ECONOMICS OF AGING: TOWARD A FULL SHARE IN ABUNDANCE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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FIRST SESSION

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ECONOMICS OF AGING: TOWARD A FULL SHARE IN ABUNDANCE

(HEALTH ASPECTS)

THURSDAY, JULY 17, 1969

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 10:10 a.m., pursuant to call, in room G308 (auditorium), New Senate Office Building, Senator Edmund S. Muskie presiding.

Present: Senators Muskie, Kennedy, Prouty, and Saxbe.

Also present: William E. Oriol, staff director; John Guy Miller, minority staff director; Patricia G. Slinkard, chief clerk; and Margaret L. Brady, assistant clerk.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE ELDERLY

Senator MUSKIE. The subcommittee will be in order.

This subcommittee meets today at a time of deep and troubled questioning about the future of health care in the United States. Much of that questioning is related to recent allegations about profiteering under medicare and medicaid.

On the one hand, we are told that cheating endangers those two far-reaching programs. On the other, we are told by representatives of organized medicine that the real problem lies in Government fumbling and lack of clear national objectives. Through it all, there is the undeniable fact that medical costs are rising at a rate which must be recognized as inflationary and dangerous.

At a time when such alarms are sounded, it is only natural for experts and laymen to argue over individual issues rather than to unravel the tangle of inadequacies, anachronisms, good starts and false starts, and new demands for service that exist in our medical system, or nonsystem, today.

Recently, for example, the Nixon administration offered its own report on the health care crisis and said, in effect, that the best way to cope with everything is to tighten up Federal administrative procedures in medicare and medicaid, and to importune physicians and hospital directors to become far more cost-conscious than they now are.

Worthy as these sentiments are, to my mind, the fundamental causes of today's problems are the following:

CAUSES OF THE PROBLEM

Narrow or clogged channels of supply for professional, technical, and custodial personnel needed in all branches of medicine.

Inadequate or irrational modes of delivering health care to those most in need.

A clear need to redefine some goals of medicare, especially under the part B medical insurance program.

There is also a need to correct fundamental deficiencies and contradictions in medicaid, or to replace it with a more general protection program against personal health care expenditure crises.

Finally, we need standards which will tell us clearly what a dollar can be expected to buy in today's health care market.

Each one of the issues I have listed has special relevance to the elderly and to the subject of this hearing, which is "Health Aspects of the Economics of Aging."

As the title suggests, the subcommittee is concerned primarily about the financial impact of health expenditures upon the elderly, and the relationship of that impact to the overall economic security of older Americans.

Our working premise is that the medical costs they must finance are a drain upon the limited resources of the elderly, and that inflation is rapidly making that drain intolerable.

Until that drain is plugged there can be no satisfactory national income maintenance program for today's generations of aged Americans and for all those in the generations ahead.

Fortunately, we are not starting from scratch. Three years of medicare have already created a climate for experimentation and new standards of health care. It may well be that, if we perfect medicare for the elderly, we can see clearly the most direct road for assuring better health care for Americans of all ages.

In exploring such premises and possibilities, the subcommittee will continue a study begun earlier this year by the full committee on the subject of "Economics of Aging: Toward a Full Share in Abundance." I am pleased that the committee chairman, Senator Harrison Williams of New Jersey, asked me to conduct this specialized hearing on the health aspects of that problem.

Without objection I will also include in the record at this point a statement of the chairman of the full committee, Senator Williams, on the subject before us today.

(The statement follows:)

PREPARED STATEMENT OF SENATOR HARRISON A. WILLIAMS, JR.

Mr. Chairman, I will take only a few moments to discuss the relationship of this hearing to the overall Committee on Aging study of the "Economics of Aging: Toward a Full Share in Abundance."

It was my responsibility, as Chairman of the Committee, to conduct survey hearings on that subject in April, following publication of a Task Force Working Paper which outlined major problems related to the economic security of 20

million Americans now aged 65 or over, and the many millions more who will reach retirement age in the next few decades.

As the Task Force report made clear—and as our initial hearing confirmed—any study of the economics of aging would be incomplete without intensive attention to the special problem of rising health costs.

Pleasant as it would be to assume that Medicare pays all bills for the elderly, such is certainly not the case.

Your witnesses today will, I am sure, show that the health care cost burden still falls unevenly and often disastrously upon elderly individuals and families.

Your witnesses today will also discuss the deficiencies in the delivery of health services for the elderly, and they will show how the elderly, in particular, suffer because the services they need are non-existent or geographically or financially out of reach.

Last October, for example, the Committee on Aging received testimony about the special problems of the elderly in the central areas of Los Angeles. We were told about the severe shortages of physicians in areas of greatest need, about crowded clinics to which the elderly flock when they cannot see a private doctor, and about the weariness that overcomes many aged people when they must spend hours waiting for even routine health care. What does it benefit a person to be eligible for Medicare or Medicaid if he has no access, or discouragingly limited access, to the care he needs?

The sad truth is that low-income elderly—those most in need of good health care—stand less chance of receiving it and thus their health problems intensify. They exhaust Medicare benefits and then quite often find that Medicaid fails to "mesh" with Medicare as well as it should.

And for the elderly who have more adequate income, a different set of problems may arise. Their savings or their retirement pension may make them too "rich" for Medicaid and too proud for welfare. If a husband or a wife happens to fall victim to an illness that does not require hospitalization, Medicare is likely to be of little help to them. Financial disaster can overtake them suddenly, or—in the case of worsening ailments which require more and more prescription drugs and special care—very gradually.

I join with you, Senator Muskie, in thanking the members of the Advisory Committee which today submitted a report in conjunction with this hearing. It seems to me that they have given a solid foundation for this hearing, and they have made a major contribution to the overall Committee study of the economics of aging.

My thanks also go to you, Senator Muskie, for acting so promptly to call this hearing. You will, I am sure, provide the full Committee with valuable testimony and insights.

The same was true of the hearing conducted by Senator Frank Church on "Consumer Aspects of the Economics of Aging" last month in Ann Arbor, Michigan. The record there is rich in helpful information. Still another special-purpose hearing will be conducted on July 31 and August 1 by Senator Frank Moss on the subject of "Homeownership and Housing Aspects of the Economics of Aging". There is some chance that one or more additional hearings on individual subjects will be conducted by subcommittees before final full Committee hearings later this year.

When all the testimony is in, the Committee will be in an excellent position to make far-reaching recommendations on income maintenance for present and future generations of older Americans. And now I am looking forward to today's hearing with great interest.

Senator MUSKIE. I am pleased that the subcommittee and witnesses have the benefit of an informative and challenging report,* issued by an advisory committee for this hearing. That report, of course, is not a final statement of conclusions by the subcommittee or the committee, but it is an excellent source book of information and highly informed commentary. I would like to personally compliment the advisory committee for their inestimable assistance in helping this subcommittee.

*See Appendix 3, p. 690, for text of report.

STATEMENTS OF AGNES W. BREWSTER, CONSULTANT ON MEDICAL ECONOMICS; S. J. AXELROD, M.D., DIRECTOR, BUREAU OF PUBLIC HEALTH ECONOMICS, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN; MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UAW; AND BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL–CIO

Senator MUSKIE. May I present Mrs. Agnes W. Brewster, consultant on medical economics; Dr. S. J. Axelrod, Director of the Bureau of Public Health Economics, School of Public Health Economics, University of Michigan; Mr. Melvin A. Glasser, director of the Social Security Department, UAW; and Mr. Bert Seidman, Social Director of the Department of Social Security, AFL–CIO.

These members of the advisory committee are here to my right and I invite them now to make their comments.

STATEMENT OF MRS. BREWSTER

Mrs. BREWSTER. Thank you, Senator Muskie. It is a pleasure to again be with this subcommittee because the sort of work they are doing is so close to my own interests.

One can hardly pick up a newspaper or magazine these days or listen to a newscast, or even a Jackie Gleason skit, without hearing something about the high costs of medical and hospital care. Last week wound up with the President expressing his concerns and this week the AMA has been in the spotlight on this score.

One of the satisfactions of serving on the Advisory Committee on Health Aspects of the Economics of Aging is its focus on the consumer and his problems. The particular consumer that is the constituent of the U.S. Senate Special Committee on Aging has passed his 65th birthday; however, this consumer's problems spill over and affect everyone whether or not they have reached the so-called golden age of 65.

The advisory committee has been rightly concerned that medicare and medicaid have held out promises of resolving the health economic problems of the aged that their implementation is unfortunately making somewhat illusory. Thus "all that glitters is not gold" to many a senior citizen and it is beginning to appear that there is no pot of gold at the end of the rainbow.

As the report issued today reveals, the committee has been following the guidelines set out by the task force of this special committee viewing the aged's problem of financing their medical care in the context of their limited income.

The advisory committee believes in the social amenity that says "ladies first" so it is my assignment to summarize the report we have prepared for the use of the Special Committee on Aging.

We have given a few cogent facts about how much more health care costs the old and why this is so—their chronic conditions, their special needs and their frail bodies that make going to the doctor difficult. We included the facts about the new coverage sold by private insurance companies and Blue Cross and Blue Shield that supplements medicare.

The first part of the report also highlights our dual system of caring for the aged. One is reminded of a circus rider astride two horses in contemplating the lack of a unified approach to finding the cure when you look at medicare and medicaid in tandem trying to get around the circus ring.

Inflation has always been a problem for those on fixed incomes, but no one anticipated the skyrocketing that has occurred in the significant portion of the expenses of the elderly that go for medical goods and services that has occurred. Part 2 of the report goes into the impact of inflation and particularly stresses the paramount importance of exercising control—expensive resources must be properly used.

It seems to the advisory committee that the total situation of the aged—securitywise, healthwise and disabilitywise—makes organized delivery and linking of services, if anything, more important for the aged than for any other age group. One stop service, and by this we mean group practice, means a great deal when mobility is limited. And the implications for quality improvement and cost control have not escaped our attention. Group practice has special values for the aged and for those who care for them.

Advisory Committee Findings

Finally, we sum up our findings and make some recommendations. May I give these to you since they are at the heart of this matter of the health aspects of the economics of aging. These are the advisory committee's conclusions.

As a vital prerequisite for establishment of a national health insurance program, and while there exists a dual system of financing, public and private efforts should immediately be made to deal with demonstrated deficiencies in medicare because:

1. Health-care problems of the elderly are still widespread, and they remain urgent.

2. Three years of experience under medicare have provided invaluable lessons in the operation of a major public health insurance program. The time has come to heed those lessons.

3. Current investigations into profiteering under medicaid and medicare have helped focus attention upon the need for cost controls and establishment of uniform standards of care. Such reforms can have a beneficial effect upon the entire health industry and can combat medical cost inflation.

4. Success in improving medicare will lead to more general acceptance of steps necessary to provide higher quality health care to our entire population.

5. The lack of adequate consumer representation in medicare and its absence from State advisory committees for medicaid is deplorable.

It is not the function of this advisory committee to offer a detailed program for action, but it can offer some general recommendations:

The committee believes part B of title 18 should be recast, to bring it under the social security payroll tax and do away with premium payments by the aged. This rearrangement would then make possible several simplifications of benefit administration, including:

(1) Permitting capitation payments to group practice plans providing hospital and physician services.

(2) Fostering use of home health services without reference to coinsurance.

The committee also believes medicare benefits should be extended:

(1) To include other services and supplies not now covered, of the chronic diseases that commonly affect the aged. Eventually all prescribed drugs should be included.

(2) The deductible and coinsurance features of both parts A and B should be eliminated.

(3) The 3-pint deductible for blood and the 3-days-in-the-hospital requirements for admission to an extended-care facility and the lifetime limitation on the mental hospital benefit should be eliminated.

(4) To include preventive and diagnostic services more fully, and eye and foot care.

No matter how much money we pump into medicaid, a mechanism that simply pays bills is not the answer to a problem that calls for improving the delivery system.

Nursing homes must be brought into the mainstream of medical care by truly being adjuncts of nonprofit hospitals. Standards for nursing home care must be constantly raised, not lowered.

Noting the absence of informed and disinterested assistance to the aged in relation to their social and financial problems we see additional reasons why the team approach to delivering medical care is essential for this age group. For example, the elderly need a place to turn for information on supplementary insurance they should buy.

Another kind of social service would recognize problems connected with discharge from hospital. As a condition of participation in medicare, every hospital should have a discharge planning committee.

Taking "Assignment" by Physicians

The committee also considers that medicare has established itself in the daily lives of millions of Americans; physicians should no longer be permitted to refuse to recognize it by not taking assignment of benefits.

The committee believes that physicians' fees cannot remain subject to the whims of individual providers of service, if medicare and medicaid are to be fiscally predictable and gross abuses are to be stopped. The same is true of hospital costs.

The committee believes that standards for physicians' qualifications should be promulgated by medicare to require that qualified surgeons alone be allowed to perform operations.

The committee hopes to see greater emphasis on prior budgeting and controls of costs for hospitals, extended-care facilities, home health agencies, and on more meaningful utilization review than is often the case.

There should be more consumer participation in the decisionmaking processes under medicare and medicaid.

Concern With Physicians Fees

A few other comments may be in order. Our report shows a concern with physicians' fees that seems to be widely shared. The rationale for paying physicians their usual fees for services to the aged is easily

justified; in the past many physicians have accepted lower fees from retired people or given free care because of their limited income. Now a new resource—the contributions of all workers to social security through payroll taxes—has come along to supplant the individual charity work of the country's doctors. But—if we assume that few if any physicians were experiencing really hard times prior to medicare—you cannot help wondering why—with proportionately more full-pay patients adding to their incomes from private practice—doctors also needed to raise fees above their previous levels. A few doctors have been frank enough to reveal an attitude that they felt they must get "theirs" before the Government clamped down. Others have gone along with hiking their fees just to keep peace with their greedier colleagues. Few have failed to raise their fees far more than the Consumer Price Index for all goods and services.

And, as the report makes clear—the CPI measures only price increases. When a price increase is coupled with an increase in volume, the effect on income is compounded. A 21-percent rise in charges plus a 10-percent increase in patient visits means the doctor's income is up 33 percent. Similarly, if hospitals can raise the occupancy rates of full-pay patients, income will rise.

In our report there are excerpts from the Health Insurance Benefits Advisory Council (HIBAC) Annual Report about the impact of medicare on costs. Read closely, these paragraphs sound like a valiant effort to carry water on neither shoulder—HIBAC points out medicare is not the only purchaser in the marketplace—so medicare is not responsible for higher hospital and medical costs.

A few paragraphs later the HIBAC report fully acknowledges the sudden price rise that has occurred since medicare started.

My own view is that, when one is the biggest customer, one's posture does affect price. There is no question that medicare and medicaid and civilian health and medical program of the uniformed services—all Government programs—constitute close to 50 percent of the income of many institutions. They have influenced the price and undoubtedly will continue to do so unless both providers and consumers begin to exercise a sense of responsibility.

Senator MUSKIE. Thank you very much, Mrs. Brewster.

I think it might be helpful now to ask Mr. Seidman to make his statement.

STATEMENT OF MR. SEIDMAN

Mr. SEIDMAN. Thank you, Mr. Chairman.

This subcommittee is to be highly commended for directing the Nation's attention to the serious problems the elderly still face in seeking to obtain adequate health care. There seems to be a widespread impression that the enactment of medicare in 1965 automatically assured every elderly person in the United States that he could obtain comprehensive quality care to meet all of his health needs. Unfortunately, that impression is erroneous. Medicare has been a great boon to the aging but it has by no means eliminated all of the deficiencies and inadequacies in the health care of the elderly which preceded the establishment of medicare.

So that I will not be misunderstood, I want to make one thing clear. While it will be my purpose in this brief statement to emphasize some of the most glaring gaps in medicare, I recognize that, despite its in-

adequacies, medicare has contributed very significantly toward meeting the health care needs of the elderly. Indeed, medicare has made it possible for millions to obtain necessary health care that they could not have obtained otherwise.

If organized labor criticizes some of the shortcomings of medicare today, it is not because we do not appreciate the contribution it has made. We criticize medicare in order to improve it so that it will fulfill its original purpose of assuring merical care of high quality to all elderly Americans. Moreover, if we make medicare the success it can be in meeting the health needs of the elderly, we will also be demonstrating that through a universal system of comprehensive national health insurance we can assure high quality health care to all the American people.

One of the most serious defects in medicare is the wide gap between what the elderly can afford to pay out of their own pockets and what medicare pays for their health care. The average single retired worker on social security today receives less than $100 a month and a couple approximately $150. Their financial problem would be serious enough if medicare met all of their health care costs, but it does not. The fact is that medicare pays for less than one-half of the health care costs of the elderly. For the great majority of the elderly who live on very low incomes this represents a crushing financial burden. For many it also means an inability to finance urgent medical care needs which results in avoidable discomfort, pain and, yes, even death.

Health Costs Not Covered by Medicare

Let me briefly list the major items of health care the elderly must still pay for out of their meager financial resources:

1. The part B (physicians' services) premium of $4 a month; for an aged couple this is $96 a year.

2. The deductibles. Medicare does not pay for any part B services until the patient has met $50 of the cost out of his own pocket. For hospitalization he must pay the first $44 of any bill and there are deductibles also for other types of services.

3. Coinsurance. This is 20 percent for all physicians' services and varying amounts, depending on length of stay, for hospitalization or nursing home care.

4. In part B, refusal of a doctor to accept assignment; that is, the "reasonable charge" determined by the insurance company or other private organization acting on behalf of Social Security, requires the elderly to pay more, often considerably more, than the $50 deductible plus the 20-percent coinsurance.

5. Medicare does not cover many items of health care. Among them are prescription drugs, most dental, foot and eye care, eyeglasses and hearing aids, and most types of medical appliances. In addition, there are limitations on the length of stay in a hospital or nursing home and the number of home health visits which are paid for.

These are the principal limitations which require the elderly even under medicare to meet more than half of their health care costs. I

have already mentioned the extremely limited incomes of the elderly which can hardly be stretched to meet the heavy financial burden of their medical costs. As our advisory committee report brings out, the health care costs of the elderly are approximately 2¾ times as much as for younger age groups. Thus, even if medicare paid for half of the health care costs of the elderly, they would still be paying out of their own pockets 37½ percent more on the average than those still working. Yet their incomes on the average are only about half those of the non-elderly.

Medicare was enacted because it was recognized that the elderly could not meet unduly large health care costs out of their limited incomes after retirement. But medicare is doing only half the job of relieving the elderly of the crushing financial burden of meeting their medical care needs. It is time to make it financially possible for all the elderly to receive quality health care.

Proposals To Change Medicare

To that end the following changes should be made in the existing medicare system:

1. Parts A and B should be combined as a single social insurance system financing the health care of the elderly. Part A of medicare conforms to recognized social insurance principles in that contributions are made while the individual is still in the labor force toward his hospitalization needs after retirement. But part B requires the retired person to pay, after he is no longer working, for more than 50 percent of the medical services not covered by part A, principally physicians' services. By combining parts A and B, we would provide for the entire financing of medical care before retirement, thus removing the onerous financial burden of payment of the monthly premium after retirement.

