Protection of Privacy and Confidentiality

Unique law protects patient records in a multistate psychiatric information system.

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General concern over issues of confidentiality and privacy in computerized data systems has increased in recent years, especially as a result of the public's exposure to the continuing debate on the proposal for a national data center (*1*). Congressional hearings, articles in the press and in professional journals, and the information sought in the 1970 census have brought these issues to the fore (*2*). The recently published report on computers, record-keeping, and privacy by the National Academy of Sciences may have allayed the fears of some of the more outspoken critics of data bank systems (*3*), but the need to examine methods of protecting privacy and confidentiality in large data collection programs continues to be important. This article describes the legal, administrative, and technical mechanisms employed to protect the privacy and confidentiality of patient information collected in a research and demonstration program in psychiatry that involves patients from several states in the United States.

All data collection systems must be concerned with protecting their records from unauthorized and improper use. The data system described here requires the best possible protective methods since it deals with information gathered from psychiatric patient records. These records provide some of the most sensitive data that can be collected, from any source, on a person's private life. Even in a study where individuals had, for research purposes, entered psychiatric institutions as pseudopatients, false names were used, "lest their alleged diagnoses embarrass them later" (*4*, p. 251). No health records, with the possible exception of information on venereal disease, are considered legally more confidential and inaccessible to unauthorized use.

Origins and Purposes of the Multi-State Information System

One of the strongest arguments for developing the Multi-State Information System for Psychiatric Patient Records (MSIS) was the opportunity of eliminating the inefficiencies that plague existing state psychiatric record-keeping programs. The majority of non-MSIS states, even now, are only in the earliest, most primitive stages of developing data processing methods to handle psychiatric material. Principally a manual operation in most states until the last few years, these programs are typically the stepsisters of statewide data processing organizations, their data often being processed after data from such agencies as the departments of taxation and motor vehicles (*5*). Many states feel the need for efficient, automated, psychiatric reporting methods in order that large budgets for mental health departments may be justified, the use of such funds may be monitored, and appropriate care for the patient may be assured (*6*).

The purpose of MSIS is to develop and run a computer-based, clinical and administrative management support information system for psychiatric facilities and programs. The idea arose out of an exhibit at the Fourth International Congress of Psychiatry in Madrid, Spain, in October 1966 (*7*). At the exhibit, developed by one of the authors (E.M.L.) and the Information Sciences Division of the Research Center at Rockland State Hospital, Orangeburg, New York, data were collected on a computer-oriented questionnaire available in four different languages. While attendees watched, the computer converted the information on the questionnaire into a readable, grammatically correct narrative report in the language used in the questionnaire or, if requested, in any one of the other languages (*8*).

The potential of this methodology did not escape officials of the National Institute of Mental Health and heads of several state departments of mental health who attended the congress. Psychiatric patient records generally contain a great deal of important information in narrative form: summaries of the patient's mental status, his clinical progress, the record of his treatment, his prognosis, descripions of interviews and therapy sessions, and information about the patient gathered from secondary sources. As a result, narrative materials make up much more of the psychiatric patient record than of the average medical or surgical case history. The exhibit suggested the possibility that a substantial portion of basic psychiatric data could be collected in checklist form and then be converted by the computer into narrative reports that could be used by therapists in treating patients (*9*). Much of the time normally spent on keeping records could be spent in clinical activity, without jeopardizing the integrity of the medical record. Thus, many purposes could be served in one operation: the physician would not need to dictate or write routine reports, clerical preparation would be eliminated, and the resultant report would be structured and complete in that a basic set of observations would have been recorded for each patient in the same format. In addition to structured, individual records that could be useful in daily clinical activities, the computers could aggregate data for administrative, fiscal, and research purposes (*10*).

Another consideration in the decision to create a multistate system was financial. A joint effort, with the federal government contributing substantial funds and the several states sharing the remaining costs, seemed the most rea-

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sonable way to proceed. Experts in many fields (computer science, psychiatry, information system design, epidemiology, statistics, and so on) would certainly be attracted by the scope of the endeavor and the resources brought to bear on the problem.

In 1967, a 5-year demonstration grant was awarded by NIMH to the Research Foundation for Mental Hygiene, Inc., a nonprofit New York corporation working with the New York State Department of Mental Hygiene to develop MSIS. The operation of MSIS is based at the Information Sciences Division, Rockland State Hospital, and the director of the division (E.M.L.) is also principal investigator of the MSIS (*11*). A 2-year continuation grant from NIMH is now supporting further research and development.

