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Washington University in St. Louis

SCHOOL OF MEDICINE

Oral History Series

Washington University Medical Center Desegregation
History Project

Paul N. Saunders, M.S.W., M.P.H.

Interviewed July 6, 1990 by William M. Geideman and
Edwin W. McCleskey

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Biography

Paul N. Saunders received his Master's of Social Work from the University of Pittsburgh in 1948. He was director of the Joint Community Health Services in St. Louis in the 1970s. He served as president to the St. Louis chapter of the National Association of Black Social Workers. He testified before congress during hearings to extend the Public Health Services Act and other related laws to the improvement of the delivery of healthcare.

We would like to start by asking you about the days when Barnes Hospital was segregated?

Well, not being a native St. Louisan, my familiarity with Barnes really began in 1978 when they initiated a policy under Mr. [Robert] Frank called “geographic separation of patients.” That is when they were separating the clinic OB/GYN patients from the private pay patients. The explanation/rational for this was way off the wall. Supposedly it was for the convenience of the physicians. It was our understanding at the time, when we filed a suit against them, that these elitist doctors did not want their private patients on the same floor, possibly sharing a semi-private room with a minority patient, primarily a Black patient. Clinic patients at that time were primarily Black. On any given week there would be no other clinic patients in the OB ward except Black patients. So even though Mr. Frank said it was not an attempt to re-segregate, that was the effect that it had. We did file a suit against them with the Department of Health, Education, and Welfare which is now called Health and Human Services. We charged them with civil rights violations and sought that reimbursement under Title XVIII and Title XIX be withheld until they retracted the policy. There were a number of hearings held and they sent a number of investigators down here.

That thing took years. From ‘79, I don’t think they got the final ruling on that until sometime in the mid-80s. Barnes is the empire of health care in the Midwest. You have to go all the way, let’s say to Chicago all the way out to the West Coast, because it is the major hospital and the major medical complex here in the Midwest. They had a lot of clout. We looked to the aid of our senators. We sent copies to [Senator John] Danforth and anybody else who would listen, Congressman [William] Clay. We talked with Mr. Frank, who refused to talk to any of the

other organizations that questioned that policy. We were alerted to this by one of the physicians on staff. The younger physicians were upset by it. So we are talking about the old hardline, staid, private physicians who thought they were above community standards I guess. Mr. Frank questioned why we were concerned about it. In fact he was very disturbed by the fact that there was quite a bit of publicity in the newspapers.

We picketed the hospital for two years. We picketed that hospital initially every day for a couple of weeks. Then we ended up picketing the hospital every Sunday for an hour with signs and groups of concerned individuals, basically they were members of the St. Louis chapter of the National Association of Black Social Workers. We had support from a handful of other community organizations. But the Black Social Workers bore the brunt of that picket line. We never missed a Sunday, rain, snow, sleet, or hail. We brought shovels out there when we had snow and cleaned off the sidewalk. In 1979 we had a national conference here of Black Social Workers and we had a couple of thousand people here. We took two days and left the Clarion Hotel where we were staying and en masse bused and [drove] ourselves down here and held up traffic and got some TV publicity out of it. But we were really not interested in the publicity, we were interested in calling attention to something that could snowball.

One of the things that you should know about the hospital situation in the city is that most of the hospitals that are now in the county, including DePaul Hospital, which is run by the Daughters of Charity, were originally located in the city. With the immigration from the city to the county, I have seen the population of the city since I came here in 1970 from Pittsburgh go from 600,000 to 700,000 to now being below 500,000. Effectively the population of the city has moved west. All you have to do is drive around the periphery of St. Louis and see all the new houses which weren't here 20 years ago. A lot of the private physicians felt that it was just too

much to ask for them to walk down one flight of stairs for the clinical patients or down one flight of stairs to see their private patients if they had obstetrical patients and gynecological patients in the hospital at the same time. It didn't hold water and the Department of Health, Education, and Welfare upheld our complaint.

Initially Barnes filed an appeal. They had a rehearing which occurred maybe a year or so later and they came out a year or two later with a reaffirmation of the fact that in their opinion Barnes' policy of "geographical separation" in fact establishes segregated health care facilities. They did not make any attempt at this point in time to look at the total hospital because actually this was occurring every place else, but dollar-wise they could not afford two floors for pediatric patients and two floors for general medicine patients. But the volume of deliveries that they had there, they had enough patients in OB/GYN to separate them in that way.