2. To remove financial deterrents to needed health care, the coinsurance and deductible features of medicare should be eliminated. Moreover, doctors should be required to accept assignment if they wish to participate in medicare.

3. Medicare should be extended to cover the cost of prescription drugs—and here I would go even further than our report does; I think this should go further and cover all prescription drugs—dental care, eyeglasses and other items whose costs the elderly must now meet out of their limited incomes.

4. Since the changes I have suggested would involve additional costs which cannot be and should not be met by raising already high rates of worker and employer social security contributions, half of the total cost of medicare should be met out of general revenue.

Adoption of these recommendations will not eliminate all the ills of medicare since, as my colleagues will describe, some defects can only be removed by changes in the organization and delivery of medical care and establishment of quality and efficiency incentives and cost controls as recommended in our advisory committee report. However, the changes in financing of medicare I have suggested will assure that

the elderly will no longer be denied urgently needed health care because of lack of individual financial resources. In this way, we will help to assure that health care is the right of all elderly Americans.

Thank you, Mr. Chairman.

Senator MUSKIE. Thank you very much, Mr. Seidman, for your excellent statement.

Mr. Glasser is the next member of the committee.

I thought we might hear from each of the members of the advisory committee, Senator Prouty, before we start with the questions.

Mr. Glasser.

STATEMENT OF MR. GLASSER

Mr. GLASSER. Mr. Chairman, Senator Prouty.

There has been a great deal of criticism, much of it valid, of the operations of the medicaid program. The advisory committee feels it is of the highest importance that there be recognition that the medicaid program was created to fill a major unmet need of the American people. There is abundant evidence that lack of effective health care is a major cause of poverty in the United States, and a major factor in the substantially poorer health experienced by low-income groups as contrasted with those in the middle and upper income groups.

Medicaid is, however, achieving only a small part of its promise and its potential. In 1966 an HEW official stated, and I quote, "When adopted by all States, the new medical assistance program can provide comprehensive high quality medical care for as many as 35 million medically needy people." Three and one-half years later, as of July 1, 1969, only 10.8 million persons are estimated by the States which have these programs to be eligible for services. In other words, less than one-third of the people deemed requiring the program are now eligible to receive benefits. In both range of services and categories of persons served, there is the widest variation.

The basic problem derives from the fact that medicaid is neither a health care nor a medical care program, it is a payments program for a limited number of medical services.

While the medicaid program is designed to take care of the medically indigent regardless of age, its major services and expenditures still go for the elderly. This in itself is an indirect commentary on the shortcomings of medicare. Forty-one percent of the people eligible for medicaid are at least 65 or older and 45 cents of each medicaid dollar is spent on the aged.

CARE FOR INDIGENT DETERIORATING

Primarily because of the cost situation, medical care available to the medically indigent is becoming progressively poorer instead of better. Most cost savings are being made at the expense of the needy through cutting benefits and eliminating classes of eligibility or through requiring sharing of payments. These widely practiced approaches of the States overlook the main source of escalation, which is the cost of providing the services. Two factors are at work: (1) the charges of nursing homes, hospitals and physicians; and (2)

an alarming increase in utilization, much of it questionable justification.

There seems to be little doubt that a not insignificant number of physicians are taking grossly unfair advantage of the program, and we have had many illustrations. Let me cite from the July 11, 1969, issue of the Detroit News. One Michigan physician received $169,000 in one year in medicaid payments alone. By his own statement this represented about one-half of his work. By a rough calculation this physician apparently devoted an average of 160 seconds to each of his medicaid patients as he delivered the high quality of medical care which is the objective of this program. 160 seconds.

Cost savings measures such as those adopted by New York State through a coinsurance program and by other States through barring the medically indigent who are not receiving public welfare grants have the self-defeating purpose not only of denying needed care but of driving large numbers of persons and families into indigency as they struggle to meet unavoidable health care bills.

The advisory committee believes that means test medicine implicit in medicaid and widely varying standards among the States are not conducive to meeting the unmet health needs of the recipients of these public programs. The team approach of physicians and ancillary personnel working together to provide comprehensive health services has been urged by numerous major groups which have studied the problem. This approach is of particular importance to the elderly who require social and environmental services in even larger degree than other sectors of the population. Such care in the judgment of the committee can and should be arranged for under present medicaid programs. More effective controls should be instituted on charges of hospitals, nursing homes and physicians. Vigorous efforts can and should be undertaken for more effective utilization review not only in hospitals and nursing homes but in physicians' offices. Huge savings could be effected through a courageous attack on this problem.

The advisory committee believes each of these recommendations will help improve the medicaid program. At the same time it recognizes that the changes suggested represent palliative treatment of symptoms that the medicaid program should be phased out, and that the basic answer will have to come through a universal health insurance system which will make possible the reorganization of the methods of delivering health services and elimination of a separate, demeaning, inferior system of fragmented health services for those of the poor who fit into the constantly changing categories of State programs.

A final word about nursing homes. This subject requires special attention because the public share of payments is going up and last year 31 percent of all medicaid expenditures in this country were nursing home payments. The costs are going up at an alarming rate. The national average under medicare was $500 a month last year, medicaid in Michigan was in excess of $400 a month for nursing homes last year and the benefits are of inferor quality.

Because of the shortage of beds a number of adverse conditions have resulted. Public programs have been required to adopt lower standards. Private programs like those negotiated by trade unions have had to lower standards to match public programs. The largest group, the elderly, whose care is primarily custodial, have gotten increasingly inferior care at higher costs and we have not had the savings in hospital days that we expected from these programs.

Major questions of public policy arise when in the neighborhood of two-thirds of the nursing home beds in this country are privately owned and operated for profit. Important ethical questions are raised when large numbers of nursing homes are owned and operated by physicians. "The typical investment group establishing a nursing home in metropolitan areas," said Business Week last year, "is made up of nine or 10 doctors."

The advisory committee believes that there needs to be examination of this whole question of continuing substantial private ownership of nursing homes and there needs to be consideration of the public sector developing increasing numbers of nursing home beds on a nonprofit basis related to the mainstream of medical care, part of the health care system, in a way which would bring the maximum benefits to the maximum number of elderly persons.

Thank you, Senator.

Senator MUSKIE. Thank you very much, Mr. Glasser.

Before asking the fourth member of the advisory committee to testify, may I emphasize again to those in the audience who are interested that these four ladies and gentlemen are members of the advisory committee organized to prepare this subcommittee for these hearings. We thought it would be useful before we began public hearings to ask a panel of experts, knowledgeable people, to analyze the problem of health care for the aged today and to suggest remedial measures in our programs. So, what you are hearing this morning from these four distinguished Americans is a summary of the findings that are contained in a printed document which was prepared for this subcommittee.

I would like again, on the basis of statements we have already heard this morning, to compliment the advisory committee on the excellence of its work.

Dr. Axelrod.

STATEMENT OF DR. AXELROD

Dr. AXELROD. Mr. Chairman, it is my task to put into perspective the health care problems of the aged in terms of our current delivery system of medical care.

Let me say first of all there is for all of us a set of problems that we face in the receipt of medical care in which the aged represent an accentuated problem. Let me list these briefly.

First of all, there is a heavy economic burden. I would like to point out that the high and rising costs of medical care are an inevitable accompaniment of our increased technology. We can do very much more for people in terms of preventing premature death and controlling

disability and we must be prepared to pay those costs. Having said that let me add very quickly that simply putting more money into our medical care system as it is currently constituted does not guarantee increased effectiveness nor increased productivity.

A second major problem has to do with shortages—important shortages of all kinds of manpower, health manpower. These shortages are being accentuated again by the increased technological base in the delivery of medical care. It takes more kinds of people with more skills to deliver modern medical care and we are very far from having an adequate supply of physicians and all kinds of health workers. Specialization will continue in an inexorable fashion. The day of the general practitioner who could handle most of the problems of most people is long gone, I am afraid. There are important shortages in facilities for caring for all kinds of people, particularly persons who have need for long-term care.

A third major feature of our modern delivery system is that there are important variations in the quality of care. While the quality of medical care in the United States is generally satisfactory, all of us recognize there are some important deficiencies and we are just beginning to bring some of these to light, particularly outside the hospital.

Fourth, we need to recognize that our system is a nonsystem as the chairman has indicated. Health services are not continuously available to people. It is difficult to get a physician to give care at nights and on weekends. In increasing fashion the emergency rooms of hospitals are being used in place of the family physician and there is some question about the adequacy of the staffing of the emergency rooms in our larger hospitals.

Health services are not available to people in the ghetto. There has been a migration of physicians out of the ghetto. Health services are not readily available to people in rural areas where there are great shortages as has been indicated so many times.

In addition we know there is inappropriate use of personnel and facilities. Highly trained manpower in short supply is being inappropriately used, hospitals with their high costs are being inappropriately used. Along with shortages we have the uncomfortable concomitant of duplication.

Accountability Not Built-In

Finally, I would say that our American medical care system is characterized by the fact that there is no identifiable point of public accountability. To whom can the older patient or indeed any patient go and say, "I don't like what's going on; who is going to do something about it?"

Now having given this general statement about health care problems for all of us, how do health care problems for the aged stack up? There are very special problems indeed as has been well pointed out, but these problems are such that they accentuate the deficiencies of our delivery system.

There is much more long-term illness among elderly people. Long-term illness means an even greater economic burden, it means even

more than need for bringing together different kinds of health personnel and for using different kinds of facilities. In a system that is unplanned and uncoordinated you can see how these basic needs of the aged are not adequately met.

There are fewer long-term beds than we need and it is clear that older people require long-term care in addition to the short-term hospitalization needs which are greater among them than the general population. Other members of the advisory committee have already commented on the need for improvement in nursing homes. Long-term care means that there are multiple health problems, and typically this means multiple fragmented care without any plan for providing care for the elderly person. There is an uneven distribution nationally of physicians and other health workers and particularly of long-term care facilities with the rural States and the rural areas of our country being at a particular disadvantage.

Alternatives to hospital care, the most expensive care for the aged, and for all groups in the population needs to be substituted for by less costly alternatives. Yet we do not have sufficient home health services, we do not have sufficient organized outpatient departments, we do not have combinations of physicians and health workers who can provide care outside of the hospital. In short, we are not going to be able to solve the accentuated and particular health care problems of the aged until we can do something about the better organization of the delivery system for all Americans.

Thank you.

Senator MUSKIE. Senator Prouty, you came in after we opened the hearings. I wonder if you have an opening statement you would like to make.

Senator PROUTY. No, Mr. Chairman, I have not. I might say that I received this report just yesterday afternoon and I have not had a chance to go through it thoroughly. I do wish to congratulate the members of the panel for pulling together so many facts concerning the economic implications of providing health care for older aged Americans. I am sure this report will be of immense help to the committee.

Senator MUSKIE. I ought to identify the fifth member of this distinguished group here, Miss Dorothy McCamman, a consultant to the committee, who has been working with the advisory committee.

I think that rather than dwell on the advisory committee report since we have the complete report to work with, it would be more useful at this point to proceed with the other witnesses on the list.

May I say this, Senator Prouty. I suggested to the advisory committee that when the Senators are through questioning particular witnesses you might give them an opportunity to ask any questions they might like to ask. I think with that background they might be able to touch upon some points that could escape even senatorial detection.

Senator PROUTY. I am sure they could.

Senator MUSKIE. We invited Secretary Finch of the HEW to discuss departmental policy on several of the major issues that are before this subcommittee. He has sent Commissioner John B. Martin of the Administration on Aging to speak for the Department and

to testify. The Commissioner has brought with him several of his people.

I wonder, Commissioner, if you would come forward and introduce your own people and present them.

STATEMENTS OF HON. JOHN B. MARTIN, COMMISSIONER, ADMINISTRATION ON AGING; HON. IDA C. MERRIAM, ASSISTANT COMMISSIONER FOR RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION; MARK NOVITCH, M.D., SPECIAL ASSISTANT FOR PHARMACEUTICAL AFFAIRS, OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS; FRANCIS L. LAND, M.D., COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE; GILBERT R. BARNHART, ASSISTANT DIRECTOR OF PLANNING AND EVALUATION, NATIONAL HEALTH SERVICE; AND PHILIP S. LAWRENCE, M.D., ASSOCIATE DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mr. MARTIN. I have with me today a team of persons from HEW to answer some eight questions which were submitted to Secretary Finch, and each of these people is going to take up one or more of those questions. I am, with your permission, going to make a short preliminary statement just in the nature of an overview to set the background for this other material.

The members of the panel who are with me here today include Dr. Ida C. Merriam, who is the Assistant Commissioner for Research and Statistics of the Social Security Administration; Dr. Mark Novitch, who is the Special Assistant for Pharmaceutical Affairs of the Office of the Assistant Secretary for Health and Scientific Affairs in HEW; Dr. Francis L. Land, Commissioner of the Medical Services Administration of the HEW; Dr. Gilbert R. Barnhart, Assistant Director of Planning and Evaluation of the National Health Service; and Dr. Philip S. Lawrence, who is the Associate Director for the National Center for Health Statistics, Health Services and Mental Health Administration.

Senator MUSKIE. I am going to make a suggestion which often boomerangs on me, Mr. Martin. I notice each of your witnesses has a statement, some longer than others. I have no objection to your reading them in full if you think that would be the best way to present the material in them. If, on the other hand, you find it useful to put the statements in the record and summarize them, that would be agreeable to the committee as well. I sometimes find when I issue that kind of invitation that the summaries are longer than the written statement. Taking that risk, please do it in the way that would best suit the presentation of your material, bearing in mind that we have not had a chance to read these statements and we do not want to overlook any significant points that you have made in them.

Senator PROUTY. Mr. Chairman, before Mr. Martin proceeds I wonder if the members of the committee could have permission to address

questions in writing to any of the witnesses who appear here today and have the questions and answers to them made a part of the record.

Senator MUSKIE. Without objection, of course, that is agreeable.

May I also identify the Commissioner as Special Assistant to the President for the Aging.

Mr. MARTIN. Thank you, Senator.

Senator MUSKIE. We like to note that tie and your two hats.

Mr. MARTIN. I hope in the two capacities I will be able to be a voice for older people.

Senator MUSKIE. It is entirely appropriate that the President should have someone who is an expert on the subject.

Mr. MARTIN. Thank you. Following your suggestion, I have a statement but I will to the best of my ability summarize it as I go along. We will follow the pattern which was set by the advisory committee panel. Do you want us to proceed with our statement and then go to questions at the end of that?

Senator MUSKIE. Yes; that would be well, unless any member of the committee would like to ask a question at some point that would appear to be relevant at that point. I think the general pattern would be better.

STATEMENT OF MR. MARTIN

Mr. MARTIN. Let me say it is a real pleasure for me to be here today to explore the health aspects of the economics of aging. I followed with a great deal of interest the proceedings of the earlier hearing and I think the study, which the committee released at that time, is of great importance in projecting the future of our aging in America. The study which has been released here today should also have a very marked impact in that regard.

I might say that the Administration on Aging considers this committee to be of enormous importance to the problems of the aging in this country. At least in my administration we feel that we are acting in partnership with this committee to delve just as deep as we can into these problems and to come up with completely unbiased answers.

In order to fully appreciate the health aspects of the economics of aging I would mention a few of the factors which bear on it.

First of all, the fact that 40 percent of our older population is poor or near poor.

The economic projections of your earlier study indicate that under existing programs the economic disadvantage of older people to the rest of the population will get worse rather than better.

The education level of our older population is low and this produces some hesitancy to seek medical attention.

In this day of vanishing house calls many older people do not get medical treatment for the simple fact that they do not have adequate transportation or funds to get available transportation.

About four-fifths of those who are over 65 have one or more chronic conditions. Of those over 75 only about one in eight is free from chronic conditions. The most serious situation in this country in this respect is found in our rural areas and in the southern part of the United States where as high as one in three of those 75 and over are unable to carry on their major activity.

Because of their high incidence of chronic illness the aged are subject to all kinds of "sure cure" approaches. Unfortunately many of them are quack approaches. The subject of the hearing in Ann Arbor dealt with some of the consumer frauds in this field.

In 1965 the Congress set forth in the Older Americans Act a declaration of objectives for older Americans, one of which was: "The best possible physical and mental health which science can make available and without regard to economic status." That is certainly still the objective of the administration on aging and the administration generally today.

We have made great progress. In fiscal 1964 the Federal outlay per person aged 65 or over for health and related services was $47.35. In fiscal 1970, we estimate that figure will be increased to $442 per person. In total this represents an increase of the Federal expenditures from both the trust and general funds from roughly $800 million to roughly $8.8 billion in a 6-year period.

So there is no question but that much is being done in this field. We feel sure that the members of the committee as well as members of the panel recognize that we are working on improvements in the system. We are working to do far better than we are doing but not without a recognition of the fact that a great deal has already been done.

The Federal programs that seek to meet these health needs of older people are numerous and I do not want to go into detail on them.

First and most important, of course, are medicare and medicaid. The legislation which the Congress has passed with respect to community mental health centers has been very effective.

The Comprehensive Health Planning and Public Health Service Amendments have provided an incentive to States to move from fragmented services to a system of totally coordinated health services.

The Veterans' Administration, of course, provides many services.

The aging program of the National Institute of Child Health and Human Development which is concerned with maintenance of positive, vigorous functional ability and not the simple absence of disease, supports basic studies on biological and behavioral aspects of aging.

The State vocational rehabilitation agencies are providing health services to many of the elderly with physical impairments, and improving these constantly.

The Administration on Aging has approved several demonstration nutrition programs which provide healthful, hot meals to the elderly.

The Food and Drug Administration is concerned, of course, with wholesome foods, safe and effective drugs, and safe labeling. We are going to hear today from the representatives of the National Center for Health Services Research and Development and the National Center for Health Statistics.

The Hill-Burton program, of course, has been very important in providing grants for construction of various health facilities.

The percentage of the health care bill for the older population met through public programs doubled from about 30 percent in fiscal 1966 to almost 60 percent in fiscal 1967—35 percent from medicare and 25 percent from all other Federal, State, and local programs combined.

If hospital costs of older people which in 1967 totaled more than $4 billion are looked at separately, about 92 percent was paid by public programs.

Yet, despite the progress, we would all agree with President Nixon's statement that "it is an unhappy fact that Americans over 65 get less adequate medical care than younger Americans, even though they are sick more often. And illness is still a major economic burden for older people, as many of you know only too well."

Unique Problems of the Elderly

Some of the problems which older people experience in purchasing quality medical care are these:

The exclusion of out-of-hospital prescription drugs.

The exclusion of long-time nursing home care from medicare creates problems for some older people.

The scope of medicare is not designed to cover comprehensive care at present; thus, certain kinds of care—dental and podiatry services and annual checkups, eyeglasses, hearing aids and so on—have not been included by the Congress in medicare.

Some older Americans have difficulty in paying the amounts required under the deductible and coinsurance provisions of medicare and have few other resources available to help meet these costs.

Medicaid which is designed to complement medicare is State administered and varies greatly among the States in the scope of services authorized, who is eligible for them, and in the availability and accessibility of services to the needy.