Operation of the System

With some $10 million in the NIMH demonstration grant, an effective program of cooperation in data collection and utilization among a group of jurisdictions, some largely urban and some largely rural, ranging from the easternmost to the westernmost state, has been established. At this writing, the participating public mental health authorities are those of the state governments of Connecticut, Hawaii, Massachusetts, New York, Rhode Island, South Carolina, Tennessee, and Vermont; also participating are the public mental health program of the District of Columbia and the psychiatry program of the University of Alabama. The MSIS operation is open to additional cooperating jurisdictions and programs. By the spring of 1972, all states participating had begun contributing to the costs of operating MSIS, while federal funds continue to support the research and development aspects of the system.

Participation in the system takes various forms. The cooperating facilities may be linked to MSIS computers by terminals located in those facilities, data may be sent to terminals by mail, or information may be collected on independent computers. Presently participating through terminals linked directly to MSIS computers are the states of Connecticut, Massachusetts, Rhode Island, and Vermont, as well as selected facilities in New York and the District of Columbia.

The cooperating facilities use specially designed questionnaires prepared by MSIS researchers to record patient data. The design, testing, and regular use of these uniform data collection instruments in vast numbers have been major accomplishments of the project. The forms now in use collect the following types of data:

1) Demographic information: basic descriptors of the patient, including sex, birthdate, address, and, in most locations, the patient's full name.

2) Administrative data concerning patients: referral sources, ward or clinic assignment, transfers, legal status, census tract of home residence, and income information.

3) Patient problem and progress information: clinical appraisals of the patient's psychiatric condition (mental status examination, periodic evaluations, and diagnosis).

4) Treatment and service data: records of medication prescribed, other direct clinical services to the patient (family therapy, crisis intervention, psychiatric evaluation), and ancillary services (laboratory tests).

5) Other services information: descriptors of more indirect services performed by psychiatric facilities (consultation and community education).

In addition to the standard reports automatically prepared by the computer from forms received, MSIS has developed simplified methods that allow cooperating users to specify information retrieval requests to meet their special needs (*12*).

The MSIS data are being used in support of many activities within the mental health delivery systems of the states. Accurate, timely statistics are available on the number of patients served, the types of services rendered, the progress made, and the resources utilized. These data are scrutinized to compare programs and treatment modes, to analyze patterns of facility utilization, and to plan resource allocation.

Data are also used in determining whether all segments of the population are served adequately and equally by a mental health facility. Statistics on ethnic group, income, age, sex, and so forth are used for planning extensions of existing programs, for developing new programs, and for correcting inequities.

In the facilities, data stored in the computer form the core of the patient record. Individual profiles detail the patient's progression through a treatment program. At the same time, data for the facility as a whole are used for administrative and management purposes—for example, to determine how much food or medication to order. Research is facilitated by the availability of large amounts of data and the computer with which to analyze them.

The system's capabilities continue to expand through the development of data collection and analysis techniques in such areas as patient billing, cost analysis, third-party payers, computer-suggested modes of treatment, automated utilization-review procedures, and program evaluation.

Administrative and Technical Steps for Maintaining Confidentiality

All of the patient information collected by MSIS from cooperating agencies is ethically and legally confidential. The information from each psychiatric facility is compiled from clinical records by clinical and administrative personnel associated with that facility. The MSIS program has respected this confidentiality and allows a facility access only to the data it has stored.

The staff of MSIS set up the system in such a way that each terminal has access only to its own data files (disks and tapes), and not those of any other terminal. Personnel at each terminal dial the computer when data are ready to be transmitted. A password is required to identify the terminal. Failure to provide the correct password results in the immediate termination of the call. The passwords are known only to a few people at MSIS headquarters, where every possible effort is made to keep the passwords secret. Key personnel at each terminal are aware of the password for that terminal and are responsible for its security. Passwords are changed periodically and as needed. A monitoring program in the computer receives all transmissions and affixes to the incoming data an identifier indicating which terminal sent the information (*13*). That same identifier is transferred to the output so that reports are returned only to the terminal which sent them.

The MSIS computers record every transaction occurring within the MSIS computers—entries of data, corrections or updating of records already in the file, requests for reports, and so forth. This file also contains a copy of the messages returned to the terminal.

Other technical precautions have been taken to avoid accidental access or damage to the data. These include internal programming checks and the use of special codes.

