
A	92	16	3	73	0	83
B	80	80	0	0	0	0
C	103	103	0	0	0	0
D	33	15	0	16	2	55
Adjacent area:						
E	<u>81</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>80</u>	99
Total	<u>389</u>	<u>215</u>	<u>3</u>	<u>89</u>	<u>82</u>	45

Institutions B, C, and E were established to serve special religious or ethnic groups or had policies which restricted admission to people of means. Each had publicly announced its policy to serve all people, regardless of race, color, or national origin.

According to the administrator at B, ECF care was provided to any person who assigned assets of at least \$30,000 to the home. He advised us that black, Oriental, or Spanish-surnamed persons had never applied for admission.

Facility C was established by and for members of a religious faith who wished to preserve their cultural and religious values, and the home gave priority to members of that faith. The administrator advised us that the home had never had an applicant of another religious faith or a black, Oriental, or Spanish-surnamed applicant.

The 80 minority-group patients at facility E were Japanese. The ECF was constructed through contributions from the Japanese community and was geared to meet the language, dietary, and social needs of Japanese patients. The administrator would not refuse admission to anyone, he said, but might try to discourage a non-Oriental by showing him the oriental atmosphere of the facility. Two Spanish-surnamed patients had been admitted during the facility's 2-year history, he advised.

According to an OCR official, none of these facilities were in violation of title VI, because their policies did not preclude admission on the basis of race, color, or national origin. He stated, however, that such admission policies effectively limited the numbers of patients of races, colors, or national origins--uncommon to the ethnic, religious, or economic character of these ECFs--and thereby defeated the objectives of title VI.

DISPROPORTIONATE USE OF COUNTY
HOSPITALS BY MINORITIES

A disproportionate share of minority-group patients received health care from county health facilities and often bypassed other facilities more conveniently located. Persons whom we interviewed attributed this to one or more of the following reasons.

1. Most patients in private facilities are admitted by a private physician, and, because of an acute shortage of physicians in the ghetto areas where much of the minority population resides, these persons turn to the county facilities for help.
2. Proportionately more minority-group patients are poor than nonminority patients and must obtain services from the county system or must rely on the Medicaid program to finance their health care. Many private physicians, disgruntled with California's Medicaid program, refused to treat Medicaid patients, or discouraged them, and thereby added to the shortage of available physicians.
3. County hospitals made special efforts to accommodate minority-group patients. Many of these patients were not aware that care could be obtained through private physicians and hospitals under the Medicare and Medicaid programs.

Ethnic composition of patients
in county hospitals

The facilities of the Los Angeles County Department of Hospitals were established primarily for the care of indigent people. The department has 6,025 beds in eight hospitals or about 23 percent of all hospital beds in the county.

We visited two large county facilities--the University of Southern California Medical Center and the Harbor General Hospital. An example of the ethnic composition of inpatients at these facilities is shown by the following data reported by the facilities.

<u>Group</u>	<u>Medical Center patients in fiscal year 1970</u>		<u>Harbor General Hospital patients during 8-day period in September 1969</u>	
	<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent</u>
White	48,364	46	479	37
Black	31,070	30	334	26
Spanish surname	23,884	23	144	11
Other minority	1,090	1	108	8
Unknown	-	-	237	18
Total	<u>104,408</u>	<u>100</u>	<u>1,302</u>	<u>100</u>

County hospital representatives advised us that similar statistics were not available for all other hospitals in the county system but that the ethnic composition of inpatients at these two hospitals was probably typical.

Medical center

The University of Southern California Medical Center is in the East Los Angeles area where Spanish-surnamed individuals represented the largest minority group. In contrast to most other hospitals in that area, its largest minority group of patients was black. (See table on p. 58.)

The medical center treats patients from all areas of Los Angeles County. Its outpatient clinic provides medical treatment to those whose illnesses do not require hospitalization. During fiscal year 1970 about 440,000 persons visited its outpatient clinic. Statistics showing the majority- and minority-group composition of outpatients were not available; however, our observation of a crowded outpatient waiting room over a 2-day period indicated that most of the patients were black or were persons of Spanish descent.