Medical care costs have been rising sharply in recent years. The Consumer Price Index of the Bureau of Labor Statistics shows percentage increases of 7.3 for medical care services, 5.7 for physicians' fees, and 13.2 for hospital daily service charges in the calendar year 1968.

The administration is also concerned about another set of problems which plague the older American who needs medical care; the problems produced by the complex and sometimes confusing system by which he purchases and consumes his health services.

Complex drugs purchased in combinations that may be not only ineffective but harmful; brand name drugs sold at widely varying prices despite identical wholesale costs; patent medicines sold because of exaggerated claims of relief from pain and the debility of age; worthless potions and devices designed to exploit the fear of illness and death; loophole-ridden health insurance plans sold to supplement medicare—these are examples of the medical maze our system has produced.

A related problem is the difficulty of security reimbursement for expenditures under medicare. Many doctors, rather than take assignment of bills under medicare, shift the burden of applying for reimbursement to the elderly patients themselves. At a recent national conference on the aging consumer, it was clear from the very vocal reaction of the older people participating that this is a major item of frustration.

Last Thursday, Secretary Finch and Assistant Secretary-Designate Dr. Roger O. Egeberg submitted a report to the President entitled

"A Report on the Health of the Nation's Health Care System" in which they highlighted the problems associated with rising health costs and delivery of health care.

In his statement on July 1, 1969, before the Senate Committee on Finance, Under Secretary of the Department of Health, Education, and Welfare John G. Veneman listed a series of steps which the Department is presently implementing in order to provide stronger administrative and managerial control over its medical programs. He specifically singled out the aged and stated:

We are committed to providing quality medical care to the aged and to other persons who could not otherwise afford it.

I strongly support these steps, which will be enumerated in greater detail later this morning and I would like to submit a copy of Under Secretary Veneman's testimony and the statement of Secretary Finch and Dr. Egeberg since they bear so directly on the subject under discussion today.*

Attached to the letter inviting our representatives of HEW to this hearing was a list of eight questions of concern to the committee. We have used these issues as the framework for our presentation this morning.

(The prepared statement of Mr. Martin follows:)

PREPARED STATEMENT OF JOHN B. MARTIN, COMMISSIONER, ADMINISTRATION ON AGING, SOCIAL AND REHABILITATION SERVICE, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the subcommittee: It is a great pleasure for me to appear before this subcommittee today as it explores the Health Aspects of the Economics of Aging. I followed with great interest the initial hearings held this April by the full Committee on the "Economics of Aging." The findings of these hearings will be of great assistance to us in developing the most effective programs possible to meet the needs of our older population.

To fully appreciate the health aspects of the economics of aging we must keep in mind such factors as the following:

40% of our older population is poor or near poor.

Economic projections indicate that under existing programs the economic disadvantages of older people to the rest of the population will get worse rather than better.

The educational level of today's older population is lower than that of the rest of the population, and they therefore are less aware of the help that is available and more hesitant to seek medical attention.

In this day of the vanishing house call, many older people may not get necessary medical treatment because of a lack of transportation or funds to use available transportation.

Older persons have the highest frequency and intensity of illness in our population. Almost four-fifths of those aged 65 have one or more chronic conditions. These range from those which do not limit activity at all, to those which make it impossible to carry on major activity.

For those who have reached and passed their 75th birthday only 1 in 7 of the men and 1 in 9 of the women who are noninstitutionalized report no chronic conditions whatsoever. Geographically, the more serious situation is found in the nonmetropolitan areas and in the southern part of the United States where as high as 1 in 3 of those 75 and over are unable to carry on their major activities as compared with 1 in 5 in the rest of the country.

Because of their high incidence of chronic illness, it is primarily among the aged that the quack tries to find customers for his "sure cure." The modern "medicine man" realizes that elderly people with their high degree of chronic disabilities can be persuaded to try many remedies since they desperately seek relief from pain or the cure of some ailment.

*See p. 647.

Institutional care represents a major cost factor in health care of the elderly. The per capita rate of use of proprietary nursing homes is highest for persons aged 85 or older, the most rapidly increasing age group in the Nation. About ⅓ of all patients in prolonged care in mental hospitals in the United States are 65 and over.

In 1965 the Congress set forth in the Older Americans Act as one of its Declaration of Objectives for Older Americans: "The best possible physical and mental health which science can make available and without regard to economic status." Progress has been made. In fiscal year 1964, the Federal outlay per person aged 65 or over for health and related services was $47.35. In fiscal year 1970, this figure is expected to increase to $442. In total, this represents an increase of Federal expenditures from both trust funds and general funds from $838,600,000 in fiscal year 1964 to an estimated $8,840,100,000 in fiscal year 1970.

Seventy-three percent of this Federal expenditure will be met from trust funds; the remainder from general funds.

Federal programs seek to meet the health needs of older people in a wide variety of ways. For instance:

Medicare and the Medical Assistance programs have removed major financial barriers to health services.

The Community Mental Health Center Act of 1966 has made possible the construction of many comprehensive community mental health centers.

The Comprehensive Health Planning and Public Health Service Amendments of 1966 and the Partnership for Health Amendments of 1967 provide Federal assistance as an incentive to States to move from fragmented services to a system of totally coordinated health service.

The Veterans Administration provides medical, rehabilitative and hospital care to the aging veteran.

The aging program of the National Institute of Child Health and Human Development which is concerned with maintenance of positive vigorous functional ability and not the simple absence of disease supports basic studies on biological and behavioral aspects of aging.

State vocational rehabilitation agencies are providing health services to many of the elderly with physical impairments.

The Administration on Aging has approved several demonstration nutrition programs which provide healthful, hot meals to the elderly.

The activities of the Food and Drug Administration benefit the health of the elderly by assuring wholesome foods, safe and effective drugs, and safe labeling and by educating the elderly to guard against frauds and cheating.

The National Center for Health Services Research and Development and the Regional Medical Program are supporting activity which hopefully will lead to major improvements in the system through which health services are delivered to older persons.

The Hill-Burton program provides grants for construction of hospitals, public health centers, nursing homes and extended care facilities; for research and demonstrations in hospital operation and design; and for areawide planning of health facilities.

The percentage of the health care bill for the older population met through public programs doubled from about 30% in fiscal 1966 to almost 60% in fiscal 1967—35% from Medicare and 25% from all other Federal, State, and local programs combined. The remainder of the health costs of the elderly were met by profit and non-profit insurance plans, charity, and of course, out of the private incomes of the elderly and their families.

If hospital costs for older people which in 1967 totaled more than $4 billion are looked at separately, about 92% was paid by public programs—about 58% from Medicare and some 34% from all other public programs combined.

Yet, despite the progress, we would all agree with President Nixon's observation during his campaign for the presidency that . . . "it is an unhappy fact that Americans over 65 get less adequate medical care than younger Americans, even though they are sick more often. And illness is still a major economic burden for older people, as many of you know only too well."

Some of the problems older persons experience in purchasing quality medical care are:

Some financially hard-pressed older persons are being helped to meet only part of their medical needs and some are not being helped at all. The exclusion of out-of-hospital prescription drugs under "medicare" is illustrative, as is the exclusion of long-term nursing home care.

The scope of "medicare" is not designed to cover "comprehensive" care at present; thus, certain kinds of care—dental and podiatry services and annual check-ups, for example—have not been included by the Congress in Medicare.

Some older Americans have difficulty in paying the amounts required under the coinsurance provisions of medicare and have few other resources available to help meet these costs.

"Medicaid" which is designed to complement "medicare" is State administered and varies greatly among the States in the scope of services authorized, who is eligible for them, and in the availability and accessibility of services to the needy.

Medical care costs have been rising sharply in recent years. The Consumer Price Index of the Bureau of Labor Statistics shows percentage increases of 7.3 for medical care services, 5.7 for physicians' fees, and 13.2 for hospital daily service charges in the calendar year 1968.

This Administration is also concerned about another set of problems which plague the older American who needs medical care; the problems produced by the complex and sometimes confusing system by which he purchases and consumes his health services.

Complex drugs, purchased in combinations that may be not only ineffective but harmful; brand name drugs, sold at widely varying prices despite identical wholesale cost; patent medicines sold because of exaggerated claims of relief from pain and the debility of age; worthless potions and devices designed to exploit the fear of illness and death; loophole-ridden health insurance plans sold to supplement Medicare—are examples of the medical maze our system has produced.

A related problem is the difficulty of securing reimbursement for expenditures under Medicare. Many doctors, rather than take assignment of bills under Medicare, shift the burden of applying for reimbursement to the elderly patients themselves. At a recent national conference on The Aging Consumer, it was clear from the very vocal reaction of the older people participating that this is a major item of frustration.

Last Thursday, Secretary Finch and Assistant Secretary-Designate Dr. Roger O. Egeberg submitted a report to the President entitled, "A Report on the Health of the Nation's Health Care System" in which they hightlighted the problems associated with rising health costs and delivery of health care.

In his statement on July 1, 1969, before the Senate Committee on Finance, Under Secretary of the Department of Health, Education, and Welfare John G. Veneman listed a series of steps which the Department is presently implementing in order to provide stronger administrative and managerial control over its medical programs. He specifically singled out the aged and stated:

"We are committed to providing quality medical care to the aged and to other persons who could not otherwise afford it."

I strongly support these steps, which will be enumerated in greater detail later this morning and I would like to submit a copy of Under Secretary Venenam's testimony and the statement of Secretary Finch and Dr. Egeberg since they bear so directly on the subject under discussion today.

Attached to the letter inviting our representatives of HEW to this hearing was a list of eight questions of concern to the Committee. We have used these issues as the framework for our presentation this morning. I have brought with me some of my colleagues in the Department of Health, Education, and Welfare whom I would now like to introduce.

Mr. MARTIN. With that, Senator, I would like to introduce the first witness to testify who is Dr. Ida C. Merriam, Assistant Commissioner for Research and Statistics, Social Security Administration, who will seek to respond to the following questions: Departmental policy on the desirability of reducing or eliminating the deductibles and coinsurance in medicare; possible new innovations for medicare benefits, departmental efforts to reduce health care costs of special importance to the elderly and other information directly relevant to the personal economics of the elderly individuals now facing severe problems of health needs and rising medical costs.

Mrs. Merriam.

Senator PROUTY. Mr. Martin made reference to statements issued by HEW recently. I think they should be made a part of the record.

Mr. MARTIN. I was referring to the statement made by Secretary Finch and Under Secretary Veneman, Senator Prouty.

Senator PROUTY. That is what I was referring to.

Mr. MARTIN. I would like those made part of the record.

Senator MUSKIE. They will be made part of the record.

(See appendix 1, item 1, p. 647.)

Senator MUSKIE. Please proceed.

STATEMENT OF MRS. MERRIAM

Mrs. MERRIAM. Mr. Chairman, Senator Prouty, thank you very much for the opportunity to discuss with your subcommittee some of the issues involved in the health needs of the elderly and rising medical costs.

If I may, I would like to submit for the record a longer statement that I intend to deliver orally as well as some supplementary materials.

I would like also to take the four questions that I have been asked to talk about in a somewhat different order and start first with a brief discussion of the health care expenditures for the aged.

We have a number of charts attached to this statement. The recent increase in medical care prices, of course, is beyond dispute. The facts speak for themselves.

Senator MUSKIE. Let me ask this. The inflationary impact upon the cost of health care and medical care really has been greater than any other item in the inflation, has it not?

Mrs. MERRIAM. That is right. In the most recent figures for the 3-year period ending May 1969, all consumer prices rose 13 percent and prices for all medical care services 27 percent. Hospital daily service charges rose 55 percent during that period. Physicians' fees increased 22 percent. There are many reasons for this and I take it that that is not a subject that you want to go into at this particular point.

Senator MUSKIE. I would like to defer it to the questioning.

Mrs. MERRIAM. Thank you.

Your task force has pointed out that aged persons as a group can expect more illness and heavier medical bills. But for them as for younger persons the burden falls unpredictably. Some will have no need for care and some will have a tremendous amount.

The medicare program has brought a new kind of security to older people with the knowledge that if they suffer serious illness a substantial part of their medical costs will be taken care of by the health insurance program. This is not to deny that there are uncovered expenditures but I think it is important to make the point that for the heavy expenditures we have done a good bit through insurance and have largely taken care of the situation.

Data are now available that assess the progress in medicare's second year in meeting its goal of reducing the financial burden on the aged of the high costs of medical care. Most of the figures in the task force report relate to the first year, fiscal 1967. Attached is a forthcoming note which gives in some detail the experience in the second year when

the program was really in full swing. I would like to give you just a few highlights from that.

Personal health care expenditures from all sources amounted to $46.7 billion in the fiscal year 1968. This is personal health care expenditures for the entire population. About one-fourth of this total was spent by or in behalf of the aged who made up only one-tenth of the total population.

AVERAGE MEDICAL BILL FOR ELDERLY, $590 IN 1968

The average medical bill for each person aged 65 or over was $590 in fiscal year 1968; it was $195 for the person under age 65.

In the year before medicare, $7 out of $10 of the aged person's medical bill had to be paid privately. Two years later only $3 out of every $10 came from private funds and $7 from public.

In medicare's second year, benefit payments under the program represented 45 percent of the personal health care expenditures of the aged during the year.

Senator MUSKIE. Do you mind if I interrupt? I cannot resist asking the reason for the statistic which you did not read, and that is the second full paragraph on page 4.

Mrs. MERRIAM. Yes.

Senator MUSKIE. Total personal health care expenditures were about 13 percent greater in the fiscal year 1968 than the amount spent in the previous year. Nevertheless, for the aged these outlays rose 21 percent, though they were only 10 percent higher for those under age 65.

I think the reason for that might well be given at this point in the record.

Mrs. MERRIAM. I am sorry I did not read that, Senator. I was trying to cut out figures.

Senator MUSKIE. I did not intend criticism in my questions but it struck me and I thought I would like to ask the reason for that while it was still in my mind.

Mrs. MERRIAM. First, the reason for the increase is partly the matter of rising cost—inflation; it is partly a matter of increasing population; it is partly a matter of increasing use of services.

We have in the attached material a chart which relates to the aged rather than to the total population in which we estimate how much of the total increase in expenditures from fiscal year 1966 to 1968 is due to the fact that the same service now costs more. How much did the total population increase and how much is increased use of services?

Now the reason that the outlays for the aged rose more than for the rest of the population is primarily due to increased utilization. We do know that as a result of medicare the aged persons have had more hospital care; I think they have had more physicians' care. You can look at chart 1* to see what has been happening there. Of course the number of older people has also increased.

Senator MUSKIE. So those percentage comparisons are not per capita?

Mrs. MERRIAM. No, this is for the aggregate. The medical expenditures for fiscal year 1968 the population as a whole were up 13 percent

*Retained in committee files.

over the previous year; for the aged 21 percent, largely because of increase in utilization. At this point the aging population is no longer increasing much more rapidly than the rest of the population.

Overall, medicare paid for about 45 percent of the personal health care expenditures of the aged.

Medicare paid more than three-fifths of the aged's hospital expenditures, however, and about the same proportion of their physicians' expenditures.

For personal health care services other than hospitals, physicians and nursing homes—in other words, the uncovered services such as dentists, private nurses, therapists, drugs, eyeglasses, and so forth—the individual aged person still bears a large share of the cost burden. Private outlays in fiscal year 1968 constituted 85 percent of the total for these services and supplies. Now in this case 15 percent, a very small amount, comes from medicare and other public programs.

One thing which I think is of some importance. Although medicare and other public programs subsidize much of the high medical costs of aged persons, the amount paid privately by the aged remains higher per capita than for the nonaged—$176 for the aged and for the nonaged—$153. The amount left over after all public benefits, or the amount paid privately is still substantially greater for the elderly.

Now unless there are questions on that I will turn to the deductible and coinsurance payments.

The required payment of deductibles and coinsurance amounts in the face of inflationary movements of medical prices clearly adds to the problems encountered by the low-income aged person in paying his own way.

Research is currently underway in the Social Security Administration that will be of special interest to the committee. Our research plans include a detailed analysis of the effects of the $50 deductible and coinsurance. Since the beginning of the program, July 1, 1966, we have obtained information on utilization and charges for medical services from our current medicare survey, a continuing monthly household survey of a sample of medical insurance enrollees.

Demographic and economic supplements have been added to our basic questionnaire and we can identify the characteristics of persons who never or seldom use services, and consequently do not meet the deductible, as contrasted with persons who have higher rates of utilization. We plan to relate medical care utilization to income, education, possession of health insurance other than medicare, size of household, welfare status, and source of payment for costs not covered by medicare. We hope to have this information before the end of this year.

We do know now that for calendar year 1967 about 14.8 million aged persons used covered services under the medical insurance program, part B. Obviously the deductible for the hospital care (part A) is of less significance than the deductible under part B. I am giving figures for part B only.

Of about 15 million persons, a few had services that were free. Close to 6 million persons did not meet the deductible; 8.6 million persons incurred sufficient charges to meet the $50 deductible. For these persons, average charges were $236, of which $159 was potentially reim-

bursable by medicare and $77 had to be paid by the individual or someone on his behalf to meet the deductible and coinsurance amounts that year.

Senator MUSKIE. The other conclusion that is rather obvious is that 6.2 million persons had charges that were less than $50 and that that is not reimbursed to any extent.

Mrs. MERRIAM. That is right. A few of those had essentially free care. For the close to 6 million who paid for their care, charges averaged $20.

It is obvious that for the elderly with very low incomes, outlays of this size, in addition to the premium payments, now $48 a year, will be difficult to meet. As of June 30, 1968, medicaid was paying the premium for about 1.6 million out of 18.8 million persons enrolled under part B of medicare, as well as the deductible and coinsurance amounts for many of the 1.6 million who used the services. The others had to take care of themselves.

While the Department is concerned about the problems beneficiaries may have, both with respect to understanding the workings of the deductible and coinsurance provisions and with respect to meeting their costs, we believe a good deal of further study of the provision and consideration of alternatives are necessary before a recommendation to reduce or eliminate them could, responsibly, be made.

In its recent report, transmitted to the Congress on June 20, 1969, the Social Security Administration's Health Insurance Benefits Advisory Council explored the present deductible and coinsurance provisions but specifically concluded that no recommendation for change should be made at the present time. They further recommended that the statutory Advisory Council on Social Security, appointed this May, study these provisions further.

This Council, which is required by law to study all aspects of social security, including, of course, medicare, will be thoroughly reviewing the deductible and coinsurance provisions under the program. It would clearly be premature, then, for the department to take a position with regard to the reduction or elimination of these amounts at this time.

Senator MUSKIE. May I ask you at this point whether you have any preliminary estimates on the cost?

Mrs. MERRIAM. Yes, I have. I was just wondering whether I am spending too much time.

Let me read the next paragraph.

By way of background, I might mention that these cost-sharing provisions under medicare were included in order to reduce costs, to help minimize the number of small claims and paper work, and to help discourage the unnecessary use of health services. The main consideration, though, was cost. Elimination of the hospital insurance deductible and coinsurance amounts would cost about 0.15 percent of taxable payroll, while elimination of the cost-sharing provisions of the medical insurance program would more than double the monthly part B premium. It was thought that, with the program paying for the most serious costs of illness, most beneficiaries would be able to budget for the cost-sharing provisions.