Having been a hospital administrator at one time, I knew that obstetric patients were on one floor and gynecology patients were on another and you didn't combine them for a number of medical reasons and a number of reasons relating to the possibility of infection. What they had to do was establish two nursing stations, because you couldn't have OB nurses also being responsible for gynecology patients. So they had to establish two nursing units on each one of these floors. So before when it was OB only they only needed one centrally located nursing station. So this policy was not cost effective. This is the primary reason that they abandoned it before the final ruling came out. It is my understanding, they never told us this, we heard this from the people who worked there, they did have an integrated staff even though they were trying to segregate the patients. They had a lot of Black nurses, and if you look at housekeeping and dietary and other departments, it is primarily Black especially at the entry-level positions. They had their ears tuned into what was going on and they heard the scuttlebutt and they could hear doctors

talking when they would be on the elevators or walking down the hall behind them. It upset them for quite a while because they became highly visible as a paragon of a segregated health care facility. We encouraged as many Black physicians who had admitting privileges to Barnes to not admit at Barnes. The bottom line is the almighty dollar. When they brought in some consultants to take a look at their overall operation, they recommended that they abandon that particular setup because it was costing them an arm and a leg just for the nursing component alone, there was a duplication of effort. They gave that up before the ruling came out. But they really never did come out and indicate that it was a *fait accompli*, that Barnes had abandoned it willingly, not because of an altruistic attitude but because it was just too expensive to complete.

Just to make sure I understand, they took OB and GYN patients together on one floor, the clinic floor, and the private OB and GYN patients were together on another floor.

Right, let's say six and seven. I remember one of the floors was the sixth floor but whether it was the seventh or the fifth floor as the other, I am not sure. One of the interesting things that occurred was that they also had separate nurseries. One day the investigator from the government was coming and they were saying that they also had minority patients on the private floor. It just so happens that the day the investigator came they didn't have any. The nursery on the private floor had no Black babies. So in order to show that they had an integrated second floor where the private patients were, they actually took a couple of babies from the clinic floor, Black babies, and put them in the private nursery. Now we got that from the nurses. That actually happened and that shows to what lengths the racists would go to try and show that they really were not all that bad.

You said you contacted Senators and Congressmen.

We corresponded with them and they wrote back expressing their concerns, but at no point in time did any of them ever call for withholding Medicaid/Medicare payments until this thing was resolved.

Even Congressman Clay?

Even Congressman Clay. He might have discussed it in the halls of Washington, I don't know. But nothing officially ever came out of that request. Because if you are in violation of Title VI of the Civil Rights Act you do not receive any federal funds. We also asked that the funds that were going into the Washington University medical school and any other organizations that received federal grants or federal research dollars, that they be withheld.

So the final ruling came in the '80s?

Yes. I can't recall what year, but it was some time in the mid-80s that we got the final ruling from Health and Human Services then. They agreed with our assessment of the situation, but the fact that Barnes had abandoned their efforts at establishing the separation made the ruling moot. Going back historically, Barnes years ago was just like all the rest of the hospitals, had totally segregated facilities. In fact the Blacks were in a totally separate building, they were not even housed in the same major structure. The Blacks referred to it as "The Barn." The health care there was an abomination. In fact one of our members' father died at Barnes Hospital and

she felt that it was because of neglect. So she did not really have any good feelings about Barnes and a lot of other people who were born and raised in this area do not have good feelings. Because as a leader you are always expected to set the tone and even though Missouri is not considered a Southern state per se, it was divided, there was a lot of conflict here during the Civil War as to whether it was blue or grey. When your leaders follow the rabble rousers and the masses generally tend to feel well it must be right since our leaders are supporting that effort. The old saying in the Black community was that up north they liked their Blacks but still managed to treat them just as bad. When I was an undergraduate at Lincoln University there was no place in this town where you could stay. When I say to my kids, you couldn't go down town and eat, the only place you could eat in this town, downtown, was Union Station. There were limited restaurants and limited hotels that accepted Black clients, so to speak. So even though Missouri looked serene and we never had any riots or any violence here in the 60s after Martin Luther King was killed, this state and this town was just as segregated as you wanted to be. It was surprising to me the complacency of the Missouri Black. And they are still complacent. There have been times in the 20 years I have been here when I have been very upset with my brothers and sisters about how well they accept certain things that I just find unacceptable, and the Barnes Hospital situation is one of them.

This is entirely news to us that this thing happened so recently. We thought that the hospital was desegregated in 1951 and that was the end of that.