The medical center is only 3 miles northeast of the border of the South Los Angeles area which has a high percentage of black persons, and it appears that many persons from South Los Angeles bypass other hospitals to receive treatment there. Of 10 randomly selected black outpatients we interviewed who would give us their addresses, five were from South Los Angeles.

Harbor General Hospital

There were medical facilities in the vicinity of Harbor General Hospital which members of minority groups appeared to bypass. Harbor General is about 7 miles south of the boundaries of the South Los Angeles area.

We visited four hospitals within a 6-mile radius of Harbor General. The racial mix of the patients at these hospitals on the day of our visits is shown in the following table.

<u>Hos- pital</u>	<u>Number of patients</u>					Percentage of minority patients to total patients
	<u>Total</u>	<u>White</u>	<u>Black</u>	<u>Spanish surnamed</u>	<u>Other minority</u>	
A	75	65	1	4	5	13
B	125	108	0	15	2	14
C	110	91	2	11	6	17
D	<u>35</u>	<u>21</u>	<u>1</u>	<u>12</u>	<u>1</u>	40
Total	<u>345</u>	<u>285</u>	<u>4</u>	<u>42</u>	<u>14</u>	17

Hospital A was about 2 miles from Harbor General, and minority groups represented 38 percent of the population of the city in which it was located. The area surrounding hospital B, about 6 miles from Harbor General, had a population of 7-percent black residents and 24-percent Spanish-surnamed residents. An official of hospital B said that it was a hospital goal to serve a more affluent white community about 5 miles to the west.

Although 403 physicians had staff privileges at hospitals A, B, and D, no black physicians and only six Spanish-surnamed physicians had privileges at these three hospitals. The assistant administrator at hospital C refused to disclose the race of the physicians having privileges at that hospital.

Shortage of physicians exists in
South Los Angeles area

In June 1970, Los Angeles County had about 13,500 licensed physicians, of which nearly 10,000 were members of the Los Angeles County Medical Association. This represented about 140 member physicians for 100,000 persons. A California regional medical program report showed--in two Los Angeles County health districts covering most of the South Los Angeles area--the number of member physicians for 100,000 persons in 1967 to be 48 and 44, respectively. The county health districts in the South and East Los Angeles areas were those ranked by the Los Angeles County Health Department as having the highest health needs in the county. According to an official of the Los Angeles County Health Department, the South Los Angeles area health districts were generally characterized by a high population density and poor economic conditions which made it more profitable for physicians to practice elsewhere.

A former officer of the National Medical Association told us that a general shortage of minority physicians was another contributing reason for the shortage of physicians in the South Los Angeles area. He estimated that about 530, or only 4 percent, of the licensed physicians in the county were black.

Physician rejection of Medicaid patients
adds to shortage of physicians for minorities

Medicaid is a grant-in-aid program in which the Federal Government shares in costs incurred by States in providing medical assistance to individuals who are unable to pay for such care.

County officials reported that minorities made up 31 percent of Los Angeles County's population but that, because a substantial portion were poor, they made up 40 percent of those eligible for Medicaid. Black persons made up 13 percent of the county's population and 21 percent of the population eligible for Medicaid. Spanish-surnamed individuals comprised 16 percent of the county's population and 17 percent of the population eligible for Medicaid.

On December 15, 1970, the Department of Health Care Services--which administers Medicaid in California--imposed a 10-percent cutback in Medicaid fees to physicians. One of the county hospitals reported that, during the following 4 months, it experienced a 26-percent increase in Medicaid outpatients compared with the same period in the preceding year. The president of an intern and resident association at this same county hospital reported, in February 1971, that cutbacks in physician fees under the Medicaid program had resulted in a deluge of patients being rejected by private physicians. During the period February 1 to March 20, 1971, social workers at this hospital interviewed 4,894 patients and found that 418, or 9 percent, had come to the county hospital because they had been refused care as Medicaid patients by private physicians. Three physicians told us that they refused to accept Medicaid beneficiaries as new patients or had set maximum limits on the number of Medicaid patients they would treat.

