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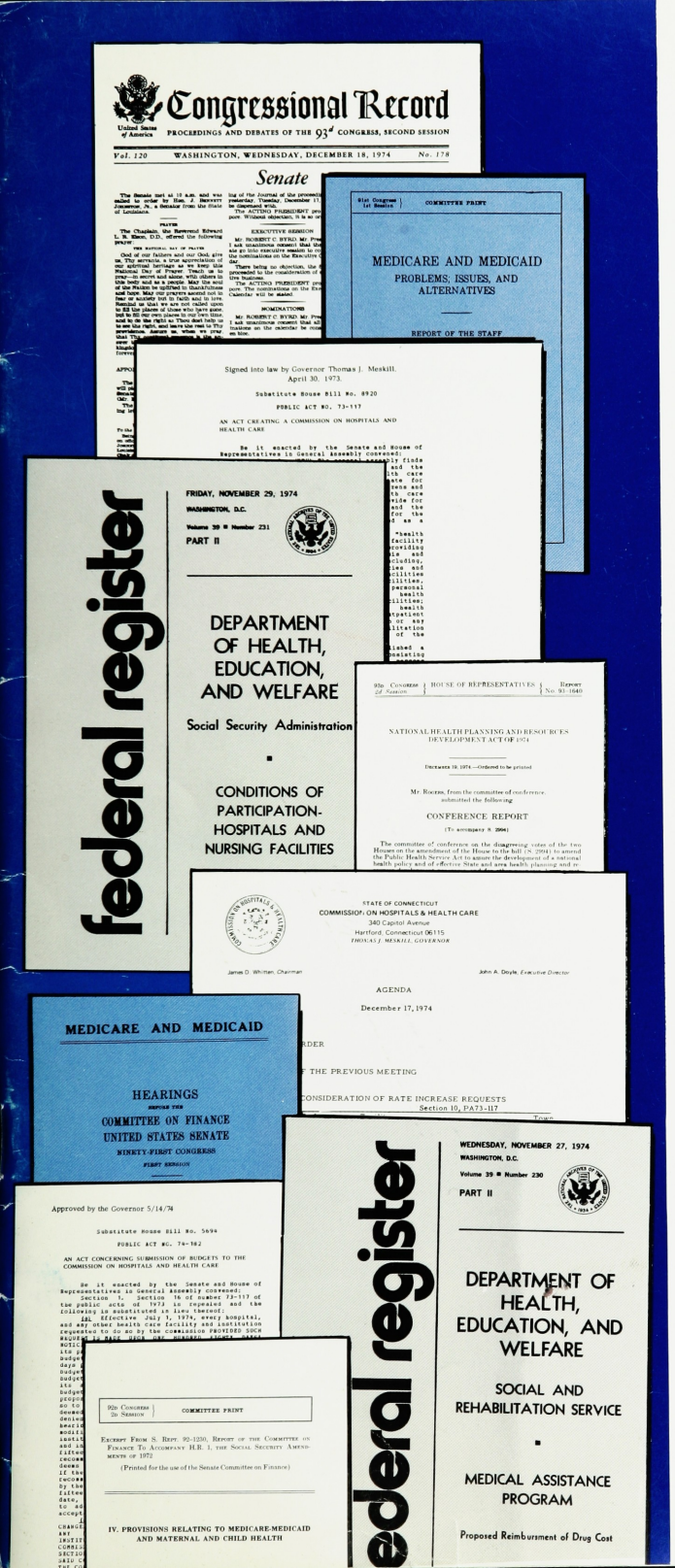
Yale-New Haven Hospital Annual Report 1974

Yale-New Haven Hospital



GOVERNMENT AND HEALTH CARE

YALE-NEW HAVEN HOSPITAL ANNUAL REPORT 1974

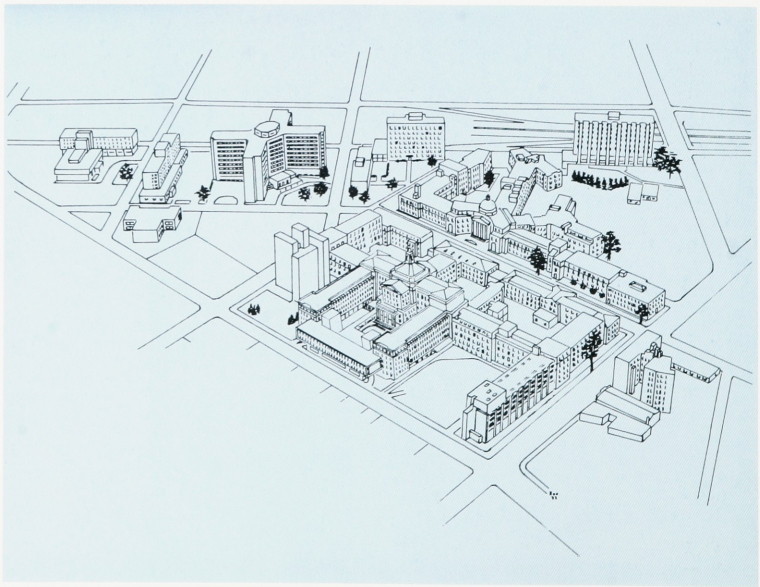
Yale-New Haven Hospital has been the teaching hospital for the Yale School of Medicine since 1826 when the Hospital was incorporated. Although both institutions cooperate closely to provide facilities for patient care, medical education and research, they are completely independent of each other and are governed by their individual corporate entities.

In 1945, the New Haven Hospital and the Grace Hospital merged to form the Grace-New Haven Community Hospital, and later, in 1965, a strengthened affiliation agreement between the Hospital and Yale University led to its name being changed to Yale-New Haven Hospital.

The combined facilities of the Yale School of Medicine, the Yale-New Haven Hospital, the Yale Child Study Center, the Yale School of Nursing, the Grace-New Haven School of Nursing, and the Yale Psychiatric Institute constitute the Yale-New Haven Medical Center. The Connecticut Mental Health Center is closely affiliated with it and is directed by full-time members of the Department of Psychiatry at Yale.

Hospital Statistics as of September 30, 1974:

Adult and Pediatric beds:	883
Bassinets:	101
Outpatient Clinics:	78
Approximate number of Hospital employees:	3,300



A number of people who have been associated with hospitals a lot longer than my seven years on the Board of Yale-New Haven have told me that running hospitals used to be "fun." What they meant was that – from the trustee or administrator's view –the job was interesting, satisfying, not overwhelmingly complicated and only occasionally frustrating. Common sense and the application of sound business practices, together with a strong sense of service to others, were the primary requirements for good management and judicious trusteeship.

Today there is clear evidence that the knowledge explosion and the needs and expectations of society have transformed the medical center teaching hospital into a complex organism of multi-ultraspecialized elements. Some of the people being hired, for example, reflect technologic change: dosimetrists, nurse epidemiologists, environmental engineers, enterostomal nurse therapists, informational systems analysts, nuclear physicists, etc.

But even more significant are the new functions of service the institution is taking on – sometimes with reluctance but generally with the recognition that the hospital must be a catalyst for an ever-increasing number of societal needs.

Three examples here at Yale-New Haven clearly demonstrate this. An Emergency Medical Communications System for integrated coordination of emergency vehicle dispatch to victims of accident or illness currently is being developed. Supported by a grant to Yale-New Haven Hospital and The Hospital of St. Raphael from The Robert Wood Johnson Foundation, the logistics of the system were developed in cooperation with a number of concerned agencies.

The Federal government made this Hospital its agent in the allocation of funds (presently $760,000 per year) to provide food supplements for women, infants and children, deemed to be nutritionally "at risk," who are registered patients in our pediatric and women's clinics.

A third example of "outreach" is still in the planning stage. As of July 1976, public intoxication will cease to be a criminal offense. In recognition of the need in our community to provide appropriate care for the alcoholic patient, Yale-New Haven and The Hospital of St. Raphael are cooperating with the Shirley Frank Foundation in its efforts to establish a detoxification treatment center.

As hospitals become more and more concerned and involved in meeting a broadened spectrum of health needs so is government becoming an increasingly active partner. As a consequence, legislation, regulations and controls at both Federal and State levels are becoming as much a part of the functioning of hospitals as operating room schedules and daily census reports.

This year's annual report discussion seeks to interpret Federal and State governmental activities as they affect the quality and the delivery of health care – particularly by hospitals.

The task of managing hospitals will continue to grow in complexity as they increasingly participate in the development of the total structure and function of the American health care system.

– G. Harold Welch, Jr.
President
Yale-New Haven Hospital

February 1975

In the Spring of 1973, the Connecticut Legislature enacted the most far-reaching health care legislation in its history. It created the Commission on Hospitals and Health Care and charged it with seeking ways to improve efficiency of health care in Connecticut; to lower health care costs throughout the State; to coordinate the use of Connecticut's health care facilities and services; and to expand the availability of health care to Connecticut residents.

To achieve these goals, the Commission was given unprecedented power to review the financial, operational and budgetary activities of all Connecticut health care institutions to determine whether they met the goals set by the new State law and to direct modifications if they did not.

The Federal government is constantly increasing its control of hospitals under Medicare and Medicaid, the new National Health Planning and Resources Development Act of 1974 and other legislation.

Thus it is timely and appropriate to review and assess how this Hospital is affected both by the new Connecticut Commission as well as by the continuing and increasing involvement by the Federal government.

The panelists in this year's discussion are especially knowledgeable. They include Dr. Robert W. Berliner, Dean of the Yale University School of Medicine and a former Deputy Director of the National Institutes of Health; Dr. Fred Hyde, Vice-President for External Affairs, The Connecticut Hospital Association; The Honorable Joseph I. Lieberman, Senator, State of Connecticut and a partner in the New Haven law firm of Baldwin, Lieberman & Segaloff.

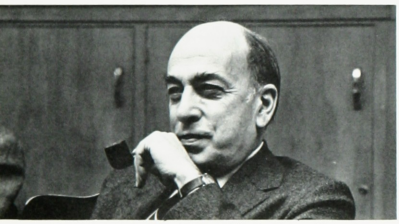
Geoffrey Peterson is Special Assistant to U.S. Senator Abraham Ribicoff of Connecticut, and Dr. Lawrence K. Pickett is Chairman of the Medical Board and Chief of Staff, Yale-New Haven Hospital.