Guards are posted 24 hours a day at MSIS headquarters to prevent unauthorized personnel from entering the computer room. At each of the participating facilities in which terminals are located, responsibility for security of the terminal room is in the hands of the director of that facility, as is the responsibility for distribution of data received and the propriety of its use.

History of MSIS Uses of Legal Safeguards

The MSIS asked the commissioner of mental hygiene of New York State to issue a formal statement of support for their practices of confidentiality. In a letter dated 18 June 1968, the commissioner, Alan D. Miller, responded as follows.

> In answer to your request, I am writing to state formally that the Commissioner of Mental Hygiene will not consent to divulge to anyone, other than the agency submitting the data, any information from that data which would in any way identify individual patients. In particular, information of facilities outside New York State will not be made available to any New York State agency or staff other than the staff working directly on the Multi-State Project in the Information Sciences Division at Rockland State Hospital.

The action of the commissioner was taken under the New York State Mental Hygiene Law, sections 20 and 34(q), which limit accessibility to departmental records and state hospital treatment records "except on the consent of the Commissioner or an order of the judge of a court of record."

For the first years of the demonstration project, the administrative practices of MSIS and the policy of the commissioner were adequate to protect the data stored at MSIS. No untoward incidents occurred as methodology was developed. The cooperating states were assured of confidentiality throughout this early period, and no more specific legal safeguards were thought necessary. It was important to gain experience with the system and to maintain flexibility in protective procedures as the types of information gathered changed and increased in amount and complexity.

Many contributors to the MSIS system demonstrated their interest in the issues of confidentiality. In a few instances, clinicians refused to report information because they believed that to do so would be a breach of their professional obligation to their patients. In several institutions, the issues sometimes changed staff discussions from quiet expressions of concern to heated debate. During the course of the project, many letters were received, as were countless verbal inquiries, about the MSIS position on these matters. Reference was often made by clinicians to practices of such agencies as the Bureau of the Census and the Internal Revenue Service, and allegations were made about breaches of confidentiality by these agencies. The credibility of MSIS's promises to maintain the confidentiality of the records in its computers was challenged typically with the question, "The commissioner has given his word, and the current directors of the MSIS unquestionably have the highest professional integrity, but what would happen if others should take control and administrative decisions should change?"

These legitimate concerns caused MSIS to seek more comprehensive legal safeguards. Thus, in March 1970, one of the authors (W.J.C.) was retained as legal counsel. After examining the situation, he suggested that the policy adopted by Commissioner Miller might not be sufficient over a longer period of time to protect the growing volume of records being received from the various cooperating states. The policy, even if fully effective, did not protect the records from subpoena or from other legally authorized discovery procedures. Also, it was thought questionable that the New York State statute referred to records other than those of the department of mental hygiene. Although they were physically stored on the grounds of a state hospital, the equipment and records of MSIS were actually owned by the Research Foundation for Mental Hygiene, Inc., the grantee of the NIMH grant. Therefore, the policy could be found inoperative in protecting the MSIS records.

Methods of providing more specific legal safeguards were examined. One possibility was to transfer control and ownership of the records to the New York State Department of Mental Hygiene. The records related to patients in many states, however, and it seemed inadvisable to place them with a government agency of another state. Therefore, it was determined that the records should remain under the ownership and control of the Research Foundation for Mental Hygiene, Inc., as a suitable, neutral, nongovernmental organization.

Another approach given serious consideration was a compact, to be entered into by all cooperating states, establishing the organizational framework of the system and guaranteeing its privacy and confidentiality under the law of each state adopting the compact. A draft was prepared by the legal counsel. The proposal was found inadvisable by a number of states, however, largely because it would have required the adoption of a formal organizational structure too soon in the project, which was still considered to be in the experimental stage.

The Special Protective Law in New York

It was finally decided to seek a special enabling statute from the New York legislature directly declaring the MSIS system and all its records confidential. The statute would make it clear that the records were private corporate records—they were not the property of the New York Department of Mental Hygiene, nor were they public.