A group practice comprising 28 physicians refused to accept any Medicaid beneficiaries as new patients and sent letters advising them to find private physicians elsewhere or go to county hospitals. Members of the medical group advised us that this action was provoked by the December 15, 1970, cutback in Medicaid fees. Although the Medicaid fee cutbacks were rescinded on July 1, 1971, the physicians in the medical group said they planned to continue to reject

Medicaid patients and refer them to county hospitals because they felt the cutback was just one example of many arbitrary and inequitable administrative practices of that program.

County hospitals have made special efforts to accommodate minority-group patients

Although county hospitals have made special efforts to accommodate patients of minority groups from surrounding areas, some private hospitals have done very little to accommodate them or to meet their special needs once admitted. Also patients of minority groups are often unaware of their eligibility to obtain services at private hospitals under the Medicare and Medicaid programs.

The administrative director of the largest county hospital advised us that officials at that hospital recognized the importance of meeting the special needs of minority groups--such as language and cultural differences--and had taken action to provide specialized services. For example, at that hospital all departments were provided with a directory showing the location of members of the staff who--in addition to their regular hospital duties--serve as foreign language interpreters for 37 languages. The hospital was also conducting an experimental project of setting aside one entire floor of the building to serve East Los Angeles residents--most of whom are Spanish surnamed--by staffing that floor with many Spanish-speaking physicians and other health personnel. This project was being funded, in part, by Federal grant funds of about \$1 million from the Office of Economic Opportunity and the Department of Housing and Urban Development.

Both county hospitals we visited--which had large percentages of minority patients (see p. 61)--had public information brochures containing pictures of minority-group staff and patients. On the other hand, a private hospital we visited--in an area where about 38 percent of the residents were members of minority groups--had only about 13 percent minority patients at the time of our visit. The administrator told us that the hospital was only 50-percent occupied and needed additional patients but had tried very little to attract or provide special services to members of

minority groups. According to OCR officials, even recognizing that patients generally cannot gain admittance to private hospitals without physician referrals, public statements by those hospitals of their nondiscriminatory policies are healthy reminders to the community and hospital staffs.

Reasons given by 39 patients (see table on p. 51) whom we interviewed for using county hospitals were, as follows (most patients gave more than one reason):

	<u>Number of patients responding</u>
Were not aware that Medicare or Medicaid coverage was accepted at private hospitals	21
Preferred hospital because of familiarity from previous use	11
Preferred hospital because they believed it would provide the best available care	5
Preferred hospital because it was convenient	3
Had no money and knew these hospitals would treat them	8
Referred to a county hospital or denied service by a private physician or health facility	14
Referred to hospital by someone else	4
Brought to hospital by government-owned ambulance	4

According to a representative of the Los Angeles County Department of Public Social Services--the agency responsible for determining eligibility and enrolling individuals in the Medicaid program--at the time of enrollment, recipients were given several brochures explaining the program's benefits including hospitalization services available. However, we noted that a brochure still being provided to recipients as late as August 1971 contained information indicating that a recipient could not stay in a noncounty hospital for more than 8 days, a provision which had been revoked in April 1970.

Regional OCR officials are aware that many minorities are using county rather than private facilities. This, in their opinion, is tantamount to the concept of separate but

equal facilities and is not appropriate. The officials offer the following comments: Major changes are needed in the Medicaid program to make the same level and quality of medicine available to all. In gaining access to the health system, discrimination against the poor is prevalent but cannot be dealt with by OCR under title VI. Past racial discrimination in such areas as employment and housing have placed members of minority groups in an economically disadvantaged position and, as a consequence, in a poorer state of general health. To deal with the subtle forms of discrimination existing today, it may be necessary to modify the law so that instances such as gross underrepresentation of minority patients in a hospital compared with community population are considered prima facie evidence sufficient for OCR to compel a facility to take affirmative action to increase the number of its minority patients or demonstrate why more minority patients are not served.