Mrs. Rosemary Stevens, Professor of Public Health (Medical Care) at Yale University is the author or co-author of four books dealing with the health field. Her latest book, "Welfare Medicine in America: A Case Study of Medicaid," co-authored with her husband, Robert B. Stevens, Professor of Law at Yale University, was published in the Fall of 1974.

G. Harold Welch, Jr., has been a member of the Board of Directors of Yale-New Haven Hospital for the past seven years and is President of the Board. He is President of the Edward F. Malley Company, a New Haven department store.

Charles B. Womer, Director of Yale-New Haven Hospital since 1968, is moderator of this year's panel discussion.

(Although the data appearing in the report refers to the Hospital's fiscal year from October 1, 1973 to September 30, 1974, the discussion was tape recorded on January 13, 1975.)



Dr. Robert W. Berliner, Dean
Yale University School of Medicine

Dr. Fred Hyde, Vice President for
External Affairs, Connecticut
Hospital Association

Joseph I. Lieberman, Senator
State of Connecticut

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Mrs. Rosemary Stevens, Professor of
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G. Harold Welch, Jr., President
Yale-New Haven Hospital

Charles B. Womer, Director
Yale-New Haven Hospital

Mr. Womer: The objective of our discussion today is to explore the background and reasons for government's increased involvement in the voluntary health care system, to assess the effects to date and to offer some predictions on the form and implications of the government's future involvement.

Senator Lieberman, what do you think have been the primary issues, or forces, that have prompted the government's increased involvement in the voluntary health care system?

Sen. Lieberman: Let me talk a bit, first, about the kinds of forces that a state legislator faces which lead to government involvement. We start with the public's general concern about the cost of health care. People are angry about what it costs to go to a doctor; what it costs to go to the hospital. They are suspicious on the one hand that they are not getting their money's worth and, on the other hand, they are just plain anxious that they won't have enough money or proper insurance coverage to allow them to pay the bill. This kind of concern becomes intensified, both in the minds of the public and, perhaps more importantly, in the minds of the public servants, as inflation becomes more serious.

A lot of the initiative for greater government involvement is really the result of either a small special interest group which is concerned about the cost and quality of health care, or of the efforts of a few legislators who choose to become leaders in this field.

Another thing that's coincidental, but significant as far as our own State is concerned, relates back to the bill adopted in 1973 creating the Commission on Hospitals and Health Care.

We were having trouble, at the time, delivering programs and getting support for them through the State administration. Therefore, we didn't seem to be doing anything new or constructive for our constituents. I think it's fair to say, however, there was a general feeling on the part of State legislators that something should be done and that we should subject the voluntary health agencies to a form of regulation through the State government. The most compelling reasons for doing so were alleged duplication of services and unnecessary expenditures of capital funds. I suppose – although I know hospital people don't like the analogy – that we wanted to create a kind of regulatory function similar to the Public Utilities Commission.

Mr. Womer: I had a strong impression at the time that the basic thrust for creating the Commission came from within the administrative and legislative bodies, and not as a result of any great public pressure. Is that fair?

Sen. Lieberman: That is true. But let me stress that although it was not in response to enormous public pressure, it was done with the sense that it was something that the public would want us to do and would like the idea that we were doing it.

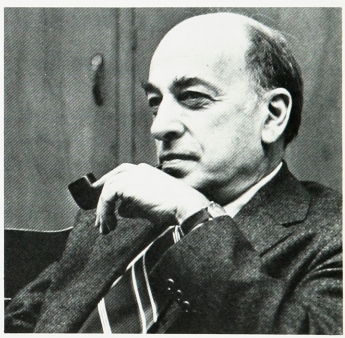
Mr. Peterson: It is the same at the Federal level. We don't have our doorbells rung all the time about the need for health regulation. Cost is the top thing, but the people don't know exactly what they want. If you were to ask them: "What do you want us to do?" they wouldn't say, "create a hospital cost commission."

If you look at the Gallup Poll, as a lot of legislators do, you see that health insurance is not one of the top issues. The economy, taxes, those sorts of things are. However, for those people who have had high health care costs, that is a top issue with them.

Another issue, of course, is the availability of health care. Congress has just started to get into this, trying to get doctors into areas where they are most needed. The mail we get in Congress shows that people complain, in addition to cost, about the fact that they can't get a doctor when they need one.

Mr. Womer: How do you see this, Dr. Berliner, having been in on it from two perspectives, first from within the governmental system as a Deputy Director of the National Institutes of Health, and now as Dean of Yale University School of Medicine?

Dr. Berliner: I think I can agree with almost everything that's been said. I think, however, one aspect that hasn't been mentioned and



that's very much involved in the Federal side of it is paying for it. The price to the Federal government is going up and it wants to be sure that it's getting what it's paying for. This is rather different from the State role where the State is not particularly involved in paying for it. The amount of Federal tax money that goes into health care is getting to be quite large and it is going to get much larger.

Mr. Peterson: In fact, Congress has just passed a major health planning bill which may do more to affect our health care system than anything else. It is the Health Planning and Resources Development Act of 1974.

I doubt that most Americans know about it, but within the next 120 days every state is going to have to establish health services areas which will be the focus for all of our health planning from now until some future date, the reason being that the Federal government wants to make sure it is getting a dollar's worth of service for every dollar spent.

Mrs. Stevens: I'd like to mention two other developments which have taken place during the past ten years which have an effect on planning. One has been the emergence of numerous groups, each of which has had a compelling need for health care. One thinks of the programs of the 1960s: for Appalachia, the migrants, the Cubans, the old and the poor under Medicare and Medicaid, and many other programs. So we have an acceptance of government involvement almost automatically.

At the same time, there is an increased acceptance of the idea that the government ought to have a "solution" to the problems of health care. But maybe the government has tried too many solutions.

Mr. Peterson: I think rapidly escalating costs have caused problems in getting any kind of health care legislation passed recently. Because costs are increasing so much, Congress is going to be more careful in the future when it enacts health laws. It's going to take it step by step rather than jump in and do everything at once.

Mrs. Stevens: I'd like to make one more point. The large infusion of Federal funds has demonstrably not improved the distribution of health care resources and has not given additional value for money in medicine. That's strictly in a money view sense, and is why the Federal government, and to some extent State governments as well, by sheer exercise of public accountability, are involved in looking at where the money is being spent.

Mr. Peterson: The danger, too, is that the Federal government sees a problem and tries to come up with a solution. The State government sees the same problem and tries to come up with a solution and they find they are at cross purposes.

Mr. Womer: Or the Federal government comes up with overlapping solutions to many of the same problems. One of the best examples of this in recent years is Regional Medical Programs legislation and Comprehensive Health Planning legislation which were passed by the same 89th Congress almost ten years ago. Many knowledgeable people are still confused about the overlapping purposes and relationships of the agencies established by these two laws, even as they are being phased out by new legislation.

Dr. Berliner: Isn't there another confusion, too? Some of the bills that have been passed are not health care bills. I don't interpret Medicare and Medicaid as health care bills. They are payment mechanisms. Fundamentally, they don't deal with the system of delivering health care. In fact, in many ways they have made the system for delivering health care that much more inadequate.

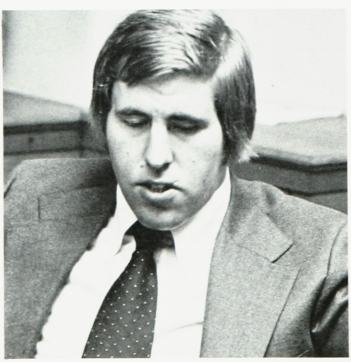
Dr. Hyde: Your comment raises a key issue. If you want to call Medicare and Medicaid income transfer mechanisms that happen to have an impact on the health system, don't we have to back up and say: Isn't that something we are very much involved in?

For example, Yale-New Haven Hospital sees all manner of problems that are only partially health care problems, such as child abuse, alcoholism, drug abuse, and so on. They're not only medical problems. In many ways it's not even a health care system we're dealing with, it's part of a social system that has extensive interfaces. It's almost as though income transfer has come in and changed the shape of things.

Mr. Peterson: I want to emphasize that it is the cost of health care and how to pay for it that is of vital importance to many, many people.

We sent out a newsletter discussing the Long-Ribicoff Bill and within a couple of weeks we had thousands of letters just from Connecticut telling stories about people being wiped out by the cost of health care. For the person or the family that gets wiped out, the top issue is what can be done about such high costs. This is selective pressure, but I don't think it is pressure to revamp the health system.

Certainly Medicare and Medicaid have played a major role in



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–Geoffrey Peterson

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–Mrs. Rosemary Stevens

paying for the health costs of poor people and old people, whatever the shortcomings of the programs are. . . . .

Mrs. Stevens: But with one qualification. Hospital bills get paid, but Medicare doesn't meet some very basic health care needs such as eye glasses, and hearing aids, which might well be far more important to many people.

Mr. Peterson: Medicare was obviously made in a political environment and was the product of compromise. I think if a lot of legislators had their choice today they would take Medicare and try to make it a pilot for national health insurance by closing the gaps that are in it, like eye glasses, dentures and hearing aids, and see how that worked before going on to do anything else. Senator Ribicoff has done just that with his Comprehensive Medicare Reform Act.

Mr. Womer: Dr. Pickett, do you think Medicare and Medicaid and other Federal efforts of the last few years have had any effect on the quality of health care services?

Dr. Pickett: I think they have established a pulling and tugging between quality and cost. For instance, the utilization review aspects of Medicare and Medicaid have kept hospitalizations shorter but they have increased the cost for hospitals because of a more rapid turnover. The first few days of a hospital admission cost more than the days of convalescence. So, if you have a higher turnover, you increase the intensity of care and thus the cost.

Utilization review and medical audit attempt to measure appropriateness of use of services and quality of care and at the same time be responsive to the consumer and the Board of Directors and the law courts. As a result, defensive medicine tends to be practiced. If the average hospitalization for a particular condition, for example, has this x-ray or that laboratory test, then all others had better have them, too, to be legal and to be safe. Thus the cost of services goes up remarkably.

The subtle, and sometimes not so subtle, pressures of the law relate to the Board of Directors of the Hospital when they ask the staff: "How do we know that you have a quality product?"