The confusion many beneficiaries faced because of these features has diminished markedly since the early months of the program—

there is still enough of a problem in this area, however—and the financial difficulties these cost-sharing amounts may create for some of the aged have been reduced to some extent by State title XIX (medicaid) plans, which provide a method whereby those among the aged who cannot meet these amounts may receive some help. However, there is still a problem in this area that is serious enough to warrant consideration by the Advisory Council.

Medicare Reimbursement Formulas

Referring to medicare's reimbursement formula, with respect to reimbursement for services under medicare, we have eliminated the 2-percent allowance (1½ percent in the case of proprietary institutions) paid above accounted-for costs that has heretofore been part of the formula for reimbursing providers of services. Also, in consultation with the American Hospital Association and other representatives of providers, we are reexamining our entire reimbursement process to assure that, with the elimination of the 2 percent, reimbursement will be fair to all concerned. As part of such reexamination we will be looking into any other possible changes that might derive from the hearings on medicare administration being held by the Senate Finance Committee.

Further innovations in the medicare reimbursement formulas might derive from the authority granted the Secretary of Health, Education, and Welfare under section 402 of the Social Security Amendments of 1967 to develop and engage in experiments with various methods of reimbursement for services under medicare, medicaid, and the maternal and child health programs. Such experiments are designed to provide additional incentives for economy and efficiency in the provision of health services while supporting high-quality services.

The extent of development of the specific proposals for experiments that have been received to date varies considerably. Most need refinement of the measurement and evaluation aspects—especially with respect to establishing reliable measurements of efficiency, economy, and quality. Thus far, five experiments have been conditionally approved. They have been proposed and will be conducted by:

1. Associated Hospital Service of New York (Blue Cross) which is testing per diem target rates.
2. Connecticut Hospital Association which will establish departmental target reimbursement rates.
3. Health Insurance Plan of Greater New York which is experimenting with capitation reimbursement for comprehensive services.
4. Hospital Cost Analysis Service of Maryland which is really doing a predetermination review of costs in Maryland.
5. Blue Cross of southern California which is looking into use of productivity indices.

I might say, Mr. Chairman, one member of your expert group over here serves on the committee which advises us on incentive experiments. Dr. Axelrod knows a great deal about this.

Although several additional proposals are in various stages of development, we believe that more flexibility is generally needed in the authority to engage in incentive reimbursement experiments and re-

lated demonstration projects and we have so recommended to the Congress. Broader legislative authority would permit a wider variety of projects aimed at increasing the efficiency of health care delivery. It would also give greater assurance that we could negotiate for participation in professionally acceptable projects aimed at fostering more effective cost control methods. At present we have to wait for people to come in to us.

Mr. Chairman, your subcommittee has contributed significantly to a fuller understanding of the special problems of the aged. The interests of the Subcommittee on Health in the health aspects of the economics of aging has focused attention on the problem of rising medical costs and their impact on the elderly. We are concerned with these problems and are prepared to assist in any way we can on the issues involved in obtaining for the aged a full share in abundance.

Thank you.

Senator MUSKIE. I might say that your prepared statement and all of your attached materials will be included in the hearing record.

STATEMENT BY IDA C. MERRIAM, ASSISTANT COMMISSIONER FOR RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION

Mr. Chairman, thank you very much for the opportunity to discuss with your Committee some of the issues involved in the health needs of the elderly and rising medical costs.

On April 29 and 30, 1969, Mr. Robert M. Ball, Commissioner of Social Security, and several members of the staff of the Office of Research and Statistics, Social Security Administration, appeared before your Committee to discuss the problems and some of the issues involved in the economics of aging identified in the Committee's Task Force report. The report identified as key factors income security and an equitable sharing by the aged in our increasing national output. The Task Force report pointed out that too many older persons today do not have the income necessary to support an acceptable level of living and that rising prices and medical care costs bear particularly hard on persons no longer able to earn.

Departmental efforts to reduce costs

Rising medical costs are the concern of all segments of the population, not only older persons. This concern culminated last week in the "Report on the Health of the Nation's Health Care System" by Secretary Finch and Assistant Secretary Egeberg that focused on the problem of "crippling inflation in medical costs." That report outlined a series of administrative and legislative actions designed to arrest this inflation and to ultimately reshape the health care system so that the same high quality medical care is available to all at a price they can afford.

In addition to the Departmental efforts to reduce health care costs, your Committee has expressed special interest in other health aspects of the economics of aging, including the personal expenditures by individual elderly persons for medical care not covered by Medicare and Medicaid, the effect of rising prices and medical costs on persons no longer able to work, and suggested changes in financing of Medicare benefits. These are the issues that I would like to briefly discuss today.

The recent accelerated rise in medical care prices is beyond dispute—the facts speak for themselves: In the three-year period ending May 1969 (the latest month for which data are available), the BLS Consumer Price Index registered significantly larger increases for medical care prices than for all other consumer prices. Prices for all medical care services increased 27 percent; hospital daily service charges rose 55 percent; and physicians' fees increased 22 percent. During the same three-year period, all consumer prices rose 13 percent and all consumer services increased 17 percent (see Table 1).

Medicare's role in financing health care expenditures for the aged

The Task Force report of March 1969 pointed out that aged persons as a group can expect more illness and heavier medical expenditures than younger persons.

But for them as for younger persons, the burden falls unevenly and unpredictably. The Medicare program has brought a new kind of security to older people —the knowledge that if they suffer a serious illness, a substantial part of their medical costs will be taken care of by the health insurance program. The fear and burden of paying for very expensive illnesses that has often wiped out lifelong savings now has been largely removed.

The Task Force report cited that the role of Medicare in financing health care expenditures for the aged during its first year. Data are now available that assess the progress in Medicare's second year in meeting its goal of reducing the financial burden on the aged of the high costs of medical care. Attached is a copy of a forthcoming Research and Statistics Note presenting these new data. The following highlights some of the findings:

Personal health care expenditures from all sources amounted to $46.7 billion in the fiscal year 1968. About one-fourth of this total was spent by or in behalf of the aged who made up only one-tenth of the total population.

The average medical bill for each person aged 65 or over was $590 in fiscal year 1968; it was $195 for the person under age 65.

Total personal health care expenditures were about 13 percent greater in the fiscal year 1968 than the amount spent in the previous year. Nevertheless, for the aged these outlays rose 21 percent, though they were only 10 percent higher for those under age 65.

The financial burden on the aged of their high costs of hospital and medical care has been substantially reduced as a direct result of the Medicare program. In the year before Medicare, $7 out $10 of the aged person's medical bill had to be paid privately. Two years later only $3 out of every $10 came from private funds.

In Medicare's second year, benefit payments under the program represented 45 percent of the personal health care expenditures of the aged during the year.

Medicare paid more than three-fifths of the aged's hospital expenditures, about the same proportion of their physician's expenditures, and almost one-fifth of their nursing-home expenditures.

For hospital care, the older person's average bill was $178 a year before Medicare, and $92 had to be met privately. Today, while the total bill has reached $282, the financial burden on the private sector has been reduced to $28.

A comparable reduction in private spending occurred in outlays for physicians' services. Private payments amounted to $65 out of the total physicians' average bill of $70 before Medicare and have now decreased to $25 out of a total of $97.

For personal health services and supplies other than hospitals, physicians' services and nursing home care (i.e., dentists, nurses, therapists, drugs, eyeglasses, appliances, etc.) the individual aged person still bears a large share of the cost burden. Private outlays in fiscal year 1968 constituted 85 percent of the total for these services and supplies. In per capita terms, the average aged person pays $102 per year out of a total of $120 for these services.

Although Medicare and other public programs subsidize much of the high medical costs of aged persons, the amount paid privately by the aged remains higher per capita ($176) than for the nonaged ($153).

Cost of drugs

The above new figures for fiscal year 1968 serve to confirm the conclusions of the Committee's Task Force that even with the help of Medicare, the aged are still burdened with substantial medical expenses. Of special concern are the cost of drugs, payment of deductibles and coinsurance amounts, and alternative financing of Medicare benefits.

The cost of drugs is of special importance to the elderly. A Department task force has studied all aspects of the drug problem, including the cost of drugs and their possible coverage under the Medicare program. Dr. Mark Novitch is here today to discuss the findings and recommendations of the HEW Task Force on Prescription Drugs.

Deductible and co-insurance payments

The required payment of deductibles and co-insurance amounts in the face of inflationary movements of medical prices clearly adds to the problems encountered by the low income aged person in paying his own way. It is in this area that research is currently underway in the Social Security Administration that will

be of special interest to the Special Committee on Aging. Our research plans include analysis of the effects of the $50 deductible and coinsurance. Since July 1, 1966, the effective date of the Medicare program, we have obtained information on utilization of and charges for medical services from our Current Medicare Survey, a continuing monthly household survey of a sample of medical insurance enrollees. Demographic and economic supplements have been added to our basic questionnaire and we can identify the characteristics of persons who never or seldom use services, and consequently do not meet the deductible, as contrasted with persons who have higher rates of utilization. We plan to relate medical care utilization to income, education, possession of health insurance other than Medicare, size of household, welfare status, and source of payment for costs not covered by Medicare.

We know now that for calendar year 1967, about 14.8 million aged persons used covered services under the medical insurance program. Of this total, 8.6 million persons incurred sufficient charges to meet the $50 deductible. For these persons, average charges were $236, of which $159 was potentially reimbursable by Medicare, and $77 had to be paid by the individual or someone on his behalf to meet the deductible and coinsurance amounts that year.

It is obvious that for the elderly with very low incomes, outlays of this size in addition to the premium payments—now $48 a year—will be difficult to meet. As of June 30, 1968, Medicaid was paying the premium for about 1.6 million out of 18.8 million persons enrolled under Part B of Medicare, as well as the deductible and coinsurance amounts for many of the 1.6 million who used the services.

While the Department is concerned about the problems beneficiaries may have, both with respect to understanding the workings of the deductible and coinsurance provisions and with respect to meeting their costs, we believe a good deal of further study of the provision and consideration of alternatives are necessary before a recommendation to reduce or eliminate them could, responsibly, be made.

In its recent report, transmitted to the Congress on June 20, 1969, the Social Security Administration's Health Insurance Benefits Advisory Council explored the present deductible and coinsurance provisions but specifically concluded that no recommendation for change should be made at the present time. They further recommended that the statutory Advisory Council on Social Security, appointed this May, study these provisions further. This Council, which is required by law to study all aspects of social security, including, of course, Medicare, will be thoroughly reviewing the deductible and coinsurance provisions under the program. It would clearly be premature, then, for the Department to take a position with regard to the reduction of elimination of these amounts at this time.

By way of background, I might mention that these cost-sharing provisions under Medicare were included in order to reduce costs, to help minimize the number of small claims and paperwork, and to help discourage the unnecessary use of health services. The main consideration, though, was cost. Elimination of the hospital insurance deductible and coinsurance amounts would cost about 0.15 percent of taxable payroll, while elimination of the cost-sharing provisions of the medical insurance program would more than double the monthly Part B premium. It was thought that, with the program paying for the most serious costs of illness, most beneficiaries would be able to budget for the cost-sharing provisions.

The confusion many beneficiaries faced because of these features has diminished markedly since the early months of the program, and the financial difficulties these cost-sharing amounts may create for some of the aged have been reduced to some extent by State Title XIX (Medicaid) plans, which provide a mehod whereby those among the aged who cannot meet these amounts may receive some help. However, there is still a problem in this area that is serious enough to warrant consideration by the Advisory Council.

Medicare's reimbursement formula

With respect to reimbursement for services under Medicare, we have eliminated the 2-percent allowance (1½ percent in the case of proprietory institutions) paid above accounted-for costs that has heretofore been part of the formula for reimbursing providers of services. Also, in consultation with the American Hospital Association and other representatives of providers, we are reexamining our entire reimbursement process to assure that, with the elimination of the 2 percent, reimbursement will be fair to all concerned. As part of such reexamination we will be looking into any other possible changes that might derive from the hearings on Medicare administration being held by the Senate finance Committee.

Further innovations in the Medicare reimbursement formulas might derive from authority granted the Secretary of Health, Education, and Welfare under section 402 of the Social Security Amendments of 1967 to develop and engage in experiments with various methods of reimbursement for services under Medicare, Medicaid, and the Maternal and Child Health programs. Such experiments are designed to provide additional incentives for economy and efficiency in the provision of health services while supporting high quality services.

The extent of development of the specific proposals for experiments that have been received to date varies considerably. Most need refinement of the measurement and evaluation aspects—especially with respect to establishing reliable measurements of efficiency, economy, and quality. Thus far, five experiments have been conditionally approved. They have been proposed and will be conducted by:

1. Associated Hospital Service of New York (Blue Cross)
2. Connecticut Hospital Association
3. Health Insurance Plan of Greater New York
4. Hospital Cost Analysis Service of Maryland
5. Blue Cross of Southern California

Although several additional proposals are in various stages of development, we believe that more flexibility is generally needed in the authority to engage in incentive reimbursement experiments and related demonstration projects and we have so recommended to the Congress. Broader legislative authority would permit a wider veriety of projects aimed at increasing the efficiency of health care delivery. It would also give greater assurance that we could negotiate for participation in professionally acceptable projects aimed at fostering more effective cost control methods.

Mr. Chairman, your Committee has contributed significantly to a fuller understanding of the special problems of the aged. The interests of the Subcommittee on Health in the health aspects of the economics of aging has focused attention on the problem of rising medical costs and their impact on the elderly. The Department of Health, Education and Welfare is concerned with these problems and we are prepared to assist in further clarifying the issues involved in attaining for the aged a full share in abundance.

TABLE 1.—PERCENTAGE CHANGE FOR THE CONSUMER PRICE INDEX AND SELECTED MEDICAL CARE COMPONENTS, SELECTED PERIODS, 1966–69

Item	3 months ending May—				6 months ending May—			
	1966	1967	1968	1969	1966	1967	1968	1969
CPI, all items	0.9	0.7	1.1	1.8	1.8	0.9	2.1	2.8
CPI, all services	1.5	.9	1.3	2.1	2.1	1.8	2.6	3.9
Medical care, total	1.4	1.6	1.5	2.1	2.4	3.4	3.1	4.3
Medical care services	1.7	2.0	1.8	2.4	2.8	4.2	3.6	4.9
Hospital daily service charges	[1]2.1	4.2	3.7	2.5	[1]4.2	9.7	7.1	6.7
Physicians' fees	[1]1.8	[1]1.5	[1]1.3	2.3	[1]3.5	[1]3.4	[1]2.4	4.3

	12 months ending May—				24 months ending May—			36 months ending May 1969
	1966	1967	1968	1969	1967	1968	1969	
CPI, all items	2.7	2.7	4.1	5.4	5.5	6.8	9.7	12.6
CPI, all services	03.4	4.5	4.7	7.3	8.1	9.5	12.4	17.4
Medical care, total	3.7	7.4	6.1	7.3	11.4	14.0	13.9	22.3
Medical care services	4.4	9.3	7.3	8.5	14.2	17.3	16.5	27.3
Hospital daily service charges	[1]7.5	21.7	13.0	12.6	30.8	37.5	27.3	54.8
Physicians' fees	[1]5.6	[1]7.0	[1]5.6	7.2	[1]13.0	[1]13.4	13.2	[1]21.6

[1] Based on estimated indexes derived from straight-line interpolation.
Source: Consumer Price Index, Bureau of Labor Statistics.

Outlays for Medical Care of Aged and Nonaged Persons, Fiscal Years 1966–68*

The Medicare program was in full swing in its second year of operation—the year ending June 30, 1968. All of its benefits were available for the entire 12 months, more institutions providing care were available, and payment of bills was on a more nearly current basis. This Note assesses the progress of Medicare in its second year toward meeting its goal of lessening for the aged the financial

*By Dorothy P. Rice and Barbara S. Cooper, Division of Health Insurance Studies.

burden of the high costs of medical care. In addition, it looks at the effect of Medicare on the outlays for and financing of health care for those under age 65. Estimates are presented for personal health care expenditures, distributed among two broad age groups—under age 65 and age 65 and over—by source of funds, and by type of expenditure for the fiscal years 1966–68. The following highlights point up some of the findings:

Personal health care expenditures from all sources amounted to $46.7 billion in the fiscal year 1968. About one-fourth of this total was spent by or in behalf of the aged who made up only one-tenth of the total population.

The average medical bill for each person aged 65 or over was $590 in fiscal year 1968; it was $195 for the person under age 65.

Total personal health care expenditures were about 13 percent greater in the fiscal year 1968 than the amount spent in the previous year. Nevertheless, for the aged these outlays rose 21 percent, though they were only 10 percent higher for those under age 65.

The financial burden on the aged of their high costs of hospital and medical care has been substantially reduced as a direct result of the Medicare program. In the year before Medicare, $7 out of $10 of the aged persons medical bill had to be paid privately. Two years later only $3 out of every $10 came from private funds.

In Medicare's second year, benefit payments under the program represented 45 percent of the personal health care expenditures of the aged during the year.

Medicare paid more than three-fifths of the aged's hospital expenditures, about the same proportion of their physicians' expenditures, and almost one-fifth of their nursing-home expenditures.

The implementation of the Medicaid program resulted in significant increases in public spending for persons under age 65—from $5.4 billion in the fiscal year 1966 to $7.6 billion 2 years later.

FINDINGS

The Nation's personal health care bill totaled $46.7 billion in fiscal year 1968 (table 1).[1] Personal health care expenditures incude all expenditures for health and medical care services received by individuals and exclude expenditures for medical-facilities construction, medical research, public health activities not of direct benefit to individuals (disease prevention and control), and some expenses of philanthropic organizations. Personal health care expenditures also exclude the net cost of insurance (the difference between health insurance premiums and benefits paid), as well as administrative expenses of several public programs.

The $46.7 billion spent in the fiscal year 1968 represented an increase of nearly 13 percent over the previous year; there had been a 14-percent increase the year before. Medical care spending for the aged, however, has been rising at an even faster rate—about 20 percent a year, as shown below:

MEDICAL CARE EXPENDITURES

[Fiscal years]

Age	Amount (in millions)			Percentage increase	
	1966	1967	1968	1966–67	1967–68
Total	$36,382	$41,473	$46,690	14.0	12.6
Under age 65	28,488	32,024	35,280	12.4	10.2
Age 65 and over	7,892	9,449	11,410	19.7	20.8

Some of the recent increase in personal health care expenditures of the aged reflected the rise in medical care prices. About $1.2 billion of the $3.5 billion increase from fiscal year 1966 to fiscal year 1968 was the direct result of inflation—that is, rising costs or prices per unit of service. Population growth accounted for $300 million of this 2 year increase. The remaining $2 billion resulted from the growth in the per capita utilization of health services and supplies and the rising level and scope of services (chart 1).

[1] Data for personal health care expenditures in fiscal years 1966–68 shown here are revisions of those published in the December 1968 issue of the *Social Security Bulletin*, page 24, as more current hospital and physician expenditure data have become available.