CHAPTER 7

SCOPE OF REVIEW

Our review was made to determine the extent to which HEW enforces the provisions of title VI of the Civil Rights Act of 1964. We examined the procedures and practices OCR follows to enforce title VI including (1) making initial title VI clearance for hospitals, ECFs, and nursing homes wanting to participate in the Medicare or Medicaid programs, (2) making continuing compliance reviews of these institutions, (3) monitoring the State agencies' reviews of hospitals and other facilities requiring title VI compliance, and (4) investigating complaints of title VI violations.

Our review was made during the period May through October 1971, at the OCR headquarters in Washington, D.C., and at three OCR regional offices in Atlanta, Georgia; Chicago, Illinois; and San Francisco, California. We visited 66 hospitals, 41 ECFs, and two nursing homes participating in the Medicare and/or Medicaid programs in the Atlanta and Birmingham areas, in Wayne County, and in Los Angeles County.

At the OCR offices, we reviewed assurance-of-compliance statements received from hospitals and ECFs, investigation reports of civil rights complaints, and reports of the activities of State agencies assigned the responsibility for reviewing title VI compliance. At each of the hospitals and other facilities, we obtained admission policies and a patient census, interviewed administrative and admitting personnel, and made a tour of the institution to see if any signs of discrimination were visible. We interviewed 79 physicians, 48 nurses, 80 patients, and representatives of 73 interested organizations including civil rights groups, medical societies, and community service organizations regarding the availability and quality of medical treatment and services afforded to minority patients, as follows:

	<u>Number of</u>			
	<u>Physicians</u>	<u>Nurses</u>	<u>Patients</u>	<u>Organization officials</u>
Atlanta	15	21	14	8
Birmingham	10	—	7	9
Wayne County	10	—	20	22
Los Angeles	<u>44</u>	<u>27</u>	<u>39</u>	<u>34</u>
Total	<u>79</u>	<u>48</u>	<u>80</u>	<u>73</u>

The 73 organizations contacted in our review were, as follows:

Atlanta

Atlanta Medical Association
 Fulton County Office of Family and Children Services
 Georgia Department of Public Health
 Metropolitan Atlanta Council for Health
 Metropolitan Atlanta Summit Leadership Congress
 National Association for the Advancement of Colored People
 National Welfare Rights Organization
 Prudential Life Insurance Company

Birmingham

Alabama Christian Movement
 Alabama Welfare Rights Organization
 Birmingham Metropolitan Council of National Association for
 the Advancement of Colored People
 Birmingham Regional Hospital Council
 Community Service Council of Jefferson County
 Jefferson County Department of Health
 Jefferson County Department of Pensions and Security
 Jefferson County Medical Society
 Mineral District Medical Society

Detroit

Black Medical Society, Wayne State University
 College of Nursing, Wayne State University
 Committee on Hospital Utilization
 Community Relations Service, Department of Justice

Detroit City Health Department
Detroit Community Relations Committee
Detroit Urban League
Eastside Voice of Independence
Greater Detroit Area Hospital Council
Indians North American Foundation
Lafayette Clinic, Wayne State University
Latin Americans for Social and Economic Development
Medical Committee for Human Rights
Michigan Civil Rights Commission
Michigan Nursing Home Association
Michigan State Medical Society
National Association for the Advancement of Colored People,
Hospital Committee
School of Public Health, University of Michigan
United Community Service
Wayne County Medical Society
Welfare Rights Organization
Wolverine State Medical Society

Los Angeles

Black Nurses Recruitment Program
Blue Cross of Southern California
California Medical Association
California Department of Human Resources Development
California Department of Public Health
California State College at Los Angeles, Nurses Training
Program
Council on Bio-Medical Careers
Council of Black Nurses
Charles Drew Medical Society
Drew Post Graduate Medical School
East Los Angeles Health Task Force
Economic and Youth Opportunities Agency
Harbor Health Task Force
Joint Commission on Accreditation of Hospitals
Los Angeles County:
Department of Hospitals
Department of Public Social Services
Health Department
Department of Mental Hygiene
Los Angeles County Medical Association
Los Angeles Urban League