Mr. Peterson: This is where the Professional Standards Review Organization comes in. In a sense, Congress wants to see high quality health care, and it also wants to see lower costs and better payment mechanisms. But it is uncertain about how to achieve these goals. It is really saying to the doctors, "We don't know what to do but you had better do something and do it quick, by 1976, or we'll come up with something."

had so many positive things in it that it was enacted.

It's almost going to national health insurance on an organ by organ basis, which doesn't make any sense at all.

It may be that Congress may want to provide for people who may die of kidney disease, but the fact is that the issue was never debated. Congress never debated whether to cover kidney disease, or whether to try heart disease first, or cancer, or some other thing.

Mr. Womer: Harry, do you think that the Board of Directors of Yale-New Haven Hospital is concerned about the issue of quality and how to monitor it?

Mr. Welch: It gives doctors a chance to review their own quality and cost controls. In this whole idea of who does what, I think the starting point ought to be what we are not going to do, rather than what we are going to do. We are a finite world and we ought to recognize that we cannot do everything for everybody.

Mr. Peterson: But the problem is that sometimes the debate doesn't even occur. I'm thinking of the kidney disease program which is now a part of the Medicare program. It has helped a lot of people; made the difference between life and death for many and I'd never want to see it repealed. But the fact is that it was enacted because of politically powerful lobbies in the last days of 1972. It was part of a gigantic omnibus Social Security and Medicare bill that the President, if it had been a bill by itself, probably would have vetoed. But it was in the last days of the year and the bill

Mr. Welch: The Board takes this matter very seriously, but it would be naive to think that malpractice suits which indicate poor quality were not spectres casting a shadow over our Board. They are. We have always been demanding of our Medical Staff through the Chief of Staff and the Director of the Hospital, but the pressure has certainly intensified.

Mr. Womer: Do you think that without governmental legislation of the past ten years the Board would be as concerned about it as it is at this point in time?

Mr. Welch: Possibly not, but this is a very enlightened Board, if I may say so, and it is an intellectually honest one. We are affiliated with a prestigious school of medicine

and if we aren't concerned with the quality of care, we are in real trouble.

Sen. Lieberman: You know, it seems to me that you people are perhaps more concerned about malpractice cases having an effect on quality and care than governmental regulations. Is that a fair conclusion?

Mr. Welch: No. Not at all.

Dr. Pickett: It's another force to be reckoned with, but not the dominant one. It just has to be filtered in with other factors. Harry spoke of Yale-New Haven as being in a sort of exalted position by being affiliated with a prestigious medical school. This is a deterrent to poor quality. Quality must be related in many ways to progress, new methods of care, new methods of delivery, new methods of treatment which are all inherently interwoven with high standards of medical education and research. Cost control can be a significant factor, however, in maintaining those standards. Progress begins to slow when there isn't money to plow back into it. Quality will begin to deteriorate if we don't have progress. The two depend upon one another.

Mr. Womer: What has been the effect of Federal initiatives such as Medicare, Medicaid and other Federal programs – in terms of cost?

Dr. Berliner: I think it's clear that they have helped push costs up, especially by increasing purchasing power in a system that was already fairly fully utilized.

Dr. Hyde: The unfortunate thing is that none of these programs has any organized measure of outcome at the individual patient level. If you start from the premise that the old-time family physician provided the highest quality of care because he knew what was happening to you – whether you were getting better, getting worse or staying the same –then the addition of other kinds of mechanisms may increase costs more than the benefits. There is nothing built into the individual programs by which they can be measured.

Comprehensive Health Planning spent about $170 million since its inception and I'm still looking around the country for a good comprehensive health plan in a state which spells out priorities and a way to get from where they are to where those priorities are.

The absence of outcome measures and of cost-benefit analyses in these programs is crippling.

Mrs. Stevens: Another point on costs: Since Medicare is largely a hospital program, or largely designed to pick up hospital bills, and since it has injected a great deal of money into hospitals, it seems to have an immediate impact on the cost of hospital care. Thus we have two things. The cost of hospital care has risen tremendously fast since 1965, and the proportion of money going into hospital care overall has risen very rapidly. I think we're now spending about 39 per cent of the total health budget on hospitals. This puts hospitals in the limelight as being agencies responsible for the increasing cost of medical care.

The word "quality," too, can mean very different things. It can mean the quality of care that a particular patient receives in a reputable teaching hospital, or it can mean the quality of health services available to the population as a whole.

Mr. Womer: I would like to move back to the State level for a moment. The Commission on Hospitals and Health Care has been in existence now for about 15 months and has been involved in all of these questions – availability, quality, cost and consumer expectations. What do you think its impact has been thus far?

Dr. Hyde: It's a little hard to measure at this point just what the Commission's impact has been, or what it will be. I know, however, that it has made people sit up straight in their chairs and look around. They are more aware of what budgets look like and mean. I think more

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–Dr. Lawrence K. Pickett

attention is being paid to the control of their own programs, the impact of wage and benefit increases on the one hand and capital expenditures on the other. But whether it all means we are moving toward better health care being made available, I really don't know.

Mr. Womer: Well, for the current fiscal year, Connecticut hospitals submitted budgets calling for rate increases aggregating an average of about 9 per cent. The Commission approved rate increases averaging about 8.3 per cent. Would you hazard a guess as to what the rates might have been without the Commission?

Dr. Hyde: Nationally they have been double what the hospitals in Connecticut submitted.

Dr. Pickett: Hasn't the Commission been a positive thing by creating a kind of creative accountability?

Dr. Hyde: It has helped create a delicate balance in setting outside parameters while allowing the people who actually run the system to be free to move around within those parameters.

However, once this Commission, which now has more than 20 staff members on the board, comes to full complement, there are going to be people whose function it is to do management audits in your hospital. That means looking over your shoulder and second-guessing any activities. It could well have a sort of metastatic consequence in terms of what you do within your system.

Sen. Lieberman: I'm interested in knowing whether there are any stories to tell, perhaps hair-raising ones, about what impact the Commission has had on decision-making here at Yale-New Haven.

Dr. Pickett: Well, it disrupted our budget timetable this past year by changing the budget completion date from the first of August to the first of July. As a result, we were not allowed the high degree of effective physician participation that we have had in the past.

Sen. Lieberman: Was there anything you would have done were it not for the existence of the Commission?

Mr. Womer: I can't think of anything of major significance. Of course, we have taken pride right along in our careful budgeting.

I would have to say, however, that this past year we looked at budget proposals in terms of their defensibility before an outside body. I think we were more insistent that people document their requirements with more care than they had previously.

I think, too, that it has helped us to educate people that we have a budget that we have to live with, come hell or high water. Two years ago, for example, if somebody came up with a brilliant idea that wasn't necessarily an emergency we tried to juggle things to implement it.

Now we say that the brilliant idea has to be submitted in March and it will be reviewed for possible inclusion in the next year's budget.

I honestly have to say, also, that I agree with Fred Hyde that the Commission has not exercised all of the powers that it could. If it wanted to be arbitrary and capricious, it could be under the law, to the detriment of the public. I am thankful it has not chosen to do so. I do think that having a public agency looking over your shoulder isn't all bad and probably is in the public interest.

Mr. Welch: As far as our Board was concerned, our budget wasn't altered at all because of the Commission. Now to be very candid, there was a discussion in the Board as to political strategy; as to what we should do. In other words: Should we put in 10 per cent more, knowing that it would be chopped in half? Unanimously, the Board said: "No, that's not right. We will put in exactly what we need and we will fight for it." And that's what we did.

Sen. Lieberman: I must say, I'm pleased with your responses. It was my concern when the Commission was originally adopted that it would have a bad effect, not only on those medium and small community hospitals, but on a place like Yale-New Haven. I was concerned that it might restrict – I'm speaking in layman's terms – the unique, expensive but not always fully used special facility which an institution of this kind must provide. But this hasn't happened and that's good. Clearly this is a measure of tribute to you people who are running the hospital, and also to the relative reasonableness of the people who are running the Commission.

Mr. Welch: I'd like to add one more point. About a year ago our Board established a trustee committee with The Hospital of St. Raphael. Three members from our Board and three from St. Raphael's make up the joint committee to address common problems and see what we can do to avoid unnecessary duplications. I'm confident this would have occured whether or not the Commission existed.

Mr. Womer: Let's talk a bit about priorities. What do you think are the major government priorities in

health care, and what are the primary motivating forces behind these priorities?

Mr. Peterson: Certainly one of them in Congress is health manpower, getting doctors and other health personnel to areas where they are needed. It got to the point that the Senate Health Sub-Committee reported out a bill that required everybody who graduated from medical school to serve in a shortage area for a certain period of time. The bill was diluted on the Senate floor changing the requirement to 25 per cent of each class. I think this issue will come up again as one of the top priorities in the health sub-committees of the 94th Congress.

Dr. Berliner: I think there has been an excessive concentration on placing the recently graduated doctor in an area with a deficit of medical manpower without much thought to the long term effect of such a process.

It is not going to be a satisfactory solution in the long run. All it's going to do is to guarantee that some of the most junior, inexperienced people in medicine will be rotating on a two-year basis through areas where they really don't want to be and where their families don't want to be. This is not going to be an adequate solution.

Mrs. Stevens: Isn't this striving for better geographic distribution an increased government responsibility simply because government is paying so much of the medical care bill?

Isn't there a question of equal protection here, also? If you receive different benefits from your taxes depending upon where you happen to live or who you happen to be, don't you think it's going to be a critical issue? Aren't we going to have to ask for some kind of equity in terms of health care benefits?

Dr. Hyde: The problem is, though that decisions aren't made in a unidirectional fashion. For example, if we were to look around Connecticut and say, "Who is doing something about primary care?" one of the places to stop would be right here at Yale-New Haven. This Hospital, by virtue of its commitment to provide care for some 15,000 persons who look to it for their primary care, is doing something about it. No one came along and said Yale-New Haven had to do it, nor is anyone going to say that every hospital with more than 600 beds has to have a primary care center. It's really allowing flexibility for the system to respond and to provide incentives for responding.

This matter of incentive becomes a very crucial problem in regard to the distribution of physicians. It might be as simple as where does the physician's spouse want to locate?

Mr. Peterson: It comes down to the makeup of society, of course. It will probably be like a revolving door with doctors spending two years in Iowa or an inner-city. . .