With expenditures for the aged rising about twice as fast as those of the nonaged, they have become an increasingly greater proportion of the total (table 2). In fiscal year 1966—the year before Medicare began—the share for the aged was almost 22 percent ($7.9 billion); 2 years later it had reached more than 24 percent ($11.4 billion). Much of this growth is attributable to greater utilization of health care services by the aged and the increased outlays since the Medicare program began.

(Subsequent to the hearing, the chairman addressed the following question to the witness:)

What Evidence Do You Have of the Costs and Impacts of the Limitations on Mental Illness Benefits in the Medicare Law as Now Written?

(The following reply was received:)

Inclusion of psychiatric benefits in the Social Security Amendments of 1965 represents a significant precedent in financing the care of the mentally ill. Coverage of hospital and medical care for the mentally ill under Medicare, however, is subject to special limitations that reflect the concern of the Government with the fiscal and policy implications of covering the long-term custodial care commonly associated with the mental hospital. The Social Security Amendments of 1965 also provided additional limitations of psychiatric benefits under Medicaid.

The Senate Finance Committee hearings on the Social Security Amendments reflected the concerns of both public and private groups with respect to the limitations on coverage of care of the mentally ill under Medicare and Medicaid. Following the 1967 hearings, the Senate Finance Committee requested the Secretary of the Department of Health, Education, and Welfare to study the experience under the 1965 Amendments to the Social Security Act and to make recommendations for changes in the current provisions in a report to the Committee by January 1, 1969.

The staff of the Social Security Administration, the Social and Rehabilitation Service and the Health Services and Mental Health Administration currently are engaged in a comprehensive study of the use of covered services by psychiatric patients under Medicare and Medicaid. An interim report was prepared by the Department and submitted to the House Committee on Ways and Means and to the Senate Committee on Finance on December 27, 1968. This report, a copy of which is enclosed, (enclosure 1) * provides considerable background information on the extent of the problem of mental illness in the United States, a brief description of the legislative history of the psychiatric benefits under Federal programs, the extent of participation of hospitals under Medicare and of the States under Medicaid, and a detailed description of the present coverage and limitations of psychiatric benefits under both programs.

Information was not available on the extent of utilization of services for evaluating the effects of the existing psychiatric benefit limitations. The interim report outlined the sources of data to be used and the questions to be answered to evaluate the psychiatric benefit limitations.

The staff of the Department of Health, Education, and Welfare has consulted with a group of specialists in the area of mental health to assist in this very important area of financing the care of the mentally ill under Medicare and Medicaid. Some additional data are now available which will assist in measuring the impacts of the limitations on mental illness benefits under Medicare. Enclosed is a *Health Insurance Statistics Note* entitled "A Study of the Use of General Hospitals by Aged Psychiatric Patients, January 1965–June 1966 and July 1966–December 1967" (enclosure 2).*

This *Note* presents the findings of a special study to determine Medicare's impact on the use of general hospitals by aged psychiatric patients. Although psychiatric patients do not represent a large proportion of the total general hospital population, the data showed that there was some increase in the utilization of short-term general hospitals by the aged for psychiatric care from the 18 months preceding Medicare to 18 months after its enactment. The number of aged psychiatric discharges in the general hospitals in the study increased 29

*Exhibits retained in Committee files.

percent. During that same time span, preliminary data from the National Institute of Mental Health indicate that the number of aged first-admissions to private mental hospitals decreased by 6 percent.

Additional preliminary data are available on short-stay general hospital discharges for the first 6 months of Medicare. Based on a 20 percent sample of Medicare discharges recorded in the Social Security files as of September 1967, these data are reported by diagnosis and indicate the extent of use of short-stay hospitals by psychiatric patients during the first 6 months of Medicare. Enclosed is a copy of these preliminary findings (enclosure 3) * that will be of interest to the Committee.

One measure of the extent of use of psychiatric hospitals by Medicare beneficiaries is the amount reimbursed under the program for this benefit. Data are now available on Medicare claims for psychiatric hospital care for the period July 1966–May 1969 (enclosure 4).* Based on information for calendar year 1967, there were 39,342 claims with 1.7 million days of care or an average of 44 days per claim. Total charges were $20.6 million and of this total, $18.0 million represented the amount reimbursed under Medicare. In terms of total hospital use, psychiatric hospital use represents .7 percent of all claims, 2.4 percent of the covered days of care and .6 percent of the total amount reimbursed.

In order to fully assess the gaps in coverage of mental illness in relation to Medicare as well as Medicaid, the HEW staff has examined the private health insurance coverage of mental illness. These data are summarized in the enclosed report, "Blue Cross and Blue Shield Benefits for Mental Illness" (enclosure 5).* The study showed that in general the Blue Cross and Blue Shield plans provide considerably lesser benefits for mental illness than for general illness and they provide markedly lesser benefits for mental disease in mental hospitals than in general hospitals.

The enclosed materials are currently being evaluated together with additional data that will be forthcoming from the Medicare program to prepare a final report together with recommendations for changes that will be submitted to the Congress by January 1, 1970.

Senator MUSKIE. Senator Kennedy.

Senator KENNEDY. Thank you, Mr. Chairman.

I am wondering if I could ask some broader-gaged questions of you as the spokesman for the social security agency and if you are prepared to respond to them I would certainly welcome any ideas and suggestions you might have and if not perhaps we can pursue it at a later time.

HEALTH INSURANCE FOR ALL?

The recommendations which have been made by the advisory commission in the development of the comprehensive insurance program which would be part of the social security system; could you give us your views on this, whether this is something that we feel would be worthwhile and useful and something which would be certainly consistent with the philosophy of the social security system?

Mrs. MERRIAM. Senator, indeed we have been studying and giving consideration to one major extension of the medicare program, and that is coverage of the disabled. As you know, there was a special advisory group that worked on that.

We are also, of course, studying various approaches to providing comprehensive health care for the population as a whole. One of them is obviously an extension of something like medicare.

We are looking into, also, the possibility of various proposals which have been made for tax credits or other types of subsidy for private insurance. At this point I think we are in the studying stage.

Senator KENNEDY. There have been those that suggested that if this proposal makes sense, and I think there is an awful lot which speaks

*Exhibits retained in Committee files.

for it, that it might be worthwhile in initiating the program for our seniors and perhaps for the blind and for the disabled. This would provide an opportunity to phase into this program and that we might begin certainly with the comprehensive health program with these groups. The second area that has been designed, as I understand, has been suggested for the program starting out for very young children.

Mrs. MERRIAM. Yes.

Senator KENNEDY. Would you give me at least your reaction to these suggestions as well?

Mrs. MERRIAM. We all recognize that it would be desirable to extend the scope of services covered under medicare. We are talking about that for the aged. Now the need for coverage of drugs and eyeglasses and the other things that are mentioned is unquestionable. How rapidly they can be prepared to move, both in terms of the costs and of the administrative problems that are involved, is a question.

Senator KENNEDY. As I gather from your response, you have no basic reservations about the philosphy of the approach that was suggested by these comprehensive health insurance programs which are associated with the social security; therefore, it is really just a question of terms of costs and availability of services.

Mrs. MERRIAM. That is right, yes.

Senator KENNEDY. But you do not have any built-in reservations about extending the social security system as such as the vehicle, as the carrier, to include comprehensive kinds of health programs, insurance programs, in and of itself?

Mrs. MERRIAM. I think that is right. We think that health insurance can be extended to be much more comprehensive than it is now.

Senator KENNEDY. And attached to the social security system?

Mrs. MERRIAM. Right.

Senator KENNEDY. I am heartened by that response. I personally feel, as I am sure that all of us would agree, that the great innovations have been in the social security system where individuals feel that they have a right to these payments they paid in over the periods of their productive and useful lives. If we realize that as well and are committed to the concept that quality health should be available to our seniors and to our citizens in this country and that it should not be just a privilege but is a right as well, it certainly seems to me to be consistent that we should have such inclusion within our social security system.

One of the things that you talked about this morning, and I believe other members of the panel are very much concerned with likewise, is the extraordinary increase in the health services for the people of our country. I think your testimony is most dramatic, particularly in terms of our seniors. If there is any group that is inelastic in terms of income, it is the seniors of our country.

I have been impressed by the fact that the Federal Government has increased its expenditures in the health field from some $4 billion, as I understand, to some $14 billion in the period of the last 3½ to 4 years with the development of medicaid and medicare. Yet we still find that we are a third-rate country, I believe—and I don't think that that is an unfair characterization if we look at the terms of life expectancy of an adult male and for females and infant mortality rates.

So what we have seen is that we have provided significant resources in recent times, but where we have increased the demand for health services we really have not increased the supply. I am very much distressed by that development and I am just wondering what views you have on what we ought to be doing in terms of increasing the supply of health services for our people generally.

Mrs. MERRIAM. Mr. Martin talked about that briefly in his presentation. I wonder if I can throw the question to him. It is something we are very much concerned with but it affects the whole department rather than just the Social Security Administration.

Mr. MARTIN. Senator, I think the problem is presented in the fact that we have made this enormous shift in expenditure in such a short time that we have hardly had time to digest what we have been doing as we went along. Consequently, there are imbalances, there are frictions, there are failures at certain points. I think we have to set that off against the fact that we have been moving at a high rate of speed. That is why this kind of hearing, I think, is particularly productive, because it focuses on the places where we are not doing all we should be doing.

NEED FOR TRAINED PERSONNEL

I think, for example, one of the most serious problems we face is the problem that you raised with me at an earlier time, the problem of training people to do the jobs that have to be done. There is no question but what we are going to have a shortage of nurses and doctors and paramedical personnel and aides and so on for some substantial period of time, because we have made health care available to so many millions more people. We have increased the demand but our training procedures have simply not kept up. I think that is an enormous step.

You ask what we can do. Anything that can be done to step up the level and speed of training in these fields is utterly essential. I do not see how we can meet the needs, no matter what we do in the way of expenditures and no matter what we promise people unless we have adequate personnel to do it with.

Senator KENNEDY. I agree with you, this is a very important aspect of it, and that is why I was distressed that with the very small budget that was even authorized for the training of personnel that that was cut by 30 percent. As I remember, it was reduced—I think it was $3.5 down to $2.8 million for just the training. What I am really trying to get at, as you have outlined it here—and, I think, most dramatically and correctly—the needs of it. As you manifest this concern and as we identify where these needs are, I think we are doing that.

I feel that they have the ability to supply these health services whether it is in trained personnel or in modernizing the whole distribution of health services. I know Dr. Knowles, who is coming on Friday, will have some very interesting ideas on this because he has been extremely imaginative up at the Massachusetts General Hospital in this area. We are distressed by the cutting back.

Let me just in one final question say to Mr. Martin the last time that you were kind enough to appear before an Aging Committee in the Labor and Public Welfare Committee I asked you about the White

House Conference on Aging. I was wondering whether you had anything to report to this committee or to all of those aging and all of our seniors as to what is the status on that question?

Mr. MARTIN. Senator, we have developed our timing schedule. We know in a preliminary way just what we would have to do. We are satisfied that if the announcement comes soon—and we expect that it will—that we will have adequate time to do what we need to do, to hold the necessary preliminary conferences, and so on. I can only say that I am completely satisfied that we will have time to accomplish what needs to be accomplished.

Senator KENNEDY. I think we have had an expression on it in terms of the Congress.

Mr. MARTIN. Yes, that is correct.

Senator KENNEDY. I think the Members of the Congress feel strongly about such a proposal and I am sure the Senators do as well. I would certainly hope now that you have been kind enough to appear—and I know on two occasions that I have had a chance to listen to your testimony and it has always been extremely important and useful and helpful to the members of the committee. But I would certainly hope that the Secretary and the President would establish these times so we would have a definite idea.

I don't really think it is fair to you and I don't think it is fair to the committees to ask you to come up here and permit us to ask this particular question and not be able to get at least some kind of answer. I would certainly hope that when you return to downtown today that you could make inquiries in the form of the chairman of this committee or members of this committee what the latest thinking on this is because I think quite frankly that—I know that you just come aboard and assumed your responsibilities, and they are enormous responsibilities, but on this question here I would certainly hope that we could have some definitive response to it.

Mr. MARTIN. Let me say I am not just expressing hope that we will be in motion on this; I am expressing certainty that we are already in motion, and we will be visibly in motion shortly.

Senator KENNEDY. Thank you very much.

Senator MUSKIE. The committee has a time problem. The Congress will be in session at 12:10 p.m. relating to ABM, and I am sure no Senator would wish to miss that. I wonder if we might end the testimony of your panel at this point with the understanding that we might invite you back so that we can question you. Your statements will be submitted at this point.

(The statements follow:)

PREPARED STATEMENT OF MARK NOVITCH, M.D., SPECIAL ASSISTANT FOR PHARMACEUTICAL AFFAIRS, OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman, I welcome this opportunity to discuss the implications for Departmental policy and action that result from the extensive studies and recommendations of the Task Force on Prescription Drugs. If you wish, Mr. Chairman, I will be glad to make available to the Committee copies of the various reports of the Task Force.

I think it is widely recognized that the Administration places a very high priority on the grave problem of rising health care costs. The President, Secretary Finch, and Dr. Roger O. Egeberg, the Assistant Secretary for Health and Scientific Affairs, have made it very clear that the sharply rising costs of health care demand and will receive the most thorough attention by the Department of Health, Education, and Welfare.

In this context, the evidence developed and reported by the Task Force on Prescription Drugs is of very great significance. The Task Force documented beyond any doubt that the elderly are very severely affected by their unusually heavy expenses for health care, and particularly by their expenditures for needed drugs.

Studies conducted by the Task Force over a two-year period beginning in May of 1967 showed that the elderly are burdened by drug expenditures averaging three times as high as those of the population under 65 years of age, while at the same time the elderly, as a group, are ill-equipped to bear this burden.

The 20 million Americans who are 65 and older make up only about 10 percent of the population, yet they account for 25 percent of prescription drug sales. While 10 percent of the aged spent nothing last year for prescription drugs, 19 percent of them spent $100 or more, and four percent spent $250 or more last year for prescription drugs.

It is of course understandable that the elderly should have a disproportionate need for medicines; they are in an age range of greatly increased illness that requires and can benefit from drug treatment. But when this information on the drug needs and expenses of the elderly is balanced against data on their ability to pay for necessary drugs, a rather disturbing picture emerges.

As the Committee is well aware, nearly half the elderly people in this country are living near or below the poverty level with incomes last year no higher than $1,800 for individuals and $2,600 for couples. Yet these are the same people who purchase nearly three times as many prescriptions per year as the under-65 Americans and who pay more than three times as much for the drugs they buy. The Task Force further found that help in meeting drug costs through tax relief, prepaid insurance, public assistance programs, and other means are simply inadequate.

Findings such as these, together with a considerable amount of information on various approaches toward assisting the elderly in meeting these drug expenses, led the Task Force on Prescription Drugs to recommend that the Medicare Program be extended to include some form of coverage for out-of-hospital prescription drugs. As you know, the drug costs of hospitalized persons are now covered by Medicare, but the program makes no provision for drugs needed by persons outside the hospital.

I will not, in this brief presentation, attempt to detail the various ways in which out-of-hospital prescription drugs might be included as a Medicare benefit. Essentially the Task Force recommended that the elderly be charged a flat fee for any covered drug, and that the Medicare program pay all costs above such a fee.

I should like to point out that this is only one of the major recommendations of the Task Force, the one that is, I think, of greatest concern to this Committee. Other recommendations pertaining to prescription drugs were aimed at questions that are of scientific and economic interest and at providing assurance that prescription drugs are of the highest quality, are obtainable at the most reasonable cost, and are being used with maximum concern both for the patient's health and pocketbook. There is, to say the least, disturbing evidence that these critical requirements are not being met as well as they might be.

But, returning to the subject of the drug needs and expenses of the elderly, the principal Task Force recommendation, indeed all the recommendations of the Task Force, were submitted by Secretary Finch to review by a group of non-government experts headed by Dr. John T. Dunlop of Harvard University.

The Dunlop committee is broadly representative of the medical and pharmacy professions, health economists, insurance groups, large and small drug manufacturers, and consumers, particularly elderly consumers. This committee has been giving careful attention to the recommendations of the Task Force and to the data which have been developed in their support. Although they have not yet submitted their report to the Secretary, it is likely that

their findings will play a significant part in shaping the Department's policy on a wide range of drug-related issues.

Because we are still awaiting the important findings of this committee, the Department has not yet reached its determination about including drug coverage as a Medicare benefit. Nevertheless, there is now substantial agreement among health professionals that some mechanism for assisting the elderly in obtaining vitally needed drugs should be provided to assist this segment of the population in obtaining necessary health care.

I will be pleased to answer any question the Committee may care to ask.

PREPARED STATEMENT OF FRANCIS L. LAND, M.D., COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE

Medicaid is a grant-in-aid program to the States in which the Federal, State, and in some instances local governments, share the cost of medical assistance for needy and medically needy people. Many of the persons who receive services are 65 years of age or older. Some receive old-age assistance payments and others are persons 65 and over who have sufficient resources for basic maintenance but are not able to pay for necessary medical care. Coverage of medically needy persons is optional with the States. Of the estimated 9.5 million persons who received medical assistance in the fiscal year of 1969, over 40 percent are 65 years of age and over. Nearly $2 billion in payments were made to providers of medical care in behalf of aged patients. The Federal share in State expenditures varies in relation to a State's per capita income. The range is from 50 to 83 percent with no maximum on the amount of expenditures which are subject to participation.

A State with a Medical Assistance program in operation must include all persons receiving assistance payments for maintenance. Federal law requires the States to provide at least the following essential services: inpatient hospital care, outpatient hospital services, other laboratory and X-ray services, and for persons over 21, skilled nursing home services. Additional services such as dental care, prescribed drugs, and other types of medical or remedial care are optional with the States. A State may elect to include Medical Assistance on behalf of persons 65 years and over who are patients in institutions for tuberculosis or mental diseases.

Most of the elderly of the nation are entitled to Medicare health insurance that pays part of the cost of care in hospitals, extended care facilities, and for enrolled individuals, most of the cost of physicians and certain other medical services. Medicaid supplements Medicare for the needy by meeting deductibles, paying coinsurance, and paying for supplementary services such as drugs. To enable as many of the needy aged as possible to receive the benefits of Medicare, the States may buy in to Supplementary Medical Insurance Benefit (pay the premiums), pay the required deductibles, and coinsurance for elderly persons eligible for medical assistance.