You have the formal structure and then you have the informal structure. Even today every attempt is made in semi-private rooms to put two Blacks in semi-private rooms and two whites in

the semi-private room. Where do you go? They will deny it. There is supposed to be an open admissions policy and if you have semi-private insurance and you go into a hospital whatever bed is available they are supposed to put you in there with whatever patient is in there. On a selective basis the admissions office are the ones that control that, but they are only doing what the administration tells them to do. Somehow they have a marking system so that they can tell that in 6000B that the patient there is "B," or maybe they put a little star next to it. That is not always true. My last child was delivered in Jewish Hospital and her roommate was a white female OB patient. If you just walk through the building there and just look into those rooms from time to time, see how many mixed occupants they have in some of the rooms. If you notice predominantly the semi-private rooms have two Blacks in them nine out of 10 times. As long as they have the option, and this is not the luck of the draw.

Barnes is not the only hospital that was guilty, in fact all of the hospitals segregated their patients. That is why Homer G. Phillips was set up. That was a travesty, the "separate but equal." The elimination of segregation in borderline areas was the result not so much of the white man feeling guilty about it, it was a matter of dollars, it was just so damn costly. Even school segregation is a very costly thing. Growing up in Western Pennsylvania I wasn't confronted with that a lot. All the hell that is being raised about busing, hell they have been busing Blacks for years. All the Blacks who grew up in St. Louis county other than Kinloch, which as I said was an all-Black community, were bused into the city. One of the nutritionists who works for the state, was raised in Kirkwood and being one of the few Blacks, she did not go to school in Kirkwood, they bused her into the city. It is the reverse now. Busing was a tradition. If there wasn't enough Black kids in a community to establish a separate school system, they would bus them to the closest all Black school in the city, 10, 20, 30 miles. If you retrace the laws back after the Civil

War, you couldn't even teach Blacks. It was illegal. They used to have a boat out in the Mississippi river that was a school, they used to teach the Black kids on it. Busing has been used to keep the races separate for years.

You mentioned Homer Phillips. You were here at the time that it closed?

Yes, I was here at that time. I thought it should have closed. It should have never really existed, but at the time that was the way of life. It left a hell of a lot to be desired, but so did the Max Starkloff City No. 1 [Max C. Starkloff Memorial Hospital, St. Louis City Hospital No. 1]. Both of them were outdated hospitals, per se. One of the brutal things about them, is you know how hot it gets here and there was no damn air conditioning in either one of those damn buildings. They had individually air conditioned offices for the professional staff but the patients just lay there and sweltered. When we had heat alerts, in the latter years I can recall, they brought in some Army air conditioning units and had them hooked up to the floors. They were still those big open wards and they would cost an arm and a leg.

In '70-'71 I worked with the old 314B partnership and planning agency, they called it ARCH, Alliance for Regional Community Health Planning. Then, we recommended that City No. 1 and Homer G. be closed and one 500-bed hospital be built to accommodate the public health needs, hospital acute care needs of the medically indigent, which wound up occurring with the creation of [St. Louis] Regional Hospital. At that time it wouldn't have cost them anymore what Regional has costing them now. It was still conceptually a good idea. Because the private hospitals are not now and never will be willing to open their doors to the medically indigent, and that is only going to occur when you have a national health insurance. Medical care segregation

will virtually disappear, although attitudes are not going to change. You still are going to have physicians who are not interested in serving poor folks, that is why a hell of a lot of physicians who used to have offices on Pine and Washington in the Central West End are out in the county. That is why all these rich hospitals have built physicians' offices right adjacent to the hospital. They got away from the less desirable patient.

Barnes Hospital oftentimes feels trapped because they are a magnet. We never questioned the care. We might have questioned the attitude but we never questioned the fact that rooms were there and you were going to get good care. It might be delayed, because you are not a priority patient when you go into a clinic situation. You might have to sit down and wait two or three hours, because that seems to be a standard for clinic patients. But once the almighty dollar flows to reimburse medical care providers at the same level regardless of whether you are Black or blue or what have you, dollars tend to change attitudes somewhat. Attitudes will change significantly if we can get more Blacks into the caring fields other than nursing. We need to get more Blacks into medical school. My feeling is that the government should be subsidizing those people who have the intelligence to become physicians. A Black who might have the mental capacity to become a doc ain't got the dough. As you all well know, it costs a pretty damn penny to go to medical school and serve your residency and internship. It is a sacrifice. It is difficult enough to just be a medical student and then not have to worry about how in the hell you are going to pay your way through.