Dr. Pickett: But while they're there, they won't be delivering the caliber of service you think they are. They're out there to be exposed to medical practice, to learn how to do it, and to see if they can go back later and deliver the right kind of care.

Mrs. Stevens: I think it's unfair to expect the educational structure in the health field to change the distribution of doctors and nurses all by itself.

I would like to have sufficient faith in the power of education to think that our graduates will go out and change the world, but I don't think the real world is like that. I think it's more likely that in the real world they will change to conform to it.

Similarly, I think it's unfair to expect hospitals to control the cost of medical care all by themselves, or individual physicians to do so through their own pricing policies.

We're somewhere in transition at this point, wanting the results of national policies without government intervention. That's plain unrealistic. If we want better distribution and cost control, there has to be planning in the health care system.

Mr. Womer: To change the subject a bit, Geoff, what is the present thinking about the shape and timing of national health insurance?

Mr. Peterson: I think it's going to be limited by two things: one, cost, and two, the capacity to administer. Right now we have enough problems with Medicare taking care of 20-odd million people who are under the system. To expand to cover 210 million is going to be an incredibly large burden on the Federal government.

The second limit of cost is where the big battle is shaping up

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—Dr. Robert W. Berliner

as to whether there's going to be a Social Security financing mechanism, or whether we're going to be paying mandatory premiums for mandated benefits to private health insurance companies.

Recently the Social Security Advisory Council reported that in the long run the Social Security Trust Fund may be facing a deficit because there are fewer people going into the labor market, and more people who are beginning to receive benefits. We have a real limit on what we can do through the Social Security mechanism. Also, we have a Social Security tax that's 5.85 per cent right now. Most people pay more in Social Security taxes than they do in Federal income tax. My guess is that we will see a combination, a small part from Social Security financing, and some sort of mandatory premiums for private health insurance companies.

I also believe that with election year 1976 looming and all the jockeying for position that will be taking place, we could well be into 1978 before anything is really implemented. In the meantime, I think we'll see changes in Medicaid and people re-introducting their bills in Congress. I just don't see anything major happening for a while. Congress will hold hearings, perhaps, later in 1975.

Mr. Womer: What do you think health priorities are on the State level, Joe, with the new administration and legislature?

Sen. Lieberman: The adoption of the Commission bill was considered a landmark, and presumably we'll go through a period now of seeing how it will work.

We have a new consideration which casts an interesting light on the State level. The Public Health and Safety Committee of the Legislature received a grant from the Robert Wood Johnson Foundation which enables it to hire a staff. This is a rare thing among State legislative committees. The committee clearly will be occupied with enacting legislation. I don't know what is on its agenda at this time, but I think at least two things will be happening in terms of State health care legislative activity this year.

One will be a fairly serious attempt by the private insurance carriers of the state to have the Legislature adopt a "mini-national health insurance plan" through private insurance carriers to cover catastrophic ailments.

The other thing that will happen, I think, although it's not directly related to our discussion at the moment, is that our State will get into investigating the nursing home industry. I think this is inevitable. If it is not, I hope to make it so.

Mrs. Stevens: I'd like to follow up on Senator Lieberman's comments and relate them back to national health insurance.

I see this as a period of consensus. It seems to me that there's

already a shift of each side towards the middle. There seems to be, for example, much more agreement about the role of private carriers and what this would mean in terms of funding health care benefits.

In addition, there's more of an acceptance of the use of employer/employee relationship contributions. I'm not sure that I approve of national health insurance contributions going directly from employer/employee deductions into third party insurance coverage, but it does have an obvious political appeal which takes it out of the already highly taxing Security bills.

Mr. Peterson: Politically, I think that Congress is going to include private health insurance companies in whatever bill is enacted. If there are mechanisms outside the government that can do the job with proper regulations, why create another giant bureaucracy? Of course, going the private mandated route means Federal regulation of private health insurance.

Sen. Lieberman: I'd like to get back to something I just mentioned. . . . It strikes me that the somewhat off-handed description I gave of the effort to adopt a so-called "mini-national health insurance plan" may have been understated. I can conceive of a situation where this would become a major item from the standpoint of private insurance companies who want to establish a kind of foothold here,

or from the standpoint of a governor and a legislature who are looking to produce results at a time when there is little public money to do so.

Another reason why I think the mini-plan may go this time is that it may be promoted as a way to spruce up the Connecticut insurance industry and perhaps even create more jobs.

Mr. Womer: There are those who say, with considerable conviction, that increased governmental regulation of our health care system can only result in standardized mediocrity, higher costs and the stifling of innovation. How do you believe that the voluntary system can respond to avoid such an outcome?

Mr. Peterson: I don't think that government intervention necessarily means standardized mediocrity. It depends on how the program is administered. If we had private health insurance that covered everybody for a limitless amount of things, we wouldn't need to talk about national health insurance. Government should come in if the private companies fail to make adequate insurance available to all at a reasonable cost.

Dr. Hyde: There is a great amount of overbelief in the government's ability to solve problems. For example, take the situation where there are two open-heart surgical units already existing side-by-side in a city, only one of which meets the criteria of the Heart Association in terms of numbers of patients. The solution is not necessarily to close down one of the units, but might be to do something with the professional staff so as to distribute their services between the two hospitals, not to restrict them by professional privilege to only one. That's one kind of experiment that ought to be tried in the private sector before the government says there can be only one cardiac unit in that town.

I have four suggestions which may apply. The first is responsibility, and I don't think there is any substitute for it in the private sector.

The second point is the participation by the private sector in activities of the government as opportunities become available.

The third, I'd say, is the preservation of the role of private capital under national health insurance.

Perhaps the fourth point would be to work for some kind of coordinating mechanism so that various levels of the government are not grinding each others gears and getting the private sector involved in the process.

"There is a great amount of overbelief in the government's ability to solve problems . . . ."
–Dr. Fred Hyde

Mrs. Stevens: It seems to me that if the government is going to continue to spend substantial amounts of money on the whole health care system, it needs to be assured that it is controlling expenses or that the money is being well spent. But it doesn't necessarily have to control the funding all the way down the line.

One of the peculiarities is that, today, instead of a government sector and a private sector in some kind of harmonious balance being able to negotiate with each other, there are literally hundreds of programs dealing with small facets of the health care system. As a result, I think there is much more government regulation than there need be in many areas.

Dr. Pickett: One of the most troublesome aspects of so much regulation is the confusion it causes. Take PSRO for example. The government delegated this to the communities; then it put national norms on top of community norms. Now, come February first, it will apply regional norms. It's pretty hard to generate enthusiasm within your own institution when this sort of thing occurs over and over.

Dr. Hyde: If we could take one action to rationalize the system, it would be to create some kind of function the purpose of which would be to try to reduce a lot of the unnecesssary, abrasive, overlapping and conflicting kinds of government activities that go on at different levels through no one's fault.

Mr. Womer: How do you feel about increasing government regulation resulting in standarized mediocrity, Rosemary?

Mrs. Stevens: I think we are heading for increased, if not total, governmental regulation in the health service system. I think this could result in some degree of standardization. Whether this will be "standardized mediocrity" I have no way of knowing.

However, I think we could go in one of two directions. We could keep bumbling on and eventually have a system which is not as good as it could be. On the other hand, there's no reason why we can't have a system that sets high standards, that does allow for innovation, for flexibility, and for a considerable degree of local autonomy.

You know, these discussions are very similar to ones that went on in my old homeland, Great Britain, in the 1940s.

One of the major effects of the National Health Service in Britain is that governmental agencies, because it is a national service, do have to recognize private groups. As a result, private groups are actu-

ally strengthened in their policy making functions rather than the other way around.

Sen. Lieberman: The public holds health care to standards that are not necessarily consistent. The public wants its bills to go down – and I think that's why it basically likes the idea of health insurance as a guarantee for getting its money's worth – and it wants to have health care readily available when it needs it. A drop in quality of service would be greeted with anger and would express itself in the political system.

For instance, if government regulations caused Yale-New Haven Hospital to close its Newborn Special Care Unit, I as a State Senator, would hear a mighty roar from my constituents, as well I should. Thus the political system creates a kind of check on governmental involvement that helps guard against mediocrity.

Mr. Welch: It seems to me that if we define our goals initially, and state what we can do and what we cannot do, we'll be making an important beginning.

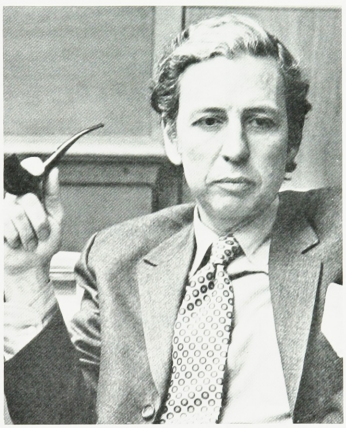
Mr. Womer: Do you think that, realistically, it is possible to really define national goals through the political process?

Mr. Peterson: Yes, I do. I think it is rather tough, but it depends upon how the question is asked. If you were to ask the American people: "Do you want to have health care as a right available to everybody, regardless of ability to pay?" about 99 per cent would say, "Yes."

If you asked: "Do you want to have the government running the health care system?" about 99 per cent would say, "No."

It is interesting to note that there's talk about lowering the Social Security tax at the very time we are talking about providing national health insurance. The people who are for more governmental involvement in national health insurance are probably the same ones who want the Social Security taxes cut. It is completely inconsistent. And

". . . the political system creates a kind of check on governmental involvement that helps guard against mediocrity."
–Senator Joseph I. Lieberman



"I think the starting point ought to be what we are not going to do, rather than what we are going to do . . . we ought to recognize that we cannot do everything for everybody."
–G. Harold Welch, Jr.

as times change, our goals change. They can't be set in concrete.

Dr. Berliner: If there is going to be regulation of the health care system, the question arises as to who is going to do it. If nobody else does, then we'll have the Federal bureaucracy doing it, which may or may not be the best thing. I think the people can take the initiative before the government does.