Expenditures for Medical Assistance financed from Federal, State, and local funds under the public assistance titles of the Social Security Act amounted to $3.5 billion in the fiscal year ended in June 1968. About $3.2 billion of those expenditures, 93 percent of the total were made under title XIX of the Social Security Act as Medicaid. Forty-five percent of that amount or $1.44 billion was in behalf of persons 65 years of age and older. The expenditures were in the form of payments made directly to the providers of medical care either by the State Agency administering the program or a fiscal agent acting on its behalf. The largest amount, 70 percent of the total, was paid for institutional care, 39 percent was paid for inpatient hospital care, and 31 percent for nursing homes services; 11 percent for physicians' services; 6 percent for dental care; and 7 percent for prescribed drugs, with the remaining 6 percent for other services. While the costs have been increasing sharply, hospital costs from some $900 million in fiscal 1967 to $1.36 billion in 1968, and in the same period the costs of nursing home care rose from $766 million to $1.06 billion, and physicians' services from $225 million to $380 million. However, the percentage distribution among the providers shows little change in a three year period. There has been

some increase in the number of aged persons receiving Medical Assistance, but littlec hange in the percentage distribution among the categories of recipients. New York, California and Massachusetts made the greatest expenditures. However, in comparison of expenditures per inhabitant, Massachusetts followed New York but exceeded California.

The Medicaid program thus represents a major resource to our older population with low incomes. It succeeded the Kerr-Mills program and came about the same time that Medicare took on responsibility for hospital expenses, doctor bills and some of the other items of health care needed by the older population. As the figures that I have given you indicate, even in these areas the expenditures for the aged under Medicaid are very substantial. Moreover, it represents the primary resource for those persons needing long-term care in skilled nursing homes and for persons who are unable to pay the cost of drugs and appliances. As my statement indicates, there is wide variation in the extent to which States have developed their programs. As Commissioner Martin stated this morning, the Administration is taking steps to improve and make more efficient and more effective the services that are available to the elderly and other Medicaid recipients.

PREPARED STATEMENT OF GILBERT R. BARNHART, PH. D., THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

The National Center for Health Services Research and Development is giving priority to research directed to improving health care programs for the disadvantaged, and to problems affecting the costs of medical care. The disadvantaged are defined as those persons who because of age, race, ethnicity, income or place of residence are denied access to high quality medical care. It is the Center's position that by strengthening the full range of health services in communities the needs of all the people, including the disadvantaged, will be met by a single, high quality system. For example, older people utilize more hospital days than those who are younger. This is the result not only of higher levels of morbidity among the aged, but also because adequate alternatives to hospitalization, which would be suitable for aged people, are not provided in an organized, readily accessible form.

The creation of a graduated sequence of health services designed to meet the varying needs of the aged with high access and reasonable cost is part of the need to improve the whole health service structure of the community. This calls for extensive research and development of all the major elements of community health services including methods of community wide general planning, provision, and allocation of facilities and finance; methods for casefinding and referral, and alternative methods of organizing and coordinating a full range of medical and medically-supportive health services as provided by hospitals, clinics, office practice, nursing homes and other care institutions.

The National Center is a new agency which, in its own right, has not yet supported large amounts of research in any subject. Some of the projects which were transferred to the Center from earlier programs are concerned with identifying the health needs of the aged, including: alternatives to hospital use (nursing homes, home care); the costs of alternative modes of care; coordination of health and welfare services; rates of utlization associated with various social and economic factors, including insurance benefit structures; overcoming distance by the use of electronic diagnostic devices; and medical education emphasizing chronic disease.

The National Center is now working with investigators, health service providers, and community leaders to initiate research and development in community settings which will incorporate a search for answers to the following questions:

What special health services are best suited to meet the needs of the aged?

How can they best be organized into programs and integrated into the larger health services system?

What will these services cost? How should the cost be borne?

Will special training be required for those who operate them. Special facilities?

What barriers (legal, economic, political, psychological) stand in the way?

An appendix lists the studies of health services for the aged currently supported by the Center.

GRANTS AND CONTRACTS RELATED TO HEALTH SERVICES FOR THE AGED, SUPPORTED BY THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT

1. *Title:* Statewide Program to Improve Care of Nursing Home Patients:
Principal Investigator: E. Crafton, R.N., Arkansas League for Nursing, Little Rock, Arkansas.
2. *Title:* Medical Care of 1,000 Insured Aged: 1965 and 1968:
Principal Investigator: Anne A. Scitovsky, Palto Alto Med Res. Fund, Palo Alto, California.
3. *Title:* Coordinated Social Services for Health Related Social Problems: Home, Hospital, Extended Care Facility and Nursing Home:
Principal Investigator: A. B. Bernard, A.C.S.W., Health Resources Center, Inc., Denver, Colorado.
4. *Title:* A Study of Aged Applicants to a Long Term Care Facility:
Principal Investigator: Sylvia R. Sherwood, Ph.D., Hebrew Rehabilitation Center for Aged, Rosindale, Massachusetts.
5. *Title:* Medical Care of the Very Aged:
Principal Investigator: A. H. Richardson, Ph.D., Brandeis University, Waltham, Massachusetts.
6. *Title:* Active Care Satellite Project:
Principal Investigator: W. E. Park, M.D., City Board of Public Welfare, Minneapolis, Minnesota.
7. *Title:* Changing Community Patterns of Health Services for the Aging:
Principal Investigator: E. A. Friedman, Ph.D., Community Studies, Inc., Kansas City, Missouri.
8. *Title:* Personal Influence and Participation by Older Adults:
Principal Investigator: N. Babchuk, Ph.D., University of Nebraska, Lincoln, Nebraska.
9. *Title:* A Neighborhood Approach to Identifying and Meeting the Health and Related Needs of the Aged:
Principal Investigator: R. H. Manheimer, M.D., New York Chapter, the Arthritis Foundation, Inc., New York, New York.
10 *Title:* Home Aide Service and the Aged: A controlled Study:
Principal Investigator: M. M. Blenkner, D.S.W., Benjamin Rose Institute, Cleveland, Ohio.
11. *Title:* To Demonstration How a Medical Social Work Consultant by Working with a Multi-County Information and Referral Service and its Component County Information and Referral Services will Strengthen Health Services for the Chronically Ill and Aging:
Principal Investigator: F. R. Brown, M.D., Oklahoma State Department of Health, Oklahoma City, Oklahoma.
12. *Title:* Nursing Home Law Research Study:
Principal Investigator: E. W. Springer, L.L.B., University of Pittsburgh, Pittsburgh, Pennsylvania.
13. *Title:* Analysis of Nursing Home Benefits of Medicare on the Nursing Homes of Wisconsin:
Principal Investigator: E. J. Connors, M.H.A., University of Wisconsin, Madison, Wisconsin.
14. *Title:* The Effect of Reimbursement Mechanism on the Levels of Nursing Home Care in Massachusetts:
Principal Investigator: Dr. Samuel Levey, Bernard Baruch College, City University of New York, New York, New York.
15. *Title:* Nursing Home Simulation Model.
Principal Investigator: Mr. Ronald Stoerts, Consolidated Analysis Centers, Inc., Arlington, Virginia.
16. *Title:* Study and Analysis of Utilization and Cost Data Concerning the Provision of Home Health Service and Extended Care Service.
Principal Investigator: Dr. Edward J. Berger, St. Louis Labor Health Institute, St. Louis, Missouri.
17. *Title:* Demonstration of the Development of a Comprehensive Adult Health Program.
Principal Investigator: R. C. Jung, M.D., New Orleans Health Department, New Orleans, Louisiana.

PREPARED STATEMENT OF PHILIP S. LAWRENCE, Sc. D., ASSOCIATE DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS

The topic upon which I have been asked to report concerns statistics which are relevant to the health of the elderly, and additional types of statistical research which may be needed in this area.

The programs of the National Center for Health Statistics are designed to provide health data on the population of the United States, and therefore all references to these programs, specific reports, or types of data, relate to the national population rather than to studies in limited geographic areas or demographic groups. With few exceptions the studies include also the full age range of the population, but classified by age, so that for any health topic the elderly may be compared with persons of younger ages.

The National Center for Health Statistics is an agency which collects, analyzes, and disseminates descriptive health data for the use of all segments of the health and related professions. It has no program of its own to espouse, other than the improvement and extension of systems to provide reliable statistical information. At the present time we have four major statistical programs, each of which provide data relative to health of the elderly.

1. *Health Interview Statistics*, which obtains information from 42,000 households annually on the social and demographic aspects of illness, disease, disability, use of medical care, and related subjects.

2. *Health Examination Statistics*, which obtains data from examinations of samples of the population concerning certain diseases and defects and to establish physical and physiological norms.

3. *Health Resources Statistics*, to provide information on various types of resident institutions, such as hospitals, nursing homes, and personal care homes, and on the health and other characteristics of people who live in these places.

4. *The Vital Statistics System*, which furnishes data on age, place, and cause of death for all deaths in the United States, and from samples of these deaths, certain data on the use of medical care during the last year of life.

It is not possible, within the limits of this presentation, to provide detailed information on the findings of the above programs, nor even on all of the demographic aspects and interrelationships that are available in the statistical reports. This information is, of course, available to the Committee and its staff in the form of published results or unpublished statistical tabulations. The material which follows is a general description of first, the types of information which are currently available on health characteristics of the elderly, and second, information which is at present being collected or processed and which will become available at intervals during the coming year.

I. TYPES OF DATA CURRENTLY AVAILABLE

A. From health interview statistics

1. Selected physical impairments, including vision, hearing, speech, paralysis, missing extremities and disorder of the limbs and back in relation to sex, race, income and degree of disability.

2. Degrees of disability caused by chronic diseases of various kinds, in relation to sex, income, type of family or living arrangements, and farm or non-farm location.

3. Limitations of activity and of mobility by employment status, and type of industry and occupation, in relation to income, race, education, and geographic region.

4. Days of bed disability and work loss due to illness in relation to income, race, and other characteristics.

5. Volume, frequency, and cost of physician visits in relation to sex. race, income, education, marital status, and geographical area.

6. Number of episodes and days of hospitalization in a year by family living arrangements, marital status, income, race, and farm or non-farm residence.

7. Extent of hospital and surgical insurance coverage in 1963 in relation to family composition, and other demographic characteristics.

8. Hospital and surgical insurance coverage in July through December 1967, including medicare.

9. Use, cost, and general type of prescribed and non-prescribed medicines by sex, color, income and education.

10. Individual and family health expenses, by type of expense, in year 1962.
11. Summary of age patterns of illness, disability, and use of medical care, including hospitalization, physician visits, and use of specialist services.

B. From Health Examination Statistics

1. Prevalence of definite and suspected heart disease, hypertension, arthritis, and diabetes.
2. Levels of loss of vision and hearing.
3. Extent of dental defects, dental disease, and measures of oral hygiene.
4. Findings from blood tests, including serology, hematocrit levels, and cholesteral levels.

C. From Health Resources Statistics

1. Utilization of short-stay hospitals, by number of discharges, days of care, and average stay by sex, race, marital status, and geographic region.
2. Number and types of institutions for the aged and chronically ill by ownership, type of service, bed size, and availability of nursing care, 1963.
3. Characteristics of residents in institutions for the aged and chronically ill, including chronic diseases, impairments, mobility, and recency of medical care by duration of stay, sex, race, and other factors, 1964.
4. Kinds and levels of nursing and personal care services received by residents of institutions.
5. Marital status and living arrangements prior to admission into nursing and personal care homes in relation to diseases of the patients.
6. Use of wheelchairs, walkers, braces, hearing aids, and other special devices by residents of homes for the aged and chronically ill by length of stay and mobility restrictions.
7. Charges for care in homes for the aged and chronically ill by characteristics of the home and source of payment, 1964.

D. From Vital Statistics System

1. Detailed data on causes of death by age, sex, race, and place of residence.
2. Hospitalization in the last year of life by type of hospital, number of episodes, duration of stay in relation to sex, race, education, income, and family living arrangements.
3. Insurance coverage for hospitalization and surgery in last year of life, 1964–65.

II. TYPE OF DATA IN PROCESS

Many of the types of data outlined above are currently being updated and will therefore reflect changes which have taken place as a result of medicare or other health and social programs. The items listed below are additional types of data in process.

1. Persons above age 55 who are receiving care at home. This includes information on types of care, duration, who provides it, cost, and source of payment.
2. Public assistance status for persons of less than $5,000 family income. This information can be related to health topics obtained on the basic interview.
3. Use of special aids (wheelchairs, braces, etc.) and mobility limitations of the non-institutional population.
4. Duration of convalescence following hospitalization.
5. Cost of hospitalization in the last year of life.
6. Needs for dental care.
7. Admission policies of homes for the aged and chronically ill with respect to exclusion because of age, limitations of mobility or self care, or specific types of disease or impairment.
8. Availability of physician and nursing services in homes for the aged and chronically ill.
9. Number and kinds of professional and semi-professional employees in long-term care facilities and their education and working experience.
10. Type of facility from which patients are admitted to long-term institutions.
11. Number of institutional patients receiving public assistance, medical payment assistance, or medicare, and whether medicare rights have been exhausted.

There are many gaps in our knowledge of health care of the population. Most of these gaps apply to the entire age spectrum but are particularly relevant to health care for the elderly. Some of the data required to fill gaps could be obtained by extensions of the existing statistical programs described early in this presenta-

tion. Others would require the development of new statistical programs, or further research in methods of collecting reliable information of the type needed. I shall not attempt here to enumerate the requirements for obtaining these types of data but shall only list the general areas in which further data or research are necessary.

1. Development of a statistical system to obtain information on ambulatory care; that is, on the characteristics of patients seen in physicians' offices, conditions treated, advice or treatment given, referrals, and sources of payment.

2. Development of a system to obtain data on the number and types of outpatient facilities and on the numbers, characterisics, and health problems of patients served.

3. Obtaining of information on the disposition of hospital in-patients; duration of stay, place to which discharged, and post-hospital arrangements for care.

4. Information on services and patients served by home health agencies.

5. Research and development of methods to obtain data on a variety of subjects related to the seeking of health care: Sources of information which people use; attitudes and constraints to seeking care; distance from and length of time required to receive care at various places of medical treatment.

6. Information on the application of standards for quality of care at in-patient facilities.

7. Out of pocket expenses and sources of payment for costs not covered by medicare.

8. Extent of health insurance coverage of family members not covered by medicare, particularly in low income families.

9. Expansion of existing statistical systems and samples to obtain increased detail on people of older ages and more fine-grained geographic coverage.

There are undoubtedly many other areas in which information is needed for planning of improvements in our health care system. The above needs have been selected from among numerous requests which come to us from all segments of the health professions, since these seem to be most relevant to the concerns of this committee.

I shall be pleased to answer any questions the committee may have, or to supply any additional information in writing.

Senator MUSKIE. I ask that in order that the next group might at least have 10 or 15 minutes.

Senator SAXBE. I have a question that I don't want you to answer today but I would like to have the information. The subject appears in Dr. Merriam's testimony on page 9. What effect does the elimination of the 2-percent allowance have on the developing of the convalescent and nursing homes? I ask this because of the resulting confusion that has almost, as I understand, put these operators who had gone into this investment with the belief that the 2-percent allowance was written. Now they are being pushed back and forth between the Federal standards and State standards and then face the loss of the allowance to the point where they are not successful financial ventures. Is this going to stop this development?

Mrs. MERRIAM. May we submit something for the record on that, Senator. We would be glad to.

Senator MUSKIE. Thank you very much for your understanding.

Mr. MARTIN. We appreciate the problem.

(The reply follows:)

The question seems to suggest that as a result of the elimination of the allowance to providers—2 percent to nonprofit and 1½ percent to proprietary institutions—for unidentified costs there will be insufficient economic incentives to encourage the development of the additional extended care facilities that over time will be needed to meet the demand for such care. It is true that elimination of these allowances will result in institutions generally receiving less revenue then they would if the allowances were not eliminated. However, the eimination of these allowances in no way changes the philosophy of the Medicare pro-

gram with respect to reimbursing participating medical facilities for the full reasonable cost of services provided to beneficiaries. The allowances in question were originally included as part of allowable costs primarly because of the hospitals' and other medical facilities' general lack of experience in identifying reimbursable costs when the program started. We believe that these institutions now have the necessary knowledge and expertise to properly identify all true cost items that are reimbursable under Medicare.

Of major significance in connection with the development of additional extended care facilities is the fact that proprietary facilities are paid a return on equity capital invested and used in the provision of patient care. The amount allowable is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rate of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund. The rate of such return is currently 9 percent. We believe that this rate of return on investment, coupled with full reimbursement of reasonable costs, provides sufficient incentives to assure the continued development of extended care facilities.

The Administration has undertaken a thorough re-examination of the entire Medicare reimbursement formula, with a view to determining what changes, if any, should be made. Meetings have been held with the American Hospital Association, the American Nursing Home Associataion, and other interested parties to insure that Medicare's reimbursement policies are as rational and as fair to providers of services and taxpayers as is possible within the context of present law.

Senator MUSKIE. May I then invite the next group headed by Nelson H. Cruikshank, president of the National Council of Senior Citizens.

Mr. Cruikshank, I will ask you to present the members of the panel.

May I suggest that I will give you the 20 minutes remaining. If that is not adequate, we will arrange another time for you. I wanted you to be sure to have some time this morning.

STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS; ACCOMPANIED BY MRS. MITTIE ROMERO, MIAMI, FLA.; MRS. EVELYN B. CROOK, WASHINGTON, D.C.; MRS. RUTH TUCKER, PITTSBURGH, PA.; AND MRS. FRANCES STANISLAWSKI, BUFFALO, N.Y.

Mr. CRUIKSHANK. Thank you, Mr. Chairman. I appreciate the accommodation of your very difficult schedule to our needs.

Senator MUSKIE. Well, when the hearing was originally set up we had anticipated to go into the afternoon. We did not realize we had this problem on the Senate floor.

Mr. CRUIKSHANK. That is a very important issue and we are glad that the Senators intend to be present for the debate on that.

Mr. Chairman and members of the subcommittee, I am Nelson Cruikshank, the recently elected president of the National Council of Senior Citizens. I am very happy to appear here on behalf of my organization to present our views on the very important subject that you have under consideration and to hear the comments and recommendations made by your distinguished advisory group.

I would like, if I might, to introduce the people who are with me. On my far left is Mrs. Mittie Romero of Miami, Fla. Mrs. Evelyn B. Crook of Washington, D.C., on my left. Mrs. Ruth Tucker of Pittsburgh, Pa., on my right. Mrs. Frances Stanislawski of Buffalo, N.Y., on my far right.

All these women are senior AIDES.

These people work in the program. In order to be eligible for the program they have to make less than $1,600 a year outside of the small amounts that can be made available to them. These folks are working in the health care program.

Now, Mr. Chairman, in view of the restrictions on time I am wondering if I might have your permission to file my statement together with the copies of the three resolutions from our recently concluded convention and make that a part of the record.

Senator MUSKIE. By all means.

Mr. CRUIKSHANK. Thank you, sir.

(The statement and resolutions follow; testimony resumes on p. 538.)

PREPARED STATEMENT OF NELSON H. CRUIKSHANK

Mr. Chairman and members of the Subcommittee, it is a very special honor and privilege to appear today before this distinguished body, the Subcommittee on Health of the Elderly of the Special Committee on Aging, to make my first appearance on Capital Hill as President of the National Council of Senior Citizens.

I was elected President of the National Council on June 7, 1969, at the Eighth Annual Convention here in Washington, D.C. This national affiliation of over 2,500 older people's groups has a combined membership of over 2,500,000. It is non-profit and non-partisan, but does not hesitate to employ all the strength its constituents can muster in support of every effort aimed at building a better America and winning a better life for all older Americans.