Medical Committee on Human Rights
National Association for the Advancement of Colored People
National Medical Association
Regional Medical Programs
Rio Hondo Health Task Force
Security Pacific National Bank (Economic Research Department)
Southern California Comprehensive Health Planning Council
Commission on Civil Rights
Equal Employment Opportunity Commission
Department of Commerce, Bureau of the Census
Department of Housing and Urban Development, Model Cities
Program
Department of Labor, Bureau of Labor Statistics
United Way
Welfare Planning Council

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U.S. HOUSE OF REPRESENTATIVES
 COMMITTEE ON THE JUDICIARY
 WASHINGTON, D.C. 20515

June 3, 1971

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 DONALD G. BENN

The Honorable Elmer B. Staats
 Comptroller General of the United States
 General Accounting Office Building
 Washington, D.C. 20548

Dear Mr. Staats:

In the interest of fulfilling the Committee's oversight responsibilities with respect to civil rights legislation, we are planning to examine the enforcement of Title VI of the Civil Rights Act of 1964 with respect to selected Federal programs. To assist the Committee in this endeavor, we would appreciate having the General Accounting Office make a review and provide a report on certain aspects of the Hill-Burton health facilities construction and modernization program and the Medicare-Medicaid programs of the Department of Health, Education, and Welfare.

With respect to the Hill-Burton program, it is requested that your Office review the policies and practices followed by the Department of Health, Education, and Welfare and selected State agencies in: 1) establishing service planning areas in formulating the State plans for facilities construction; and 2) approving construction projects--to determine if there are inherent factors in performing such functions which may make it difficult for certain communities to obtain Federal funds for health facilities, particularly where the communities may be largely composed of minority groups. For example, we would be interested in: 1) an evaluation of the criteria used in establishing State-wide service planning areas under the Hill-Burton program; and 2) an analysis of the composition of service areas with consideration given to the location of medical facilities and minority areas; and 3) an explanation as to why priority areas may have been passed over in approving construction projects.

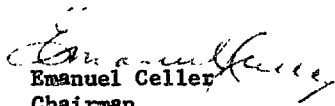
APPENDIX I

With respect to the Medicare-Medicaid programs, the Committee would be interested in an analysis of available data in selected areas in order to obtain information as to whether the benefits of the Medicare and Medicaid programs are being made available to minority groups to the same degree as to others. In this regard, examination into the Department of Health, Education, and Welfare's Office of Civil Rights compliance monitoring activities might be helpful in determining whether hospitals, extended care facilities, and nursing homes participating in the Medicare and Medicaid programs are complying with Title VI.

These matters have been discussed with your staff. Any other suggestions you or your staff may have in fulfilling our objective will be appreciated.

Your report on these programs would be most helpful if it could be available to the Committee by December, 1971.

Sincerely yours,


Emanuel Celler
Chairman
House Committee on the Judiciary

EC:jh

BEST DOCUMENT AVAILABLE

PRINCIPAL OFFICIALS
OF THE
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
RESPONSIBLE FOR THE ADMINISTRATION OF THE ACTIVITIES
DISCUSSED IN THIS REPORT

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
DIRECTOR, OFFICE FOR CIVIL RIGHTS:		
J. Stanley Pottinger	Feb. 1970	Present
Leon Panetta	Mar. 1969	Feb. 1970
Dr. Lloyd Henderson (acting)	Jan. 1969	Mar. 1969
Mrs. Ruby Martin	Apr. 1968	Jan. 1969
F. Peter LiBassi	Jan. 1966	Apr. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
John D. Twiname	Mar. 1970	Present
Mary E. Switzer	Aug. 1967	Mar. 1970