Mr. Womer: To summarize our discussion, it seems to me that we all accept the fact that government is fulfilling an appropriate responsibility in regulating the voluntary health care system. We've talked about a few of the negative effects of that regulation, but I sense that we all feel there have been more positive effects than negatives ones up to this point in terms of public policy objectives. On balance we appear to agree that Medicare, Medicaid, et al, and the apparently endless regulations associated with these programs have resulted in improved accessibility to health care and probably better quality, which seem to be the results all concerned are seeking.

Our one significant plea appears to be that government should look at the total system at one time so that a national health care policy may be formulated which will coordinate the government's and the voluntary system's total activities in the field to create a viable program to safeguard the health of the American people.

". . . we all accept the fact that government is fulfilling an appropriate responsibility in regulating the voluntary health care system."
–Charles B. Womer

BOARD OF DIRECTORS AS OF SEPTEMBER 30, 1974

President
G. Harold Welch, Jr.

Vice-Presidents
John M. C. Betts
Richard H. Bowerman
Mrs. Angus N. Gordon, Jr.

Secretary
John Q. Tilson

Assistant Secretary
Richard H. Judd

Treasurer
Earle E. Jacobs, Jr.

Counsel
John Q. Tilson

Mrs. Robert Adnopoz
Mrs. Robert L. Arnstein
John M. C. Betts
Richard H. Bowerman
Kingman Brewster, Jr.
Henry Chauncey, Jr.
Stanley R. Cullen
Abbott H. Davis, Jr.
Milton P. DeVane
John E. Ecklund
Alfred B. Fitt
James H. Gilbert
Mrs. Angus N. Gordon, Jr.
Earle E. Jacobs, Jr.
Harry D. Jefferys
James C. Lamberti
Ernest L. Osborne
Henry E. Parker
*Mrs. Lawton G. Sargent, Jr.
C. Newton Schenck, III
Charles H. Taylor, Jr.
John Q. Tilson
G. Harold Welch, Jr.
Charles E. Woods

*ex-officio

THE AUXILIARY AS OF SEPTEMBER 30, 1974

12 Officers

President
Mrs. Lawton G. Sargent, Jr.

First Vice-President
Mrs. Charles Gesner

Second Vice-President
Mrs. Stuart C. Finch

Corresponding Secretary
Mrs. Richard E. Fearon

Recording Secretary
Mrs. Andrew J. Graham

Treasurer
Mrs. Robert A. Peck

Treasurer of the Carryall Shops
Mrs. Allan K. Poole, Jr.

Elected Officers of the Medical Staff

President
Saul S. Milles, M.D.

Vice-President
B. Marvin Harvard, M.D.

Secretary
Andrew J. Graham, M.D.

Past President
Harold Stern, M.D.

Medical Staff as of September 30, 1974

Honorary	*13*
Consulting	*44*
Emeritus	*11*
Attending	539
Associate	162
Courtesy	94
Adjunct Physicians	3
Dentists and Physicians to the Ambulatory Service Staff	182
House Staff	
Clinical Fellows	147
Interns and Residents	305
Professional Staff (non-M.D.)	32
Total	1,532
Less duplications	*7*
Total Medical Staff	1,525
*Full-time Physicians	300
General Practitioners	45

*The numbers given here include physicians with offices at the Veterans Administration Hospital and the Connecticut Mental Health Center who also hold Yale-New Haven Hospital appointments.

Annual Meeting of the Hospital Board of Directors

G. Harold Welch, Jr., a member of the Hospital Board of Directors since 1968, was elected president of the board at its annual meeting on February 27, 1974.

He succeeded James H. Gilbert who had served as president for two terms and continued as a director.

Newly elected officers were Richard H. Bowerman, vice-president, and Earle E. Jacobs, Jr., treasurer.

Three other civic leaders were named to the board for three-year terms. They were Stanley R. Cullen, chairman of Sargent & Company; Abbott H. Davis, Jr., vice-president for marketing, Southern New England Telephone Company; and James C. Lamberti, president of New Haven Food Terminal, Inc., and Lamberti Packing Company.

Two members retired from the board. They were William B. Ramsey and William A. Thomson, Jr.

Mr. Ramsey had served on the board for six years. Mr. Thomson had been a member since 1956 and treasurer of the Board of Directors since 1968.

MEDICAL STAFF LEADERSHIP AS OF SEPTEMBER 30, 1974

Department of Anesthesiology

Chief
Luke M. Kitahata, M.D.

Assistant Chiefs
A. Richard Pschirrer, M.D.
Robert I. Schrier, M.D.

Department of Clinical Laboratories

Chief
David Seligson, M.D.

Assistant Chiefs
Joseph R. Bove, M.D.
Alexander W. vonGraevenitz, M.D.

Department of Dentistry

Chief
Herbert R. Sleeper, D.D.S.

Assistant Chief
Wilbur D. Johnston, M.D., D.D.S.

Department of Dermatology

Chief
Aaron B. Lerner, M.D.

Department of Medicine

Acting Chief
Gerald Klatskin, M.D.

Associate Chief
Samuel D. Kushlan, M.D.

Continuing Care

Acting Director
John E. Schuman, M.D.

Department of Neurology

Chief
Gilbert H. Glaser, M.D.

Assistant Chief
*Jonathan H. Pincus, M.D.

Department of Obstetrics and Gynecology

Chief
Nathan G. Kase, M.D.

Associate Chief
Stanley R. Lavietes, M.D.

Department of Ophthalmology

Chief
Marvin L. Sears, M.D.

Assistant Chief
Andrew S. Wong, M.D.

Department of Pathology

Chief
Vincent T. Marchesi, M.D.

*On Leave of Absence

Department of Pediatrics

Chief
Howard A. Pearson, M.D.

Associate Chief
Paul S. Goldstein, M.D.

Department of Psychiatry

Chief
Malcolm B. Bowers, M.D.

Assistant Chief
Robert K. Davies, M.D.

Department of Radiology, Diagnostic

Chief
Richard H. Greenspan, M.D.

Department of Radiology, Therapeutic

Chief
James J. Fischer, M.D.

Department of Surgery

Acting Chief
Hastings K. Wright, M.D.

Associate Chief
John E. Fenn, M.D.

Cardiothoracic Surgery

Section Chief
William W. L. Glenn, M.D.

Associate Section Chief
Harold Stern, M.D.

General Surgery

Section Chief
Hastings K. Wright, M.D.

Associate Section Chief
Nicholas M. Passarelli, M.D.

Neurosurgery

Section Chief
William F. Collins, Jr., M.D.

Associate Section Chief
Lycurgus M. Davey, M.D.

Oral Surgery

Section Chief
Herbert R. Sleeper, D.D.S.

Associate Section Chief
Wilbur D. Johnston, M.D., D.D.S.

Orthopedic Surgery

Associate Section Chief
Ulrich H. Weil, M.D.

Department of Surgery (Continued)

Otolaryngology

Section Chief
John A. Kirchner, M.D.

Associate Section Chief
Charles Petrillo, M.D.

Pediatric Surgery

Section Chief
Robert J. Touloukian, M.D.

Plastic and Reconstructive Surgery

Section Chief
Thomas J. Krizek, M.D.

Associate Chief
Irving M. Polayes, M.D.

Urology

Section Chief
Bernard Lytton, M.D.

Associate Section Chief
John B. Goetsch, M.D.

MEDICAL BOARD AS OF SEPTEMBER 30, 1974

Chairman
Lawrence K. Pickett, M.D.

Vice-Chairman
David Seligson, M.D.

Secretary
Richard H. Judd

Robert W. Berliner, M.D.
Malcolm B. Bowers, M.D.
Thomas F. Dolan, Jr., M.D.
John E. Fenn, M.D.
James J. Fischer, M.D.
Gilbert H. Glaser, M.D.
Paul S. Goldstein, M.D.
Richard H. Greenspan, M.D.
B. Marvin Harvard, M.D.
Wilbur D. Johnston, M.D., D.D.S.
Nathan G. Kase, M.D.
Luke M. Kitahata, M.D.
Gerald Klatskin, M.D.
Samuel D. Kushlan, M.D.
Stanley R. Lavietes, M.D.
Aaron B. Lerner, M.D.
Vincent T. Marchesi, M.D.
Saul S. Milles, M.D.
John C. Moench, M.D.
Howard A. Pearson, M.D.
Marvin L. Sears, M.D.
Herbert R. Sleeper, D.D.S.
Harold Stern, M.D.
Charles B. Womer
Hastings K. Wright, M.D.

ADMINISTRATIVE STAFF DEPARTMENT HEADS SEPTEMBER 30, 1974

Director
Charles B. Womer

Associate Directors
C. Robert Bruckmann
Richard H. Judd
William T. Newell, Jr.
Herbert Paris
Miss Anna E. Ryle, R.N.

Assistant Directors
Carl R. Fischer
Kenneth L. Grubbs
David Stockton
Joseph A. Zaccagnino

Executive Assistant to the Director
L. Todd Berman

Accounting
Leonard A. Reilly

Administrative Engineer
John W. Manz

Anesthesiology
Luke M. Kitahata, M.D.

Building Services
Grant L. Berger, Jr.

Business Services
Charles N. Starbranch

Clinical Laboratories
David Seligson, M.D.

Continuing Care Program
John E. Schuman, M.D.

Data Processing
Russell J. Caprio

Dentistry
Herbert R. Sleeper, D.D.S.

Dietetics
Miss Doris Johnson, R.D., Ph. D.

Diagnostic Radiology
Richard H. Greenspan, M.D.

Discharge Planning and Home Care
Mary C. Sayers, R.N.

Emergency Service
Paul P. Lally

Employee Education
Lawrence A. Loomis

Engineering
Norman B. Fischer

Information and Development
Donald R. Kleinberg

Linen Service
Miss Josephine Locarini

Minority Recruitment
Courtland C. Wilson

Nursing, Division of
Miss Anna E. Ryle, R.N.

Operating Rooms
Mrs. Luba Dowling, R.N.

Patient Care Studies
Phyllis J. Pallett

Patient Support Services
T. Brian Condon

Personnel
Kenneth L. Grubbs

Personnel Health Service
Herbert D. Lewis, M.D.

Pharmacy
Robert F. Miller

Physical Therapy
Reivan Zeleznik

Public Relations
Thomas H. Barnett

Purchasing
Joseph E. Monahan

Radiologic Technology
Ralph W. Coates

Religious Ministries
The Rev. Edward F. Dobihal, Jr.