I am sure that you, Mr. Chairman, and your colleagues, know of the role played by the National Council of Senior Citizens in the long nationwide campaign to highlight the desperate need for health care for the aged under social security. Our senior citizens are not just narrowly interested in themselves—though this nation's long neglect of their problems would give them justification for making their personal needs a priority. They seek no privileged position over the young or middle-aged in terms of our national priorities. They seek merely a fair share of the prosperity they helped to create, to enable them to live out their lives with dignity and with something approaching adequate health care. Only then can they enjoy meaningful retirement.

Until my retirement in 1965—shortly after the enactment of Medicare—I was director of the Social Security Department of the AFL-CIO, and during the years we struggled for the enactment of the Medicare program, I made many appearances before committees of both houses of Congress discussing the very same subject we are scheduled to discuss today—"Health Aspects of the Economics of Aging." I am happy that in my testimony today I can report that Medicare has been operational for three years, and is rendering a major service to the nation's aged. Yet, the aged still have many health care needs.

Though retired from active participation in these matters on behalf of the AFL-CIO, I have served continuously since the fall of 1965 as a member of the statutory Health Insurance Benefits Advisory Council established under the Social Security Amendments of 1965, and charged with advising the Secretary of Health, Education, and Welfare on matters of general policy in the formulation of the regulations and administration of the Medicare program; the 1967 Amendments added to HIBAC the responsibilities of a Medical Review Committee and recommending improvements in the program either through changes in program administration or in legislation.

Consequently, I have been able to keep in close touch with the Medicare program's effects on the economics of aging with regard to general governmental policies, regulations, and administrative procedures.

Since the fall of 1965, as a member of the National Council of Senior Citizens' Advisory Council, I have been in frequent consultation with individual members and club leaders of the National Council of Senior Citizens—representing users of Medicare and Medicaid.

My comments today will reflect the views of these elderly citizens on health care problems and will also reflect the considered opinions of the 1500 official delegates from all parts of the U.S. who attended our Convention last month.

With your permission I would like to submit for the record copies of resolutions on Medicare, Medicaid, Nursing Home Standards and National Health Insurance which were unanimously enacted by our convention delegates.

At the conclusion of this testimony, Mr. Chairman, you will also hear briefly some of the experiences of four Senior AIDES who are working in "outreach" programs operated by the National Council of Senior Citizens as part of a Senior Citizens Community Service demonstration program financed by the U.S. Department of Labor.

This demonstration program began in June last year utilizing 40 senior AIDES (aged 55 years and over) in part-time community service jobs in ten U.S. cities. Because of its instant success our demonstration program has been expanded and extended until March, 1970 to cover 19 communities and employing 1142 Senior AIDES.

These low-income elderly people work for an average of $2 an hour for 20 hours a week. The small amount of money they earn helps them make ends meet. But every Senior AIDE will also tell you that this part-time job is worth twice as much to them in the therapy of feeling they are doing a useful job helping their fellowmen in their local communities.

Only 400 of our Senior AIDES work on health care and related problems. After you've heard them I'm sure you'll agree with me that the delivery of health services to the nation's elderly would be vastly improved if we had 40,000 Senior AIDES engaged in this work.

The excellent working paper which has been prepared by the Task Force appointed by this subcommittee makes abundantly clear the fact that, although older Americans—because of Medicare—have protection against the most crippling of health care costs, they are still confronted with serious health problems. The truth is that, despite the value of Medicare in freeing older people from the heaviest costs of illness, the actual cost of comprehensive health services is still a heavy burden for most older Americans and an intolerable one for the elderly poor.

This was emphasized by Secretary Robert H. Finch of the Department of Health, Education and Welfare at last week's White House press conference. He warned that a breakdown in the delivery of health services is imminent unless action is taken to prevent it.

He did not refer directly to the chaotic, disjointed, inadequate fee-for-service medical care system but his colorful description of it as a cottage industry leaves no doubt that it prompted his warning.

The fee-for-service system is steadily restricting the delivery of health services.

Secretary Finch summed it up in a paper read on his behalf by Dr. Roger Egeberg, Assistant Secretary of HEW for Health and Scientific Affairs, before the 22nd World Health Assembly at Boston July 8.

The Cabinet Officer pointed out: "The continuing upsurge in medical costs can be explained in part by the classical economic equation. While the demand for health services has risen sharply—through private insurance, through Medicaid, plus an apparent public insistence that abundant health services be regarded as fundamental rights—the supply has simply not kept pace."

Mr. Finch continued: ". . . We have to bring the supply of (health) services—the right kinds of services at the right time and place and at the right cost—in line with demand."

I applaud the Secretary's decision to ask for legislation to withhold Federal funds available under the Hill-Burton Act from medical facilities not approved by a regional or local health care planning group, his efforts to raise the number of doctors and other trained medical personnel, and his moves to place reasonable controls on medical charges and fees paid with Federal funds. I welcome the suggestion of Dr. Egeberg that medical school graduates be required to spend a year in areas now lacking medical services in lieu of military service.

These are realistic ideas reflecting the trend away from the present harsh, restrictive fee-for-service aspect of medicine.

Members of the National Council of Senior Citizens want health care suppliers to be fairly rewarded financially. What they object to is the denial of modern health care to those who cannot afford it. This is the curse of the prevailing fee-for-service medical care system.

Delegates to the National Council of Senior Citizens' annual convention last month went on record unanimously for a program of national health insurance guaranteeing the best possible health care on equal terms for all Americans.

Realization of this goal still appears to be a long way off but the obvious inadequacy of the horse and buggy system is bringing it nearer.

Because adequate health care is so essential—it should be recognized as a basic human right as education has been for over a hundred years—the idea of limiting it to those who can afford it is no longer acceptable to a nation which this very day has a man on the way to the moon.

It is this realization that won Medicare, the program of health insurance for the elderly under Social Security. Medicare represents a tremendous step forward. It has made modern health care available to millions of elderly but, unhappily, millions of elderly who are without the cash required for Medicare's deductible and co-insurance provisions are still denied modern health care.

The National Council of Senior Citizens—which frankly admits the difficulty of collecting adequate raw data from the "invisible" poor—is convinced that the deductible and co-insurance requirements of the Medicare program have proven most frequently to be cruel barriers between the elderly poor and health services which they need. As you know, at present they are required to pay $44 for each spell of hospitalized illness. The annual $50 deductible and 20 percent co-insurance for doctor bills is particularly cumbersome and burdensome.

The rising cost of health services—which has already resulted in a 33% increase in the monthly premiums paid by the elderly for the Medicare Part B Supplemental Health Insurance, from $3 to $4, is also causing much concern because of threats of further increases.

Medicare did not create the problems which resulted in the high cost of health care now prevalent, but the fact is, that if runaway costs and fees are allowed to undermine the Medicare and Medicaid programs, it won't be just the elderly who will suffer. Medicare and Medicaid can be just as effectively "repealed" by runaway costs as by legislative action. We believe that if these programs are to be repealed the United States Congress, not the doctors, should make the decision.

We must think of the best ways we can to provide maximum economy in our programs through eliminating waste, overutilization and overcharging. But we cannot permit operating economies to contribute to a kind of second class medical care to any group of citizens. We believe the American people will not object even to increases in total dollar outlay if they know they are getting their money's worth in medical care and that neither participating physicians, nor other providers, are taking advantage of the program to enrich themselves.

There have been times when efforts to hold down costs have resulted in poorer quality of care. At other times laxity in budget controls has resulted in extravagance and waste. There have even been some instances where misguided government action has resulted in both higher costs and lower quality. The new interim regulations recently published in the Federal Register which provide for the lowering of nursing standards in skilled nursing homes caring for Medicaid patients will present a striking case in point if permitted to become operative.

These new regulations, effective July 1, 1969, to July 1, 1970, would allow practical nurses licensed "by waiver" to assume charge nurse responsibilities in skilled nursing homes which receive Medicaid payments.

Current Medicare and Medicaid regulations both require that skilled nursing homes employ at least one registered nurse to oversee patient care on one shift each day. When this nurse is not on duty, a licensed practical nurse who is a graduate of a State-approved school may assume charge nurse responsibilities. Only the Medicaid regulations regarding this provision are being revised; the Medicare regulations remain the same.

Now I am sure it was not the intent of Congress—when it passed the Medicare and Medicaid provisions of 1965—to provide one standard of care for those covered by Medicare and another, lower, standard of care for those covered by Medicaid, who are primarily citizens with severely limited incomes.

Health care is a right and not a privilege. When federal funds are involved we must have equal standards of care for *all* health programs provided by public funds. In particular, federal funds should not be used to perpetuate substandard nursing care.

At present there are thousands of practical nurses who are licensed in their states "by waiver," which means that they have not necessarily fulfilled the educational and training requirements for their jobs. We agree with Miss Dorothy Cornelius, President of the American Nurses Association, who said, "Although many conscientious LPN's licensed by waiver may be employed in nursing homes,

the quality of nursing care for the public simply cannot be assured when those who may have had no formal educational preparation or testing of their acquired knowledge are placed in charge nurse positions which require a high level of nursing judgment and knowledge."

In addition to this lower quality of nursing care for the poor, the new regulations will almost certainly make the cost of the Medicaid program skyrocket, since they will permit nursing homes previously denied Medicaid funds because they did not meet the nursing regulations, now to apply for and receive such payments. Americans are therefore being asked to finance for quality care at higher and higher costs.

In effect, many Medicaid patients who require "skilled nursing care" will actually receive custodial care. However, nursing homes will be reimbursed by the government for "skilled nursing care" at higher rates than rates alloted "custodial care" facilities.

This matter of the quality of nursing supervision highlighted by the Secretary's proposed regulations is only one aspect of the tragic situation with respect to nursing home care in this country. I have just returned from cross-country speaking tour, and everywhere I go and talk to members of our senior citizens clubs I hear complaints about high charges for services, and neglect. The dread of the possibility of ending their days in one of these predatory institutions haunts the minds of millions of elderly. Recalling that nine out of ten nursing homes are privately owned and operated for profit—an increasing number of them, incidentally, by doctors—raises the whole question as to whether this is an appropriate area for private investment.

Here are some of the complaints about quality of care that have come in to our office:

"They tie my 75-year-old mother to a chair beside her bed and leave her alone for hours at a time—it's criminal," a New York City member recently wrote, protesting the neglect of patients at a Manhattan nursing home.

A Miami, Fla., member writes: "My poor, dear father—he's 69—is told to get back in his bed and lay down whenever he decides to walk around the nursing home where he is a patient."

A Philadelphia, Pa., member writes: "My mother is awakened at all hours by demented people, some going around naked, at the home she's in—and it's supposed to be a good nursing home."

A Kansas City, Mo. member writes: "My sister-in-law, who is 81, simply can't get any one to attend her when she calls for assistance because, apparently, they haven't got enough help (at the nursing home where she stays.)"

From Los Angeles, a member writes: "My aunt, who is 90 and recovering from a broken hip, is in a room with a window that looks out on the back of a tire shop with discarded auto tires piled so high she can hardly see the sun or sky. She's supposed to get physical thereapy but can't even get any one to give her a back rub."

"The welfare pays to keep my father, who is senile, in a nursing home. They got him in a place where the beds are so close together you can hardly get in there to see him," writes a Chicago, Ill. member.

These are a small sampling of the letters received—I have spared you some of the revolting details in complaints received from National Council members about nursing homes.

Let me return again, briefly, to the matter of medical costs and the proposals for preventing further inflation in this important area of the economics of aging.

TheNational Council of Senior Citizens applauds the administrative decisions of February 25, 1969, to put what has been described as a fee "freeze" on Medicare physicians' reasonable charges and of July 1, 1969, to put similar controls on the mounting fees physicians are collecting from Medicaid—both controls to last until July 1, 1970. However, we might question whether these limited period controls will be enough to stem the tide of rising medical costs which threatens these programs.

Actually, the Administration's directive which went out to Medicare carriers, ordering a clamp-down on physicians' fees, cannot constitute a "freeze" on what the doctors charge, though it will affect what Medicare will reimburse the physician.

Medicare regulations offer participating physicians the option of accepting Medicare assignments—in which their bills are paid directly to the physicians

by the carriers—or doctors may insist on direct billing of the patient. Up till the time the directives were issued concerning fees, it is estimated that about 60% of all participating physicians accepted Medicare assignments. The percentage varied across the country. For example, one Medicare carrier for 32 counties in New York State reports 75% of the physicians covered accept assignments. At the other extreme, only 25% of the physicians in Ohio take assignments.

There are now very genuine fears that the government's directives may cause more and more doctors to turn to direct billing. This simply means that the government will be paying for less and there will be a heavier burden for health care on the backs of the older people.

I wish we could get the government and the health care providers started on control of costs based on the principle of negotiation. By this I do not mean simply negotiated fee schedules. Fees are only a part of the problem, though an important part. Utilization, quality, comprehensiveness, and the groups to be covered by the program are just as much components of the whole package of problems to be dealt with as our physicians' fees.

In the area of Medicaid, for example, I think it would be entirely possible to direct the states to bring together key officials, key legislators in the appropriations process, representatives of the public, representatives of the provider professions and the recipients themselves. This group should then anticipate, on the basis of available facts, what the cost of the medical program for the population involved would be.

If, in terms of the resources of the State and the matching sources available from the Federal government, they find it is not practical to assume the full load, then this group should face up to the problem of establishing priorities and design the best possible program under the circumstances.

Costs for the program should be projected on the basis of reasonable charges and the group should include in the negotiation process the method of determining the reasonable charges. They might find that a fee schedule was the most appropriate device. They might even agree on a moratorium or they might settle on a relative value scale or some other device—but whatever they devise it should be tailored to knowledge of a clearly predicted area of responsibility and the financial resources available to meet that responsibility.

These negotiations should be conducted with the greatest degree of public knowledge about the issues involved—"open covenants, openly arrived at" if you will. Not only the dollar costs should be considered and publicized, but the social cost of medical neglect should be given equal weight. In such circumstances it may well be that the public will be called on to assume a higher tax burden. It may also be that the providers are asked to accept only partial reimbursement for their services. If so, this would be consistent with the long standing tradition of the medical professions, namely, to provide medical care to the indigent under financial arrangements differing from those under which they provide care to others.

I believe negotiation has definite positive values. It has been my observation that when responsible people are brought together and faced with a problem, though they come from widely divergent points of view, and even conflicting interests, after a brief time they stop making their propaganda speeches across the table.

Unless we resort to establishing Medicare and Medicaid fees and charges by law, we must have a system for determining charges which will have the sanction of the widest possible public and professional acceptance. Violators then would not only have to bear the stigma of overcharging the beneficiary but of having violated an agreement arrived at by his own representatives and professional peers.

I have dwelt heavily on the question of health costs because they lie at the heart of the problem for the government and the aged people themselves. Let me highlight some of the other health problems of the aged.

Those 65 or over spend proportionately three times more for drugs than persons under age 65. A high proportion of the aged suffer from chronic conditions, arthritis, heart disease, etc. Many are blind. Others are confined to their homes or need help in getting about. A broad program of comprehensive health services must be provided to meet these problems.

The National Council of Senior Citizens seeks expansion of Medicare to include payment for drugs prescribed on an out-patient basis. Many elderly men and women are unable to meet their prescribed drug needs out of their poverty level

retirement incomes, their meager savings or their present limited private insurance coverage. It is utterly inconsistent to provide in-hospital drug coverage and provides no help for those in need of drugs outside the hospital.

There is no question that some unnecessarily high-cost hospital use could be reduced if out-patient drugs were provided under Medicare. It is also true that an expansion of out-patient home health services, for example, would permit older persons to remain in their own homes if they so desired. The National Council of Senior Citizens also urges that routine eye care, dental care, foot care and the cost of eye glasses, dentures, and hearing aids be included under Medicare.

Our Senior AIDES working in out-reach programs in our urban areas have discovered large numbers of poor elderly people who live in lonely rooms, disengaged from the main stream of society.

All too frequently we have found the disengagement began when the first signs of simple foot trouble wrecked the confidence of old people to use their legs, or failing eye sight set up fears of not being able to walk around to visit their relatives, their churches or their clubs.

Eventual consideration should be given to a broader Medicare program including periodic health examinations, disease detection and related services. The development of out-of-institution health services should be accelerated to enable more of the aged to remain in their homes for care and treatment.

The objectives of Medicare are to increase the ability of older people and their families to enjoy life by removing, through an insurance program, the major financial burden associated with the purchase of health care and to provide older citizens with access to high quality medical care and other health services. We have not yet fully achieved these goals for all our elderly citizens. There is considerable room for improvement.

In closing, and before I present the Senior AIDES who accompany me, let me say again how deeply my organization appreciates the opportunity for me to present our views to this Committee. You are to be congratulated on your courage in attacking what is admittedly one of the toughest problems confronting our country at this time. Making high quality medical care and services available to all our citizens, including the elderly, is a difficult and complex task—difficult and complex—but not impossible.

As you undertake the solution of this problem, I pledge you the full support and cooperation of the National Council of Senior Citizens and its affiliated organizations across the land.

NATIONAL COUNCIL OF SENIOR CITIZENS EIGHTH ANNUAL CONVENTION,
WASHINGTON, D.C., JUNE 5–7, 1969

RESOLUTION ON NURSING HOME STANDARDS

The National Council of Senior Citizens is deeply concerned for the well-being of nearly half a million of our fellow citizens who are in nursing homes under Medicaid and other Federal-State programs.

Mounting evidence of poor professional standards, exploitation, and neglect of these patients cries out for corrective action.

The National Council reiterates its appreciation for and support of the legislative leadership of Senators Frank E. Moss (D., Utah) and Edward M. Kennedy (D., Mass.) in their efforts to relieve the plight of these patients by improving the quality of nursing home care.

We note with dismay and indignation that the Department of Health, Education, and Welfare has done nothing of significance to make effective the commendable guidelines for Federally assisted nursing home care set out in the 1967 amendment to the Social Security Act.

The passive posture of Federal Medicaid administrators, their retreat from recognized professional standards for nursing home care in the face of opposition by provider groups, and the action of these administrators in employing a paid representative of the nursing home industry to write regulations for nursing home participation in the Medicaid program, all reflect on the integrity of the program's administration and cast doubt on its commitment to quality medical care for all.

The National Council of Senior Citizens calls upon the Department of Health, Education, and Welfare to: purge itself of undue influence of vendors' special interests; assume an aggressive role in looking after the health and welfare of

the Medicaid patients in nursing homes; and assign resources and priorities to fully implement and enforce guidelines for nursing home standards laid down by Congress.

The National Council of Senior Citizens calls upon Congress to exercise its broad responsibility to assess the performance of Federal Medicaid administrators in implementing the nursing home standards, to insist that the law be fully enforced, and to assure that Congressional concern for the proper care and protection of patients is honored.