A bill including these provisions was drafted by the legal counsel. It was submitted to the New York General Assembly early in 1972 (*14*). The bill further provided that the records and information stored in the system by facilities located outside of New York then and in the future were not open to inspection by any agency or individual other than the agency or facility submitting them and were not subject to subpoena in any court, tribunal, or administrative agency. The prohibition of any subpoena was justified to the legislature on the grounds that all of these records are secondary sources of the information contained therein. The best evidence is in the records maintained by the facility in the original jurisdiction. Therefore, any subpoena should be addressed, not to MSIS, but to the facility at which the records originated. The bill also denied other governmental inquirers, such as state auditors and investigators, access to the records. With protection for the records guaranteed, accountability of the system had to be assured. Therefore, it was proposed by the legal counsel that a single public official, the commissioner of mental hygiene, be empowered to conduct an annual review of the system to assure its proper and lawful operation in the interests of the cooperating states and facilities. The commissioner accepted this responsibility, and it was incorporated into the bill. Last, the bill spelled out the authority of MSIS to release aggregate data for research and planning purposes as long as all personal identification was removed. This authority is similar to that granted the Census Bureau, which is prohibited from using "the information furnished . . . for any purposes other than the statistical purposes for which it is supplied" (*15*).

The bill was passed by the General Assembly and was signed into law on 15 May 1972. It became part of the law of New York as Section 79(j) of the Civil Rights Law (*16*). Most of the features of this statute are unique in American law in providing safeguards concerning the privacy and confidentiality of the material stored and in limiting access to authorized parties. The idea of a protective law for a large, cooperative, computer-based medical records data bank was first suggested in 1969 (*17*).

Privacy and Confidentiality in the Various States

The security of patient records at their source in the institutions is, of course, still governed by the various state laws. The MSIS commissioned an analysis of the law in each participating jurisdiction (Connecticut, Hawaii, Massachusetts, New York, Rhode Island, Vermont, and the District of Columbia) in the fall of 1971 and the winter of 1972.

The first question examined was the legal relation between MSIS and the particular jurisdiction. For the most part, the head of MSIS and the appropriate official of the state mental health agency (its commissioner or director) negotiate directly with each other. Only the State of Connecticut has explicit statutory authorization to contract with an interstate data bank (*18*); that law (to be examined later in this article) also prohibits the submission of "identifiable patient data" to such an interstate system.

While the other states have no specific legislative mandate, their mental health agencies may participate in MSIS by administrative arrangement or by contract, as an appropriate and efficient means of carrying out their statutory responsibilities regarding administrative operations and recordkeeping. No law or regulation in any of the jurisdictions in any way prohibits arrangements such as those made with MSIS. Feeding information into the MSIS computers is not a disclosure of that information to a third party. As indicated earlier, the information stored by the particular facility is accessible *only* to that facility; MSIS is merely a guardian of the information.

It should also be noted that each jurisdiction's involvement with MSIS is somewhat different because the program is still in a developmental stage. Similarly, individual facilities are free to make their own administrative or contractual arrangements with MSIS for special purposes.

The newest area of law within the scope of this article, other than specific laws covering data banks, is the general law of personal privacy. This legal right was first examined in 1890 (*19*). A few years later, a New York court refused to acknowledge a Common Law right of privacy and indicated that the creation of such a concept would require legislative action (*20*). The New York legislature acted promptly the following year and enacted the first statute in the United States protecting a personal right of privacy (*21*). This statute has remained relatively unchanged over the past 70 years. Like the special statute protecting the MSIS program, it is a part of the New York Civil Rights Law.

Among the eight jurisdictions involved in MSIS, New York is the only one with a clear statutory right of privacy. The right, in some respects at least, has been recognized in Common Law decisions of the courts in Connecticut (*22*), Hawaii (*23*), Massachusetts (*24*), and the District of Columbia (*25*). Rhode Island and Vermont have not recognized a legal right of privacy, either by statute or by case law.

The law of confidentiality concerning psychiatric and other mental health agency records is more specifically relevant to a mental health information system than is the general law of privacy. Physicians are bound in a trust relationship with their patients not to disclose indiscriminately any information derived from the patient in the course of treatment. This restriction is contained in the Principles of Medical Ethics of the American Medical Association and in the Hippocratic oath. A violation of this obligation would be considered serious professional misconduct. Moreover, professional licensure laws in all states participating in MSIS provide for the revocation or suspension of a physician's license to practice medicine for "unprofessional conduct." Some of the laws specifically prohibit the willful violation of a privileged or confidential communication.

Even clearer than ethical standards and state licensure laws are the many statutes that recognize medical confidentiality and establish testimonial privilege. New York's law has the broadest coverage in the field. It recognizes a confidential relationship and creates a testimonial privileged communication between patients and physicians, psychologists, nurses, and social workers (*26*). Hawaii (*27*) and the District of Columbia (*28*) recognize confidentiality and privileged communications in the general medical area, but require physicians to answer in court concerning a patient's "sanity."