Respiratory Therapy
John J. Julius

Security Services
Thomas L. Kramer

Social Service
Ms. Carol Cooper, Chairman

Special Projects
Edward J. Hammerbacher

Special Services
Albert P. Freije

Therapeutic Radiology
James J. Fischer, M.D.

Volunteer Service
Norcott Pemberton

NEW APPOINTMENTS AS OF SEPTEMBER 30, 1974

Russell C. Caprio, Director
Data Processing

Ralph W. Coates, Director
Radiologic Technology

John E. Schuman, M.D., Director
Continuing Care

Mary C. Sayers, R.N., Director
Discharge Planning and Home Care

COMPARATIVE STATISTICS

	1974	1973
Patients discharged during the year	35,606	34,159
Patient days care provided	276,258	261,911
Average length of patients' stay (days)	7.8	7.7
Average daily patient census	757	718
Clinic visits	155,034	150,270
Emergency service visits	87,924	87,105
Operations	15,753	16,170
Recovery Room cases	13,497	13,244
Births	4,207	3,968
Diagnostic Radiology examinations	144,732	125,580
Laboratory procedures	1,646,387	1,376,477
Physical Therapy treatments	31,631	28,661
Electrocardiology examinations	39,193	33,337
Electroencephalography examinations	3,006	3,090

INPATIENT STATISTICS

	Discharges		Patient Days	
Adults	1974	1973	1974	1973
Dermatology	172	17	2,615	369
Gynecology	3,970	4,010	17,778	16,961
Obstetrics	4,625	4,340	17,044	15,191
Ophthalmology	797	706	4,970	4,610
Psychiatry	403	420	12,359	13,001
Radiology	159	102	1,379	824
Medicine	6,082	5,626	63,828	58,468
Neurology	571	441	6,211	4,538
Surgery:				
Cardiothoracic (Cardiovascular and Thoracic)	543	542	8,469	8,115
Neurosurgery	869	878	12,590	12,964
Oral	194	138	520	528
Orthopedic	1,643	1,537	19,346	17,529
Otorhinolaryngology	1,014	1,001	4,123	4,264
Plastic	827	842	6,989	6,858
Urological	1,539	1,668	13,115	14,743
General	3,851	3,814	40,042	39,471
Total Surgery	10,430	10,470	105,194	104,472
Total Adults	27,259	26,132	231,378	218,434
Children				
Medical	1,955	1,890	11,690	13,193
Surgical	1,908	1,875	10,573	9,398
Total Children	3,863	3,765	22,263	22,591
Newborn				
Normal	3,803	3,606	13,571	12,355
Special Care	681	656	9,046	8,531
Total Newborn	4,484	4,262	22,617	20,886
Total All Inpatients	35,606	34,159	276,258	261,911

CLINIC VISITS

	1974	1973
Medicine		
General	7,899	7,445
Allergy	1,961	2,162
Arthritis	457	428
Cardiac	1,298	1,439
Chemotherapy	1,550	1,101
Convenience	43	74
Gastrointestinal	3,624	3,311
Hematology	1,002	1,014
Liver	816	1,048
Metabolism	1,196	1,638
Physical Medicine	68	107
Private Referrals	6,170	5,171
Pyelonephritis	96	161
Rheumatology	944	863
Winchester Chest	3,769	4,046
Total Medicine	30,893	30,008
Dermatology		
Total Dermatology	7,522	7,073
Neurology		
Total Neurology	1,232	1,375
Surgery		
General	9,440	8,785
Cardiac	1,395	1,413
Dental	6,552	5,931
Evening Gynecology	2,806	2,174
Hand	342	361
Minor Surgery	954	849
Neurosurgery	1,987	1,832
Orthopedic:		
General	4,051	3,559
Fracture	3,753	4,018
Pediatric	329	510
Otorhinolaryngology:		
General	2,972	3,021
Hearing & Speech	3,787	3,965
Private Patients	2,280	3,499
Pacemaker	345	368
Pain	210	449
Peripheral Vascular	410	321
Plastic	3,518	3,299
Surgical Tumor	12	60
Thoracic	226	171
Urology	5,207	4,159
Total Surgery	50,576	48,744
Ophthalmology		
Total Ophthalmology	14,765	14,566

	1974	1973
Obstetrics & Gynecology		
Family Planning	1,030	873
Gynecology–General	6,148	5,977
Gynecology–Tumor	222	230
Obstetrics	6,984	7,022
Private Referrals	7,668	7,766
Total Obstetrics & Gynecology	22,052	21,868
Pediatrics		
General	7,573	6,871
Adolescent	1,562	1,499
Allergy	900	717
Cardiac and Surgical Cardiac	2,489	2,651
Child Care	104	206
Convenience Clinic	8	33
Cystic Fibrosis	311	362
Dermatology	196	213
Endocrinology	646	433
G. Powers Development Evaluation	58	122
Gastrointestinal	491	257
Genetics–Birth Defects	564	643
Hematology	1,955	1,539
Lead Poisoning	171	165
Nephrology	308	455
Neurology	784	762
Neurosurgery	100	182
Newborn Follow Up	121	8
Spina Bifida	159	82
Surgical	265	231
Total Pediatrics	18,765	17,431
Psychiatric		
Total Psychiatric	9,229	9,205
Radiology		
Radiation Follow Up Visits Not included in Clinic Visits		
1970 2,578		
1971 2,695		
1972 2,630		
1973 2,895		
1974 3,334		
Total–All Clinic Visits	155,034	150,270

NOTABLE EVENTS DURING THE YEAR, OCTOBER 1, 1973 THROUGH SEPTEMBER 30, 1974

DEPARTMENTAL AND ORGANIZATIONAL ACTIVITIES

Although the patient has always been the first concern of Yale-New Haven Hospital, formal documentation of this came in a policy of Patients' Rights which was adopted by the Board of Directors on October 3, 1973. This action confirms a long-standing, but previously unwritten, set of principles upon which this institution bases its concern for its patients. Copies of the policy, printed in both English and Spanish, are prominently displayed in all patient divisions and clinics.

Six Army chaplains joined the Department of Religious Ministries to participate for one year in its clinical pastoral education program. Supported by the Department of the Army, the program enables the Hospital to increase its services to patients while providing a learning experience for the chaplains. Yale-New Haven is the only civilian hospital in the country to have such a program.

For the first time since the Commission on Hospitals and Health Care was created in 1973, the Hospital was required to submit its budget for approval. After hearings, the Commission approved a gross revenue budget of $66,966,000, which was $297,000 less than requested.

Yale-New Haven Hospital and The Hospital of St. Raphael announced, on June 9, the formation of a "Joint Policy Planning Committee." The Committee is responsible for reviewing services of the two hospitals and for identifying areas in which the public interest will best be served by increased cooperation between the two institutions.

It was announced on July 1, that Dr. Edmund D. Pellegrino, Chancellor of the Medical Units of the University of Tennessee System, will serve as the first Chairman of the Board of the Yale-New Haven Medical Center, Inc. The appointment will be effective January 1, 1975. The new corporation is charged with planning and development responsibilities for Yale-New Haven Hospital, the Yale School of Medicine and the Yale School of Nursing.

Dr. Howard A. Pearson, who was appointed to the Pediatric staff in 1968, was named Chief of Pediatrics to succeed Dr. Charles D. Cook. Dr. Pearson is a specialist in childhood diseases of the blood.

Dr. William W. L. Glenn, Chief of Cardiothoracic Surgery, was named the first Charles W. Ohse Professor of Surgery at Yale. This appointment is the result of a bequest from the late Mr. Ohse to the Hospital and Medical School.

A $361,970 grant for the establishment of a ten-town Emergency Medical Communication System was received by Yale-New Haven Hospital and The Hospital of St. Raphael from the Robert Wood Johnson Foundation. The new system will provide a centralized communication system for the dispatch of emergency vehicles, thus decreasing the time between report of a medical emergency and arrival at a hospital. It will also provide direct communication between emergency vehicles and hospital emergency services in a 400-square mile area encompassing the towns of New Haven, North Haven, Hamden, East Haven, Branford, North Branford, West Haven, Orange, Woodbridge and Bethany.

Volunteer Services: Volunteer service time increased 23 percent over the previous year: 887 volunteers contributed 85,000 hours in 1973/74 as compared with 879 who gave 69,000 hours in 1972/73.

With the increased continuity of service, volunteers were able to spend more time with patients in the Emergency Service, adult patient divisions, recovery room, free library, among other areas. They have continued to instruct patients who are scheduled for diagnostic radiology procedures and have provided supplementary services to many areas such as physical therapy, respiratory therapy, chemotherapy, admitting, and the information desks.

There was significant growth of the inner-city high school program in which more students than ever before volunteered six hours per week during the school year. The enthusiasm resulting from involvement with the diversity of disciplines within the Hospital has caused students from the inner city as well as the rest of the greater New Haven area to act in a responsible and commendable manner. This and the assistance of the staff of Lee High School exemplifies the cooperation which exists between Yale-New Haven and the community.

The Auxiliary: The Auxiliary served patients, visitors and staff through the continued operation of the Carryall Gift and Coffee Shops. Proceeds of $48,000 from the shops supported Hospital projects and personnel programs. Included were the renovation of the electrocardiography and blood drawing areas in the Memorial Unit; the purchase of ten isolation carts; and the refurbishing of pediatric waiting rooms.

Personnel positions, funded by the Auxiliary, included a part-time social worker and a social work aide in the Child Abuse Program and the Community Relations Worker for Patient Assistance.

Contributions to the Auxiliary's Remembrance Fund continued to support the patient library and book cart, which increased services to patients. The library is also available to employees.

The Auxiliary is in the process of evaluating its activities and redefining its objectives in relation to changes within the Hospital and the community.

EMPLOYEE ACTIVITIES

The week of July 22 was designated "Mutual Respect Week" at Yale-New Haven and was highlighted by an art exhibit sponsored by the Mutual Respect Committee. More than 200 exhibits were displayed in the lounge of the Grace Education Building, demonstrating the wide range of the artistic talents of Hospital employees.

An Employee Performance Review Plan was established to promote improved work performance and increased self-development.

The annual Service Awards Reception in the Memorial Unit on January 30 provided the setting for recognition of 369 Hospital employees who had reached their 5th, 10th, 15th, or 20th year of employment.