With the abolishment of the public health service physicians, we are going to see a decrease in that three percent of the licensed physicians being minority. It has hovered around three percent without any significant decreases and now it is sliding backwards. At one point in time we had somewhere around 350,000 licensed physicians a number of those are still licensed

but are not in full practice. The mass exodus of the hospitals, DePaul, St. John's [Hospital], you name it, they all went west for one reason, because that is where all the well-to-do patients who used to live around the Central West End and the interior parts of the city moved to with the white flight out of the city.

So the indigent people of this city, now are they primarily treated at Regional?

There are some at all hospitals. You have Black patients who go to DePaul out on there on [Interstate] 70, [Interstate] 270, because there is a semblance of integration in the acute care field. Most hospitals attempt to have at least some Black practitioners on staff, which means that they also have admitting privileges. So since Black docs tend to have 99.9% of their patients being Black, when they admit a patient it's going to be a Black patient. Even within the medical field now there is segregation because the average white dude don't want his wife being seen by a Black physician. So it just stands to reason that the Black physicians have Black patients and they have admitting privileges at DePaul or St. John's and what not, because it looks good and it avoids the stigma of being all white and Title VI still carries some clout with the hospital administrators.

Title VI is what?

That is the civil rights act that requires the semblance of integration. I would say that Barnes because of their long standing in the community has a disproportionate share, Barnes and Jewish probably get a disproportionate share of the medically indigent because they are in a city,

they are near the hard core, and more convenient. You go to St. Anthony's [Hospital] or some of the other hospitals that are in the city they are in the fringe areas. We have CMC, Central Medical [Center], which started off right there on Kingshighway right down from DePaul. I think when Christian [Hospital] abandoned that facility then CMC relocated over there, and well they should because that little L-shaped hospital off of Kingshighway and Natural Bridge was an abomination. But no hospital can survive based on reimbursement from just Medicaid/Medicare and very limited private pay patients. Private insurance reimbursement more or less covers the cost. To my estimation hospital care, in the acute care field anyway, should only cover one's costs with a reasonable amount to cover other kinds of long range projections, expansion, renovation, rehabbing, maintaining the facility. I don't think that hospitals should end up with multi-million dollar reserves based on sickness. When we get into the private sector, health care should return a reasonable standard of living to physicians in the field. I do not know where I would draw the line. We are approaching national health insurance incrementally, which is what Title XVIII and Title XIX did, and we have a lot of little, incremental, federally-funded programs that help pay for care. But it is such a screwed up system that you really don't know what you are going to end up with when you see a patient.

Everybody wants to hold out what they see is the failure of the English health insurance and the Canadian health insurance program. But if we look at their life expectancy and the general wellbeing of their population, it stands head and shoulders above ours. So it has to be a better system than what we have. They always want to point out the long waits for care. Well they are talking about elective kinds of things and not life threatening. The system takes care of those life threatening situations. Somebody wanting cosmetic surgery or those things that are not medically required right now may have to wait, but again that depends on the supply of

physicians. I mean if the whole system is nationalized and we are seeing to it that an adequate flow of providers, including docs, are coming out of the schools, then we can offset the long waits. But if you don't have an adequate flow of physicians, because we have plenty of beds—based on the projections of the planners we are over bedded in most of our metropolitan areas. They say that the system will be abused when we get national health insurance. If it is abused who is at fault? You cannot admit yourself to a hospital. A doctor has to admit you to a hospital, whether it is a resident in charge or what not. If I walked over there now and they did a triage and said, "Well hell, there ain't nothing wrong with you." Well, if I want to get into a hospital, I can't admit myself. So if people are in the hospital unnecessarily then we have to fault the medical profession because they put them in there unnecessarily. So that particular opposition to national health insurance doesn't hold water with me.

You mentioned how people talked about "The Barn." Does there remain in your opinion a kind of a negative feeling toward Barnes in the Black community as a result of the old days of segregation?