Massachusetts and Connecticut take opposite approaches to that of Hawaii and the District of Columbia. These states have recognized a confidential relationship protected by privileged communication in the psychiatric area, but not in other medical fields. The Massachusetts law protects confidentiality of communications between a patient and a "psychotherapist" (*29*). The term is defined as a licensed physician who devotes a substantial portion of his time to psychiatry. The statute also prevents any "witness" who receives such a communication from testifying. It would seem, therefore, that a patient could refuse to permit testimony by other persons associated with the psychiatrist in professional practice, such as nurses, secretaries, consulting psychologists, and social workers.

The Connecticut law is broader and more complex than the Massachusetts law (*30*). Here, too, the psychiatrist is defined as a licensed physician who devotes a substantial portion of his time to psychiatry, but it adds "persons reasonably believed by the patient to be so qualified" (*31*). Additional provisions protect confidential communications to a clinical psychologist and to people who work in mental health facilities or who participate in the care and treatment of mental patients under the supervision of psychiatrists.

Patient's clinical records, consultant reports, psychological tests, drug administration records, and other such records are maintained by mental health facilities for convenience in treating and caring for patients. These records are the physical property of the facility (*32*). Of the states participating in MSIS, Connecticut, Hawaii, Massachusetts, Vermont, and New York have statutes establishing the confidentiality of psychiatric records in mental health facilities.

Connecticut has enacted the most rigorous legislation relating to the confidentiality of psychiatric records and communications in mental health facilities. Limited access and restricted disclosure apply to all communication of mental patients' records where the patient is "identifiable." The term is defined to include disclosure of the name of the patient or other descriptive data from which a person acquainted with the patient might reasonably recognize such patient, or the use of codes or numbers which are in general use outside the mental health facility preparing the record (for example, Social Security numbers).

The Connecticut statute severely limits the use of mental patients' records beyond the necessities of intrafacility patient care and treatment, including communication to the commissioner of mental health. However, the statute does permit the transmittal of nonidentifiable records and information from any mental health facility to the commissioner for purposes of administration, planning, and research. A code developed by, and remaining in the possession of, the mental health facility must be the exclusive means of identifying patients in such communications.

These Connecticut statutes might have constituted a legal barrier to cooperation with an interstate record collection and analysis program or data bank had it not been for the inclusion in the law of a *specific authorization* of transmittal of patient records and information from mental health facilities to the commissioner of mental health; this authorization empowers the commissioner to enter into intrastate and interstate contracts and compacts "for the efficient storage and retrieval of such information and records" (*33*). As mentioned earlier, the law requires the facility to remove patient identification from the records transmitted, and any code developed to identify such patients must be kept at the facility.

The Vermont Department of Mental Health and the Hawaii Department of Health are required by statute to maintain mental health records relating to patients and programs. Moreover, in both states, all certificates, applications, records, and reports that directly or indirectly identify a patient must be kept confidential. This provision is particularly noteworthy in Vermont, which does not recognize the confidentiality of the physician-patient relationship or create a general medical testimonial privilege. However, disclosure of psychiatric information is permitted in both states as deemed necessary to carry out the provisions of the statute, as directed by a court in the public interest, or with the written consent of the patient or his guardian.

Massachusetts law requires that the Department of Mental Health "keep records of the admission, treatment and periodic review of all persons admitted to facilities under its supervision. Such records shall be private and not open to public inspection . . ." (*34*). The statute permits the court access to such records upon judicial order and, at the commissioner's discretion, permits either the patient's attorney or others access, when in the patient's best interest. Departmental regulations permit access to identifiable patient data and records for research purposes, subject to a number of conditions such as protecting patient anonymity.

New York's Mental Hygiene Law spells out in great detail the required content of patient records maintained by mental health facilities and by the Department of Mental Hygiene (*35*). The department has also adopted extensive regulations concerning recordkeeping and disclosure of patient information (*36*). Access to institutional and departmental records is restricted to named parties, such as the facility director and the commissioner of mental hygiene; only the consent of the commissioner or an order of a judge of a court of record may expand access to psychiatric records (*37*).

Neither Rhode Island nor the District of Columbia has explicit provisions protecting the confidentiality of mental health records. Public hospitals in the District are required to maintain records of mental patients. These records must be made available, upon the patient's written authorization, to his attorney or personal physician, and they must be preserved until the patient's discharge from the hospital (*38*).