On April 30, 133 past and present Hospital employees with 25 or more years of service were guests at the annual Quarter Century Club dinner held in the Presidents' Room at Woolsey Hall.

An employee softball team, organized for the first time in conjunction with the New Haven Parks and Recreation League, played six games during the season. This new employee activity took its place with the other team programs including ten-pin bowling, basketball and a volleyball team composed of Hospital nurses who played in the West Haven League.

Hospital employees responded to the United Way campaign by contributing $26,622. The number of contributors was 1,551.

Employees also responded to the ever-important blood drives by contributing 762 pints in three Bloodmobile drives held in the Hospital.

Employee Benefits:
Yale-New Haven remained competitive with the local labor market by improvements in its benefits program. Among them were:

Blue Cross and CMS premiums fully paid by the Hospital;

Waiting period for group health and life insurance coverage reduced from six months to two months;

Community Health Care Center Plan (CHCP) offered to employees as an alternative to the Blue Cross, CMS, and Major Medical Plans;

Overtime premium pay added for hours worked over eight in a work day;

A third floating holiday added, making the allowance three per year in addition to designated holidays;

Certain Educational Assistance benefits were made available to part-time employees.

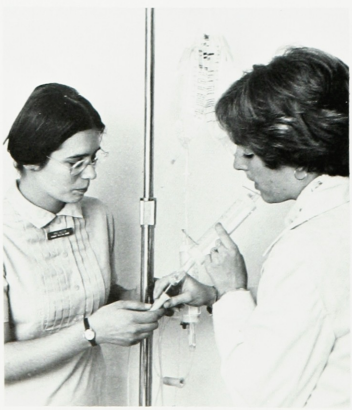
Maternity Leave and Sick Leave plans were revised to allow: sick leave benefits to employees unable to work due to pregnancy; a carry-over of unused sick leave allowances for employees changing from part-time to full-time positions, or vice versa; and an increase from one month to six months during which the Hospital will continue to pay a portion of the monthly premium for Blue Cross, CMS, Major Medical or CHCP while an employee is on sick leave of absence.

TRAINING PROGRAMS

During the year, 168 persons completed apprenticeships, clinical training for baccalaureate requirements, internships, residencies or received certificates or diplomas in the following: Dietetics, Engineering, Hospital Administration, Medical Technology, Nursing, Operating Room Technology, Pharmacy, Physical Therapy, Practical Nursing, Radiologic Technology and Respiratory Therapy.

Employees who took advantage of opportunities offered through the Hospital's Employee Education Program included 66 who completed the Supervisory Development training course; 586 who applied for tuition assistance for advanced education in collegiate and special fields; and six who enrolled in the High School Equivalency classes.

Among other special educational opportunities were noontime lectures for Hospital employees in Spanish language and culture.



COMMUNITY ACTIVITIES

The Hospital continued its cooperative relationship with the New Haven school system in the City's effort to demonstrate careers in the health field to eighth grade students.

This relationship was exemplified in the career training orientation program at the Sheridan Middle School on March 29 and April 1. Operating room technology, respiratory therapy, practical nursing, and the engineering department's apprenticeship program were represented with demonstrations and materials. A display on career training opportunities, originally prepared for use at New Haven's Black Expo in the Fall, was also used.

A city-wide disaster drill involved more than 100 simulated patients from two schools of nursing. "Injuries" were sustained in a mock industrial explosion. Hospital emergency procedures involving medical, nursing, admitting, social service, religious ministries and public relations departments supported New Haven's fire, police and civil defense agencies.

PATIENT PROGRAMS

An alcoholic referral and rehabilitation program was implemented in cooperation with The Hospital of St. Raphael, the Connecticut Mental Health Center and the Connecticut Correctional Center. Weekly Alcoholics Anonymous sessions were held at Yale-New Haven.

Cardiac resuscitation teams were formed to assist in instances of sudden medical emergencies in all parts of the Hospital. A team is available within seconds of an emergency at all hours of the day or night.

The Preparation for Childbirth and Parenthood Program was moved from inadequate facilities in the New Haven Unit to a new area close to the obstetric service in the Memorial Unit. The area provides a more pleasant environment for prospective parents to become acquainted with facts of childbirth and parenthood.

Under a grant from the Department of Health, Education and Welfare, an outpatient clinical research area was added to the 10-bed inpatient Clinical Research Center on Hunter 5.

The Women's, Infants' and Children's Food Supplement Program was begun under a grant from the Department of Agriculture. The Program supplies nutritional supplements to pregnant women, nursing mothers and children under four years of age who are patients of the Hospital's clinics.

The Child Play Program in pediatrics introduced "Johnny Goes to the Hospital." Johnny, a puppet who goes through the experience of being hospitalized, helps the young patient to understand what is happening in the process of his care.

A "Patient Support Line" was established. The new system enables patients to dial a special number—24-hours a day, seven days a week—to seek assistance concerning needs which they feel the staff has been unable to resolve.

The Selective Care pediatric unit now provides a facility especially for the short-term pediatric admission. The role of the pediatric nurse in the preparation of child and family is a key to the emotional and physical well-being of the pediatric patient.

A preoperative teaching class continued to inform and comfort gynecology patients and members of their families. The sessions, developed and conducted by the nursing staff, orient patients and those concerned for them to what is to be expected during the balance of their hospital stay.

CONSTRUCTION AND RENOVATIONS

Memorial Unit

In order to keep pace with the constantly changing techniques of health care and the increasingly critical illness level of the average person admitted to hospitals, Yale-New Haven embarked, this year, on a renovation of the Memorial Unit.

Included in the $1,900,000 renovation program are oxygen and suction outlets at each bed; airconditioning; new and more efficient windows; new ceilings to conform with current fire codes; carpeting for patient comfort and noise control; bed modules for more efficient lighting and easy access to the many outlets and systems required in a patient room; an improved nurses call system; and handrails for unsteady patients.

The renovation program will be completed floor-by-floor in order to maintain maximum available bed space to meet patient requirements.

Expanded Patient Care Facilities

Other improvements in services and facilities include the opening of a new coronary care unit on the first floor of the Fitkin Building; and the addition of a "satellite-inpatient pharmacy" in the Memorial Unit.

Among the projects underway this year have been construction of a neurosurgical intensive care unit on the third floor of the Tompkins Building and the renovation of an area for the placement of new radiologic scanning equipment. The ACTA Scanner will make available to the radiologist the visual image of cross-sections of tissue, as well as plane surfaces, and will permit increased accuracy in diagnosis. Many other projects required to keep pace with electrical, safety, conservation and esthetic expectations are also under way.

Primary Care Center

Of the patients seen in emergency services across the country, only 25 percent are of a true emergency nature.

About 75 percent of current Emergency Service visits are for non-emergent problems. Yale-New Haven broke ground this year for a Primary Care Center which is designed to provide ongoing health care services to those patients who look to the Hospital as their family physician. The Primary Care Center will provide continuity of care rather than episodic care for those patients who were repeated users of the multiple services of the Emergency Service and the clinics. The Center will also relieve the Emergency Service of those patients who have sought non-emergency care through that source, thus making it possible for more concentrated attention to be placed on true emergencies. It will offer services in general medicine, pediatrics and prenatal care, supplemented by specialty consultation as needed. Evening and Saturday morning hours will be available to accommodate those who are unable to seek care on weekdays.

Deep Radiation Therapy

Groundbreaking for the Hospital's new 32-million volt linear accelerator, for use in the Department of Therapeutic Radiology, took place in the early Spring. The equipment, together with the structure to house it, will cost in the neighborhood of $1,400,000. This, the third such installation in the country, will make possible the treatment of tumors at far greater depth and accuracy than heretofore possible.

The equipment is scheduled for use in the late Spring of 1975.

REVENUES AND EXPENSES

Comparative Statement of Revenues and Expenses
Unrestricted Fund

	September 30			
	1974		1973	
Revenues From Services to Patients (Note C):				
Room, Board and Nursing	$28,338,909		$25,087,296	
Special Services – inpatients	24,248,609		21,078,123	
Clinic patients	3,810,371		3,081,059	
Emergency Room patients	2,850,633		2,722,008	
Referred outpatients	2,323,587		1,840,496	
Total		$61,572,109		$53,808,982
Deductions From Gross Revenue (Note B):				
Contractual and Other Allowances	5,029,904		3,985,797	
Provision for uncollectible accounts	3,781,733		3,800,651	
Total		8,811,637		7,786,448
Net Revenues from Services to Patients		52,760,472		46,022,534
Other Operating Revenues		243,040		147,647
Total Revenues		53,003,512		46,170,181
Operating Expenses:				
Salaries	31,848,352		29,025,545	
Supplies and Other Expenses	21,142,153		18,264,826	
Depreciation	2,046,874		1,770,963	
Interest	583,026		407,530	
Total	55,620,405		49,468,864	
Less – Recovery of expenses from grants tuition, sale of services, etc.	3,394,176		3,094,311	
Net Operating Expenses		52,226,229		46,374,553
Operating Gain or (Loss)		777,283		(204,372)
Non-Operating Revenues:				
Free bed funds, Endowment income and other	620,596		496,508	
Investment Income on Plant Improvement and Expansion Fund	214,915		182,599	
All other	24,160		52,058	
Total		859,671		731,165
Excess of Revenues Over Expenses		$ 1,636,954		$ 526,793

See Notes to Financial Statements

Comparative Balance Sheet

Assets

Unrestricted Fund	September 30 1974	1973
Cash	$ 203,895	$ 282,986
Accounts Receivable – Net	13,019,365	12,863,413
Inventories	903,368	817,019
Prepaid Expenses	84,669	50,764
Rental Pledge Fund Deposits (Note C)	289,847	297,589
Escrow Funds for Long-Term Lease (Note C)	1,022,207	1,024,512
Due from Restricted Funds	1,950,141	1,801,612
Deferred Financing Costs and Unamortized Bond Discount	359,668	372,070
Other Assets	334,131	317,743
Land, Buildings and Equipment – Net (Note C)	27,348,156	28,321,780
Construction in Process	1,989,121	677,855
Board-Designated Funds Reserved for Plant Improvement and Expansion	2,722,270	1,984,294
Total – Unrestricted Fund	$50,226,838	$48,811,637
Restricted Funds		
Temporary Funds:		
Cash	$ 21,649	$ 3,507
Marketable Securities	1,604,570	891,569
Accounts Receivable	250,965	135,969
Due From Unrestricted Funds	-0-	260,099
Total – Temporary Funds	$ 1,877,184	$ 1,291,144
Major Capital Campaign Fund:		
Cash	$ 3,055	$ 968
Marketable Securities	42,000	58,000
Total – Major Capital Campaign Fund	$ 45,055	$ 58,968
Endowment and Special Funds:		
Cash	$ 22,306	$ 11,945
Marketable Securities	16,274,095	15,272,625
Due From Unrestricted Fund	34,113	146,724
Land, Buildings and Equipment	918,025	918,025
Total – Endowment and Special Funds	$17,248,539	$16,349,319
Total – Restricted Funds	$19,170,778	$17,699,431