Well, not necessarily just Barnes. The system itself creates negative attitudes on the part of Blacks because they can look at the aberration called Regional Hospital and realize that it is inadequate and look across the street or up the block and see another hospital that may have empty beds, but their emergency rooms are geared towards trauma centers. Get yourself a helicopter and a helipad and be a trauma center. This is glamour. You would be surprised at the competition that existed amongst the different hospitals to have trauma centers. My emergency medical service technician here had some problems with hospitals that wanted to be different

classes of trauma centers. To be the top you have to have somebody trained in trauma and either on staff or available 24 hours a day and they can get to the hospital in 24 hours or something. But the emergency rooms in most of our hospitals out in the peripheral areas, the county, are really not geared to emergencies, per se. They try to get away from the clinic setting by having the physician's office physically adjacent to the hospital so rather than have to go into the hospital proper, you are referred to the private physician's office, which is connected in most cases to the hospital. Then try and get an appointment with some of those docs. They will deny it but hell, they don't see Black patients or they don't take Medicaid, they don't take Medicare, which realistically eliminates the medically indigent or low-income population. So they gravitate to Barnes and Jewish, which still have basically an open door policy in terms of walk-in emergency room patients. As long as I have been in the health field, since 1966, and study after study of emergency room patients, it hasn't varied more than five percent, that generally 50% to 60% of the emergency room patients are non-emergent. When you triage them, it is just the mother who works and she comes home and the baby was running a temperature when she left and still has a temperature and grandma kind of just taking care of it. She gets upset and she takes the baby to the emergency room because she doesn't have a one private physician or the private physician's office doesn't have late evening office hours or the neighborhood health centers don't have evening clinic hours. They go to Barnes or they go to Jewish emergency rooms.

So Barnes and Jewish are different because they don't have this interface that there are a bunch of private physicians that you have to go to before getting into the hospital?

Right, right.

That may change now because Barnes is making a big 15-story building to hold the private physicians' offices.

Well, I think DePaul still has a traditional kind of emergency room out there but they are far removed from the urban patient who routinely would walk in. It is difficult to catch a bus to get to DePaul. You almost have to have a car to use the hospitals that are out in the county. Even county residents, the low-income residents need a car. In the city, you can catch a bus to Barnes and Jewish very easily from any place in the city. That is not possible for any other hospital.

How about Regional?

Well, Regional too. But Regional is over loaded. Regional is not capable of handling the off hour demands for health care. And off hour demands for health care become emergency room visits. They are not staffed and they also wind up in the catch-22 situation where the majority of their patients are uninsured. We look at Medicaid and Medicare patients basically as uninsured, because it is a federal program and it does not have enough fudge in the reimbursement to actually pay for the cost of care. And even though there might be co-payments, let's say in the case of Medicare, it is waived. You don't say this emergency room visit is \$175, and you have a 30% co-pay, which comes out to like \$51 or something—they ain't got it, because it is the middle of month and they get their social security check, like the first or second of the month. Then two weeks, three weeks at the most, depending on how well you pinch pennies, even if you've got \$50 or \$60 that you are pinching to make it until the next check comes in, you are not

about to give that up, because they are a public hospital, so you ain't got it and they can't refuse care. But there is \$51 that is not generated in revenue.

Of course I think the cost of health care is overpriced anyway. When I ran Courtney Health Center back in '72-'74, and we would do a cost per unit of service, the reimbursement at that time just about met my costs. We were federally funded. The feds at that point in time provided 100% of our budget, although there was a big push then and it has become a reality now, that the federally funded health centers that were created to care for the medically indigent that the private sector was reluctant to treat and in a lot of cases refused to treat. We had a lot of walking sick. We still do have a lot of walking sick, they are called homeless now. Where do we go from here? Who do we look to for guidance since our elected officials seem to be persuaded more by the power structure, which is big business, which is Blue Cross/Blue Shield, which is the American Medical Association, which is the American Hospital Association, not to move toward a national health insurance. Although there is a lot of talk about it now. Piecemeal, incrementally, we have got to do something in this country to make sure that health care is a right. And whether or not you have \$100 in your pocket should not determine whether you get health care.

But the neighborhood health centers are in a catch-22 position. When they were first created, the health centers here were kind of like in that second wave of federally funded health centers because that first wave was the OEO, Office of Economic Opportunities, and the second wave was those health centers that their funds from the Department of Health, Education, and Welfare. When they were first created the Department of Health, Education, and Welfare didn't want a damn thing to do with them. That is why the initial funding for the handful of health centers that emerged were funded through that Office of Economic Opportunity. Dr. Jack Geiger

established the first neighborhood health center in Mound Bayou, Mississippi as an experiment and it was through the medical school. That was the beginning of setting up a health center for people for which there were no docs, no medical care and people were just walking around without any access to health care. He set up that health center down there in Mound Bayou, Mississippi and the idea caught on. OEO funded more health centers in small rural towns, but also in urban areas. It was so successful that then the Department of Health, Education, and Welfare got into the act.