Conclusion

A multistate, cooperative program seeking to develop better methods for the effective and efficient gathering, storing, analyzing, and utilizing of mental patient records has made a comprehensive effort to protect the confidentiality and privacy of these psychiatric patient records. Administrative, technical, and legal safeguards have been implemented. The discussion of legal safeguards involves two areas: the protection of the system itself, located at Rockland State Hospital; and the specific legal environment of confidentiality and privacy of mental health records and information in the group of cooperating jurisdictions.

On the whole, adequate legal and administrative protection can be afforded the confidentiality and privacy of an electronic data system in the mental health field, and access to the records can be restricted for the welfare of the patients. At the same time, access to aggregate data in the system can be allowed, under proper standards, for important research and planning purposes. The methods adopted by MSIS to preserve confidentiality and privacy by limiting access to such records could well prove an important model for the development of protective methods in other electronic data programs—not only those in psychiatry, but those in other fields where the data collected are sensitive and confidential.

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NEWS AND COMMENT

NIH: Plan to Charge Research Patients Provokes Protest

Caspar Weinberger, Secretary of Health, Education, and Welfare (HEW), has decided that charging research patients at the National Institutes of Health (NIH) would be a good way for government to make a little extra money. His proposal, which is one of a long series of generally successful moves to reduce the federal commitment to biomedical research, has convinced many members of the NIH community that the Nixon Administration really is out to get them. Something of a "this is the last straw" atmosphere prevails among clinicians at the NIH campus in Bethesda.

Representative Paul G. Rogers (D–Fla.), chairman of the House subcommittee on health and environment, has accused Weinberger of wanting to "change the world's greatest clinical research center into a community hospital."

Since the inception of the NIH Clinical Center in 1953, its patients, who are said to give as much as they get when they check into the 300-bed research-only hospital, have always been treated free. NIH investigators fear that the move to charge patients will destroy the intellectually special environment of the center which, over the years, has earned an extraordinary reputation for excellence in clinical research. NIH is often the place that the latest results of laboratory research are first applied at the bedside. It is often there that new ideas for therapy are developed to the point at which they can be widely used to patients generally. And the explanation for this, NIH supporters argue, is that the Clinical Center is such an ideal place for doing the kind of front-line research that it does. Every patient the center gets is an experimental subject. It is argued that guinea pigs should not be charged for the privilege of contributing to the advancement of medicine.

Charles C. Edwards, assistant secretary for health at HEW, is one member of the Administration who is sympathetic to those who would leave the Clinical Center and its way of doing business in tact. In a 26 October memo, he told Weinberger that he "would recommend against" charging Clinical Center patients. Edwards surely echoed the thoughts of NIH investigators when he wrote:

> I think it is important to emphasize that the Clinical Center is not a typical health facility. While most hospitals exist to provide direct benefits to patients, the Clinical Center's only reason for existence is to increase biomedical knowledge through the support of clinical investigation. Center *research patients*, although they may be receiving useful treatment and the best of patient care, are also directly participating in diagnostic and therapeutic trials. *These patients are occasionally on placebos and undergo many diagnostic tests unrelated to normal treatment.* Many patients suffer from diseases which have no established treatment and are actually studied rather than treated. Generally, all Clinical Center patients give their time and cooperation by accepting research procedures which are often uncomfortable and restrictive. In my view . . . it is simply inappropriate to ask or request research patients for payment under such conditions.

The thing that makes this all so difficult for NIH investigators to take is that the financial stakes are so comparatively low, measured in almost any terms, compared to the intellectual and psychological stakes which, for them, are so high. The figure that is being bandied about as that which the government would earn if it started charging patients is $9 million, give or take a little. Researchers feel that it is unwise to jeopardize a program of proven value for a sum as modest as this. They are afraid that if they have to start charging, patients won't come in many instances, which would mean an end to the Clinical Center.

If a charge system were put into effect at the Clinical Center, most of the money would come from third-party payers—insurance companies, Blue Cross and Blue Shield, and the like. To get some rough information about the insurance coverage of patients in the Clinical Center, a survey was made of the 284 persons who were in the hospital last 6 September. Seventy-four percent carried either private or government insurance; the rest had no health insurance at all.

Weinberger is quoted as having said that there is no point in having the government spend money if insurance companies will. "Most people have some sort of hospitalization coverage and not to even investigate whether it is applicable at the center is ridiculous. There seems to be a great alarm that