See Notes to Financial Statements

Liabilities and Fund Balance

Unrestricted Fund	September 30 1974	1973
Accounts Payable	$ 1,882,777	$ 1,457,452
Accrued Expenses Payable	1,983,506	1,855,340
Due to Third-Party Reimbursement Agencies (Note B)	240,073	526,466
Due to Restricted Funds	34,113	406,823
Medicare Advance	-0-	403,273
Current portion of long-term debt and lease obligation	327,551	326,967
Long-Term debt – less portion classified as current liability (Note C)	101,728	119,279
Long-Term lease obligation – less portion classified as current liability (Note C)	8,630,000	8,940,000
Deferred Liabilities	1,010,479	1,011,892
Fund Balance	36,016,611	33,764,145
Contingent Liability (Note D)		
Total – Unrestricted Fund	$50,226,838	$48,811,637
Restricted Funds		
Temporary Funds:		
Due to Unrestricted Fund	$ 135,943	-0-
Fund Balance	1,741,241	1,291,144
Total – Temporary Funds	$ 1,877,184	$ 1,291,144
Major Capital Campaign Fund:		
Fund Balance	$ 45,055	$ 58,968
Total – Major Capital Campaign Fund	$ 45,055	$ 58,968
Endowment and Special Funds:		
Due to Unrestricted Fund	$ 1,814,198	$ 1,801,612
Due to Others	111,612	-0-
Endowment and Special Fund Balances:		
Free Bed	2,928,024	2,922,841
William Wirt Winchester	9,228,074	9,074,629
Other	3,166,631	2,550,237
Total – Endowment and Special Funds	$17,248,539	$16,349,319
Total – Restricted Funds	$19,170,778	$17,699,431

Note A – Accounting Policies

The accounting policies that affect significant elements of the Hospital's financial statements are as summarized below and as explained in Notes B, C and F.

Inventories
Inventories of supplies are stated at the lower of cost or market. In determining cost, the last-in, first-out (LIFO) method was used in 1974 and the first-in, first-out (FIFO) method was used in 1973. The effect of the change in 1974 was immaterial.

Investments in Marketable Securities
Investments in marketable securities included in the Unrestricted Fund and Restricted Funds are carried at cost or if received as a donation or bequest, at the fair market value on the date received. No adjustment is made to carrying amounts of marketable securities unless in the opinion of the Hospital a decline in market value represents a permanent impairment of the value of the investment.

Property, Plant and Equipment
Property, plant and equipment are recorded on the basis of cost. Routine maintenance, repairs, renewals, and replacement costs are charged against income. Expenditures which materially increase values, change capacities, or extend useful lives are capitalized. Upon disposition or retirement of property, plant and equipment, the cost and related allowances for depreciation are eliminated from the respective accounts and the resulting gain or loss is included in the results of operations.

The Hospital provides for depreciation of property, plant and equipment for financial reporting purposes using the straight-line method in amounts sufficient to amortize the cost of the assets over their estimated useful lives.

Deferred Medicare Reimbursement
Deferred Medicare reimbursement arises from the additional reimbursement from the program under the election to compute depreciation on an accelerated method for assets acquired prior to the year ended September 30, 1971, which is in excess of the amounts of depreciation recorded for financial purposes.

Restricted Funds
The Hospital receives certain contributions, grants and bequests which are restricted as to use by donor. Any income derived from these restricted funds and any expenditures of the funds are credited or charged directly to restricted fund balances.

Pension Plan
The Hospital's pension plan covers substantially all employees. The Hospital's policy is to fund accrued pension cost, which includes amortization of prior service cost over a 40-year period.

Note B – Third-Party Reimbursement Agencies and Prior Period Adjustment

Patient accounts receivable and revenues are recorded when patient services are performed. The Hospital is a provider under terms of contracts and agreements with third-party agencies including Connecticut Blue Cross, Incorporated; the Social Security Administration (Medicare); and State Welfare programs. The reimbursement of cost of caring for patients covered by the programs referred to above is subject to final determination of these third-party agencies. The difference between the Hospital's standard rates for services and interim reimbursement rates is either charged or credited to deduction from revenues.

Provision has been made in the accounts of the Unrestricted Fund for estimated adjustments that may result from final settlement of reimbursable amounts as may be required on completion of related cost-finding reports for the year ended September 30, 1974, under terms of agreements with the Social Security Administration (Medicare) and Connecticut Blue Cross, Incorporated and Connecticut Welfare Department. Final settlement of the amounts reimbursable from third-party agencies for 1974 is not finally determinable until completion of such cost-finding reports.

The Unrestricted Fund balance at September 30, 1972 has been restated from amounts previously reported to include, retroactively, additional income of $293,367, representing a settlement with the State of Connecticut rising out of litigation involving clinic rates for years prior to September 30, 1972.

Note C – Long-Term Lease Obligation and Other Mortgage Notes Payable

The Hospital entered into an agreement and lease dated August 16, 1971 with the State of Connecticut Health and Educational Facilities Authority for construction of additional facilities and conveyed title of the property to the Authority. To finance this construction,

the Authority sold $9,250,000 of revenue bonds, which will mature serially from 1974 through 2003 with interest at a net average annual cost of approximately 5.563%.

Annual rentals and other payments by the Hospital to the Authority are based on interest costs and principal repayments on the bonds, amounts required to establish and maintain reserve funds required under the agreement and lease, and annual fees and certain expenses of the Authority. Future rentals and fees are as follows:

Year ending September 30:	Bond Principal	Interest and Annual Fees	Total
1975 to 1979	$1,550,000	$2,733,840	$ 4,283,840
1980 to 1984	1,550,000	1,934,940	3,484,940
1985 to 1989	1,550,000	1,355,780	2,905,780
1990 to 1994	1,550,000	908,450	2,458,450
1995 to 1999	1,540,000	536,570	2,076,570
2000 to 2003	1,200,000	166,600	1,366,600
	$8,940,000	$7,636,180	$16,576,180

The bonds may be retired at an earlier date from funds held by the trustee, and from such additional funds as the Hospital may provide, pursuant to the terms of the Series Resolution and Agreement. The Hospital will take title to the property when the bonds are redeemed. In addition to the rental and other payments, the Hospital, under the terms of the agreement with the Authority, will pay costs of insuring the property and of operation and maintenance.

The Hospital is required under the agreement to establish a rental pledge fund, to which monthly payments are to be made thereto generally equivalent to one-twelfth of certain other required payments. Rental payments to the Authority are payable from the rental pledge fund or, if such fund is insufficient, from the Unrestricted Fund of the Hospital. As security for its obligations to make payments under the agreement, the Hospital has granted to the Authority a first lien on all of its gross receipts (as defined).

In accounting for this long-term lease agreement, the Hospital's obligation thereunder is recorded in the Unrestricted Fund in the aggregate remaining amount ($8,940,000) of rentals to be paid by the Hospital in respect of the Authority's liability for bond principal. The cost of the facilities constructed are included as assets in the Unrestricted Fund.

In connection with the lease agreement, Yale University has issued a guaranty agreement to the Authority not to exceed $9,250,000. In addition, the Hospital has issued two mortgages to Yale for this guaranty. The mortgages are subordinate to an existing mortgage.

In addition, the Hospital has the following long-term debt outstanding as of September 30:

	1974	1973
4½% Mortgage note payable in monthly installments of $1,265, including interest, to April, 1978	$ 48,003	$ 60,714
Loan payable in monthly installments of $722, including interest to June, 1991	71,276	75,532
	119,279	136,246
Less portion due within one year classified as current liability	17,551	16,967
	$101,728	$119,279

Substantially all property, plant and equipment are pledged as collateral for the above obligations.

Note D – Contingent Liability-Hospital Cooperative Services, Inc.

The Hospital and four other area hospitals established a central laundry facility to serve their laundry needs. To accomplish their objective, the five hospitals organized a non-profit charitable corporation. In connection with this corporation, the five hospitals and an additional hospital in 1974, have jointly and severally guaranteed notes payable to banks by Hospital Cooperative Services, Inc. to a maximum of $4,800,000. At September 30, 1974 $4,263,660 was outstanding.

Note E – Pension Plan

Total pension expense was $504,000 for each of the years ended September 30, 1974 and 1973. The Employee Retirement Income Security Act of 1974 has no material effect on the operations of the Hospital for 1974. The effect of this Act on the operations of the Hospital in future years is presently not determinable.

Note F – Reclassification of Financial Statements

The financial statements were restated in 1973 to conform to the presentation recommended in the Hospital Audit Guide issued in 1972 by the American Institute of Certified Public Accountants. This reclassification of funds had the effect of increasing the excess of revenues over expenses of the Unrestricted Fund in 1973 by $234,657, which amount substantially represents income from marketable securities.

Contributions and Bequests

The Tax Reform Act of 1969 added a number of incentives to support non-profit charitable organizations.

One of the major provisions of the Reform bill increases the amount an individual may deduct as a charitable contribution. Other provisions impose serious restrictions on "private foundations."

Any contribution to the Hospital may be restricted to capital equipment or designated to a special fund for such purposes as the donor may direct.

Should you, your attorney, or financial advisor be interested in knowing more about the needs of the Hospital, please contact the Office of Information and Development, Yale-New Haven Hospital, 789 Howard Avenue, New Haven, Connecticut 06504. Telephone: (203) 436-4700.

Prepared by the Office of
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YALE-

NEW HAVEN

HOSPITAL

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