Eventually the Office of Economic Opportunity pulled out of it and all those health centers got their funding directly from Health, Education, and Welfare. They have survived despite government attempts to gut them. Now they are so ingrained that it is almost physically impossible for them to say that they are going to defund you totally, but they are making it tough for them to exist. One, because they are losing their public health service physicians. A lot of health service physicians were the backbone of the federally funded health centers, although at Courtney I didn't have any, I had private physicians that I recruited. Dr. Max Pepper was a giant around St. Louis University. He spearheaded this health as a human right coalition that is still functional under Dr. Blumenthal. Max washed his students through the neighbor health centers, basically Yeatman [Medical] Health Center, which was over on Grand. He saw to it that they got a practical experience in primary care, because he headed up the primary care program at St. Louis University and tried to steer as many students as possible into primary care rather than going into specialty care.

When we first started we were prohibited from charging. We couldn't charge although if you read the grants, they were five-year grants, they indicated that at the end of five years you had to be self-sufficient. It was a conflict. I don't know how you can be self-sufficient if you

never have the opportunity to bill. We were created to care for the medically indigent who had no money, they couldn't pay. But then we supposedly become self-sufficient serving the poor, impossible. That was abandoned eventually. We saw that that really wasn't a practical approach. But when the health centers were first created we couldn't even bill Medicaid/Medicare. The National Association of Neighborhood Health Centers, which was created as an advocacy group to speak for health centers before Congress, filed a suit against the government that would permit us to bill Title XVIII and Title XIX, so that we could generate revenue. Because even though we were 100% federally funded, the federal funds were still not adequate to do the kind of job, the demand exceeded the capacity to provide, let's say that. So by billing Medicaid/Medicare, health centers started generating \$300,000 or better depending on the size of the health center.

What the feds eventually did then—suppose I had a \$2 million grant, but I generated \$500,000 in revenue through Medicaid and Medicare and contributions, because you know we had a sliding fee scale, they then started reducing the grant by the amount of revenue you generated. So you were in a no growth situation. You couldn't expand, you couldn't add new facilities as needed, you couldn't add additional staff, because you couldn't look at that generated revenue as operational revenue over and above what the feds provided, because they were reducing your grant by that much. That is where they are right now. They are at the point now where they are borderline operations, fiscally. It makes it tough. And you don't know from one year to the next how much money is going to be allocated by Congress for that program. If they just maintain the funding level based on the incremental cost of living increases, let's just say, in supplies, consumable supplies that you use, cotton balls and gloves and things like that, you are losing ground.

So maybe we could just close things here by just getting your thoughts on the future of medicine in St. Louis.

The future of medicine in St. Louis is not going to be any different than the future of medicine in New York or California, although New York and California, certainly their Medicaid program, their reimbursement rates are much higher. You just go across the river in Illinois, their reimbursement and the services they provide under Medicaid for the medically indigent is much higher than what Missouri provides. You see the individual states have some flexibility in the services that they provide. There are a handful of services that all states have to provide and then there are some options. There is a direct relationship in the amount of Medicaid dollars that you get based on your willingness to match it. I think that it is a 10% match. Missouri has never accepted all of the Medicaid money that was available to them because they were unwilling to come up with the match. Suppose I had \$100 million available to them, the 10% match would be \$10 million, but they would only be willing to come with \$5 million so they got \$50 million. Those aren't the actual figures. There is more Medicaid money available in Missouri than what they have actually applied for because they are not willing to come up with the match. You take a place like Illinois, California, or New York and Pennsylvania, or places like that, they take just about 100% of the money available. But they are also willing to come up with \$20 or \$30 or \$40 million match for it, which then permits them to have a little bit higher reimbursement and provide a little more additional medical care services.

Missouri or St. Louis will follow the national trend but slowly. What do they say about Missouri, the "Show Me" state? They ain't going to do a damn thing innovative. They are going to sit back and see what happens elsewhere. Rather than be the leaders, they are the followers

and they follow very slowly. National health insurance would change all that because everybody then would be in the same bag. But attitudes also have to change. We have to quit looking at people as foreign-born or Black or white or Hispanic or what have you and say these individuals are all God's children and if they are sick we treat them and let the Devil take the hindmost. We have to structure our institutions, our medical schools, our nursing schools, and all the rest of them to be a little more humane.