NATIONAL COUNCIL OF SENIOR CITIZENS 8TH ANNUAL CONVENTION
WASHINGTON, D.C.—JUNE 5–7, 1969

RESOLUTION ON MEDICAID

The Convention demanded these improvements in Medicaid:

Restoration of the cutbacks in Federal support of Medicaid ordered under the 1967 amendments to the Social Security Act.

Adjustment for the low income elderly of the definition of "medical indigency" under which States set a ceiling on personal property or assets in determining Medicaid eligibility.

Comparable fees and payments under Medicare and Medicaid so there is no discrimination against any group of recipients.

Action by Congress and the State Legislatures setting minimum standards for medical care when it is financed by Federal or State funds, with adequate provision for enforcement of such standards.

There should be expanded Federal programs offering health care suppliers incentives to meet the need for trained personnel and facilities generated by Medicare and Medicaid.

The National Council supports a bill by Congressman Jacob H. Gilbert (D., N.Y.)—HR 10296—to authorize payment for a home maintenance worker as part of the home health services provided under Medicare.

RESOLUTION ON MEDICARE

Titles 18 and 19 of the Social Security amendments of 1965, which set up Medicare and Medicaid, have brought to the nation's senior citizens a basic health insurance program and, for poor older persons, extensive free medical care.

These two landmark programs have had enormous impact. However, there is a great need to correct inequities and eliminate deficiencies of the two programs.

Widows and the disabled are discriminated against under Medicare. The elderly still are faced with substantial outlays for medical care, frequently beyond their means. Physician fees are often unreasonably high.

The National Council of Senior Citizens recommends that:

All persons entitled to social security benefits be included under the Medicare program.

Deductible and co-insurance provisions of Medicare, requiring the recipient to pay $44 for the first 60 days of hospital care, $50 on doctor bills and a fifth of the remaining doctor bills, and to meet other out-of-pocket charges, be eliminated.

Reasonable Medicare fee schedules be set and doctors' bills be paid by the assignment method (payment to doctor by agency or carrier), not by patient.

Hospital stays under Medicare should be extended from 90 days to 365 days.

The National Council of Senior Citizens seeks expansion of Medicare to include payment for drugs prescribed on an outpatient basis (Medicare does not cover out-patient drugs).

Medicare should also pay for all eye care, dental care, hearing aids and foot care. (Medicare does not now cover routine eye care or the cost of eye glasses, routine dental care or the cost of false teeth, the cost of hearing aids or foot care.)

There should be a program of preventive medicine under Medicare, providing without charge to the recipient medical tests and services for detection of incipient illness.

RESOLUTION ON NATIONAL HEALTH INSURANCE

The Federal Government must assume its responsibility for meeting critical health needs of the American people not met by Medicare, voluntary plans, and health protection guaranteed under collective bargaining.

Present fragmented, costly, inefficient and inadequate health care arrangements must be replaced by a Federally-sponsored, comprehensive national program to assure all Americans, regardless of income or status, equal access to the high quality health services which this nation is capable of providing and to which all American people have a right.

Because of the chaotic organization of U.S. health services, the high cost of private health insurance, exorbitant fees of some doctors and the soaring prices of prescription drugs, Americans must pay more and more for their medical care and those on low incomes increasingly are unable to afford it.

The Federal Government provides complete health care for members of the armed forces and their families, members of Congress, the President and the members of the President's Cabinet and their families.

There is a desperate need for a plan of national health insurance that covers all Americans.

Mr. CRUIKSHANK. I just would like to make one observation that comes to me after hearing the significant discussions this morning. Much has been said about the structure of our medical care system and its inefficiency and inability to do the job that a medical care system should do.

In one sense I disagree with this conclusion. I am not being facetious when I say that when you look at what our medical system is really set up to do, you find that it is doing a magnificently efficient job. The trouble is, it is not structured nor set up to provide health care for the people of the Nation. It is designed to make money for entrepreneurs with an M.D. degree, and this job it does very well. There are, of course, notable exceptions. Among them are the prepayment group practice programs, a few outstanding medical care centers and clinics, and the programs operated in teaching hospitals connected with our better universities. But these are notable chiefly because they are exceptions. In the main, our so-called medical industry can be compared to the manufacture of Cadillacs. The makers of these fine cars are not primarily concerned with providing a transportation system for the people of the Nation. They are concerned with making a profit for themselves and their dealers—transportation is incidental. The medical industry too is set up to make money for those who provide medical care to those who can afford to pay for it—the carriage trade, if you will. You don't find Cadillac agencies in the ghetto and, for precisely the same reasons, you don't find many good health care centers there either.

A BASIC NEED FOR RESTRUCTURING

Our first task, as has already been suggested, is to see what basic restructuring of the system there needs to be. Medicare has highlighted this need, medicaid has highlighted it, and I think we are going to have to tackle this big job. I congratulate your committee for the courage to approach a difficult and complex job—difficult and complex but not impossible. I assure you you will have the full cooperation of the National Council of Senior Citizens' over 2,000 affiliated clubs and about two and a half million members, in this great undertaking.

Now with the observation I offered and with the submission of my statement I would like to present our first Senior AIDE, Mrs. Mittie Romero of Miami, Fla., who, I am sure, will also bear in mind the time limitation with which we are confronted.

Mrs. Romero, will you make your statement?

STATEMENT OF MRS. ROMERO

Mrs. ROMERO. My name is Mrs. Mittie Romero. I was born and raised at Jacksonville, Fla. My first husband died in 1956. I recently remarried.

I have been a housewife and have also been an insurance agent, a salesman for a shoe firm and fashion firms. For 10 years I operated my own business, a grocery, and I have worked as a peanut vendor.

I sold peanuts from a pushcart in Miami before being employed on the Senior AIDES program.

In the area I serve; namely, the Edison Court Senior Center at Miami, I have found in regular visits that there are a great many elderly who live alone and whose health is bad because they seldom get to a doctor.

Some are desperately poor. Recently, I visited a couple—he is 75 and she is 71—that had no usable cooking utensils or suitable furniture. There was a nest of mice in the bed they slept on. I could see the wife needed help so I arranged to get her to a hospital where the doctors said she suffered from an advanced stage of anemia.

My work consists of going to different homes, writing letters, shopping, taking meals to them, taking them to the doctor, taking them for a walk even. I am able to cheer them up when they are depressed or are feeling lonely.

I call on the new senior residents in this area to tell them of the center and urge them to join it, and participate in any of the many activities there. I work very closely with my supervisor, the caseworker, to discover senior citizens with serious problems. For example, I discovered an elderly lady who was in an advance stage of diabetes and referred her to my supervisor. She and the nurse arranged for proper treatment and care for this lady, who is now resting in a nursing home.

I average seeing six or eight people a day. I visit them in the hospitals and nursing homes when they become ill and have to go there. Being a Senior AIDE "lifts me up" helping others and seeing them happy. When I'm late or didn't come the day before, they want to know why I am late or why I didn't come.

Next month will be 1 year that I have been with the project. So far, I have not received any complaints about my services. I have always been a missionary at heart, and have longed to do for many years just what I am doing now—helping older people. I'm still young—69 years young.

The senior centers of Dade County have been fortunate to have not only our Senior AIDE project to provide work for the elderly but also a program called search and serve. Many Negro organizations hearings of the many things and services offered at the six senior centers requested similar services for their elderly. Through this search-and-serve grant, we are now able to take professional casework, health and group work services to six Negro locations—five economic opportunity centers and James E. Scott Community Association—that have senior citizen groups. We started in July 1968 with part-time help and found so many needs we have now a full-time caseworker and a nurse.

In October 1968, influenza immunizations were given at each of the six locations. The health education program that month was "Quack-

ery—food and drug problems." Speakers and a film were utilized. In November we cooperated with the local diabetic association. We found at least one member in each center that had diabetes.

In December, when the Hong Kong flu vaccine became available, we gave this to over 1,500 members. In just 1 year, we have over 600 members in the search-and-serve locations and 4,500 in the total membership of senior centers of Dade County.

Screening for Glaucoma

One thing I will always be grateful for is that I am a member of the center in which a pilot screening program for glaucoma was provided. They tested 123 and discovered 11 had possible glaucoma and were referred for further testing and treatment. The reason I am so grateful, is that when I was tested the doctor told me that I had the worst case of glaucoma he had seen. The doctor said that if I did not receive treatment immediately, I would go blind very soon. I am now taking the drops and am not blind. I can read this paper and am able to be here today. This need for glaucoma screeing is being met in Miami and within a year each member of a center will have an opportunity to be checked for glaucoma. The glaucoma screenings are made possible by the Bascom-Palmer Eye Institute. They also provide treatment of eye diseases and conditions, and prescribe glasses to correct these conditions for those unable otherwise to afford glasses.

We are fortunate in Miami to also have the Lion's Club which provides many, many people with glasses who cannot afford them. But let me remind you that most of the communities in our country do not have these facilities and our senior citizens have desperate need for eye care which is not covered by Medicare.

Let me tell you of some unmet needs that I see and hear about almost every day. Some of our elderly need foot care which is not covered by Medicare and the elderly just simply cannot go to a doctor for foot care. Some of them cannot even reach down far enough to cut their toenails. They are subject to dizziness when they lean over.

Some of the elderly do not eat properly because they can't afford dentures. There is a 3-year waiting list at the local dental clinic.

At our local hospital they will pull your teeth but are not able, so they say, to give dentures. Many of our people, therefore, either do not have any teeth, or they have ill-fitting teeth. Dental care is not covered by Medicare.

Some of our elderly need hearing aids. Some do not even come to the centers because they cannot hear what is going on. Therefore, they just sit in their rooms, many times excluding all other people, because they cannot hear visitors. Since you have already had hearings on hearing aids, I won't go further on this subject.

High Cost of Drugs

One other great problem affecting nearly all of us, as senior citizens, is the high cost of drugs. It is an awful feeling to need drugs you cannot afford to buy. The State gives $20 per month for certain drugs. When I have a cold, the $20 would not pay for the cough

medicine. You must have a prescription from the doctor to get the $20 in drugs. Many senior citizens do not have the $20 per month for drugs and with the cost of antibiotics and many other drugs going higher and higher every time we go to the store, people are less and less able to afford them.

Now you might be thinking, Mrs. Romero, now that you are working as a senior aide, can you afford the cough medicine?

Let me remind you, to qualify financially to be a Senior AIDE your income must not be over $1,600 a year. I work 20 hours a week at $1.75 an hour. After deductions, my take home pay every 2 weeks is $65.34. You know with that income you cannot buy much medicine. Many senior citizens have health problems requiring a great number of drugs to control their heart conditions and other ailments. They cannot pay the 20 percent in doctor bills not covered by Medicare or for costly drugs.

So Senator Muskie and subcommittee members, I am so honored to have the privilege of coming here and representing some of the 20 million or more senior citizens in our country and their health needs. We are truly grateful for the Senior AIDES project and the search and serve project but, as you can see, there are still many very important unmet needs of the elderly and we surely will appreciate anything you can do in meeting these needs by the help of God.

I thank you.

Mr. CRUIKSHANK. Mrs. Crook.

Senator MUSKIE. May I interrupt just a moment. It is obvious that these statements will not be completed by the time I have to leave and I do not think they ought to be shortened. I have to leave in 3 or 4 minutes to get to the floor. If you have no objection, I will ask Mr. William Oriol, who is staff director of the subcommittee, to hear the rest of your testimony so that the people in the room can hear it. I think it is terribly important that it be heard.

I would like to take these few minutes left to me to thank Mrs. Romero and Mrs. Crook and Mrs. Tucker and Mrs. Stanislawski of Buffalo, the city from which I come, for being here. It is terribly important work that you do. Your are the eyes and ears of the community and of America with respect to this problem which reflects our own people. You see them where they are, you see these problems as they arise, you see the frustration that is generated by the lack of services that these people ought to have.

This is why I ask you to come forward because I think your story needs to be heard, it needs to be told. I am grateful that you have come. Although I cannot remain to hear all of your testimony, I will read it—indeed, I have read some of it already.

I would like to ask Mrs. Romero just one question. You work in the Atlanta region?

Mrs. ROMERO. Yes, sir.

Senator MUSKIE. Just how adequate is the Senior AIDES program there? How many more people could you use in that area doing what you are doing?

Mrs. ROMERO. Well, quite a number more can be used, because there are so many that do not know about the senior centers and what they can have, the help that they can get. Residents of a senior center

that I have visited have problems, but I also visit outside the center and I find out about their problems. I invite them to come over and join in the centers and then I talk with them about their conditions and what can be done and what can't be done.

Senator MUSKIE. Do they respond to this program?

Mrs. ROMERO. Some of them do, some reject it.

Senator MUSKIE. It takes time to engage their confidence?

Mrs. ROMERO. That is right.

Senator MUSKIE. Mr. Cruikshank, I wonder if I might ask you a question. Now this program with Senior AIDES is really conducted by your organization, is it not?

Mr. CRUIKSHANK. It is sponsored by my organization and financed by grant. It started out with 10 cities, it has been expanded to 15. We expect it to be in 19 cities before very long. However, we could use many times the number of AIDES that we have now. We have just begun to bring into focus the vast need that there exists here.

Senator MUSKIE. How many AIDES do you have now?

Mr. CRUIKSHANK. We now have 800 AIDES providing services in the 15 cities.

Senator MUSKIE. How many cities?

Mr. CRUIKSHANK. Fifteen at the present time.

Senator MUSKIE. How long has the program been in existence?

Mr. CRUIKSHANK. Just a little over a year. It got started quite quickly. The pickup time was surprisingly short to me. I was surprised how quickly they would pick it up. We have received thousands of applications for the jobs. We are limited in the amount of money and the number of job slots allocated. We have requests for programs from dozens of cities, and for more Senior AIDES in the cities in which the program is now operating. We could use many times the amount of money that has been allocated and I believe do a constructive job in every instance.

Senator MUSKIE. You have all you can now support out of your grant, is that right?

Mr. CRUIKSHANK. That is correct, yes. The enrollment complement is filled.

Senator MUSKIE. Well, let me say this to you. The purpose of this subcommittee is not simply to explore a problem but to do something about it. [Applause.]

We are going to hear a lot of talk—that is the way the Americans begin. We intend to move beyond the talking stage to the action stage. What you four ladies are saying is representative of what 396 others could tell us, so it is important testimony and I want you to understand that, and I emphasize it because I have to leave. I will read your testimony as I consider it terribly important.

Thank you all very much for coming.

Mr. CRUIKSHANK. We are sorry you have to leave, Senator, but we understand. We appreciate the arrangements you have made to conclude the presentation. While you have to leave, we know what you are doing is important—the seniors are interested in that problem, too.

Senator MUSKIE. There is one other on the witness list who will not be heard this morning, Dr. Dean Fisher of the Maine State De-

partment of Health and Welfare. I am going to reconvene the committee at 3 o'clock this afternoon to hear him—hopefully we will be finished on the floor at that time. So any of you who will be interested in his testimony will be back hopefully here at 3 o'clock.

Mrs. STANISLAWSKI. It is nice to meet you, Senator. (Spoken in Polish.)

Senator MUSKIE. It is nice to meet you, too. (Spoken in Polish.)

Mr. CRUIKSHANK. Mr. Oriol, I would like to present Mrs. Evelyn B. Crook of Washington, D.C., another of our Senior AIDES.

STATEMENT OF MRS. CROOK

Mrs. CROOK. Mr. Chairman and subcommittee members, I am Mrs. Evelyn B. Crook. I have been a member of the faculty of the University of Maine, Ohio State University, Smith College, and Fisk University. I have also been executive director of the Council of Social Agencies at Wilkes-Barre, Pa.

During World War II I worked in the nonwage appeals division of the War Labor Board and also for the Office of War Information. In 1967 I did a short term of duty in interviewing for the Senate Special Committee on Aging. I later joined the staff of the senior citizens community service program as research assistant.

In Washington, D.C., we have 60 Senior AIDES working with seven public and nonprofit private agencies.

As research assistant under the program, I have interviewed these aides and from them learned that many have health problems associated with advancing years.

CASE HISTORIES

Here are some case histories based on these interviews.

Mrs. G., whose husband is in a State Hospital, uses the George Washington Outpatient Clinic. Before she reached the age of 65 last year, doctors' bills were paid by a "State Fund" whose exact name she cannot at the moment supply. Until 3 years ago, she personally met the costs of medicines—about $75 in the course of a year for treatment of thyroid deficiency and lesser ailments. She then enrolled in medicare which now pays a large part of her health care expenses.

Mrs. C., aged 64, incurred approximately $100 in expenses during the past year in doctors' charges for treatment of high blood pressure. She has no record of costs of medicine. She has an insurance policy which is supposed to cover hospitalization and home calls. This she used last year to the extent of one home visit at $10. Thus she was out of pocket for some $90 in physicians' bills, plus an unstated amount for medicine.

Mrs. C., aged 62, during the year paid over $200 in doctors' bills and a like amount for medicine. Her disabilities are of the heart, arteries and nerves. She is enrolled in Blue Cross, Blue Shield, which she did not use.

It should be noted that the age range of our Senior AIDES runs from 55 to 77, that full old age benefits under social security start at 65, that approximately one-half of the aides are under 65 and therefore not yet eligible for medicare.

Enrollment in medicare does not necessarily insure resort to it. One reason is that it does not meet expenses for urgent needs such as eye and dental care. Mrs. X last year paid $300 for her second set of dentures. Two other aides who are almost devoid of teeth are unable to afford dentures or to discover any source of help in getting them.

Mr. ORIOL. What is the rough income of the people you are describing, Mrs. Crook, and does not most of it come from social security?

Mrs. CROOK. Some of it would come from social security in some cases. Most of them would have certainly under $1,600 a year from all other possible sources. It is very doubtful if these people have that much.

Mr. ORIOL. What did you say the expenditure for dental work was?

Mrs. CROOK. $300.

Mr. ORIOL. $300 out of less than $1,600?

Mrs. CROOK. Approximately out of less than $1,600. I do not have her exact income here.

Again, people often hesitate to resort to medicare for legitimate claims for lack of experience in the required procedures. Persons accustomed to poverty often find the paper work hopelessly elaborate. A characteristic response to queries in this field is:

> So many forms to fill out, so much time spent trying to get the doctor's part done. If I have to pay the first $40 or $50 anyway, I might as well pay that little more—in installments.

To sum up, many of our aides have minor, and a few have major unmet physical needs. Though such disabilities lower their efficiency to an incalculable extent, they endure them for years. They accommodate to them, work as well as they can under the handicaps, and go on waiting.

Thank you.

Mr. ORIOL. May I ask, Mrs. Crook, and perhaps Mrs. Romero, too, what is your experience in terms of doctors taking assignment under part B? Do you find that most doctors will accept this assignment or refuse it?

Mrs. ROMERO. Speak a little louder, I can't hear very good.

Mr. ORIOL. Did you hear the question?

Mrs. ROMERO. No.

Mr. ORIOL. Whether doctors in your area are accepting assignment or refusing assignment under part B of medicare.

Mrs. ROMERO. I have not contacted any doctor yet that refused because I take medicare patients to a clinic. It is about three or four doctors. They all take medicare patients. I have not contacted any as yet that have refused medicare patients.

Mr. ORIOL. Mrs. Crook, I do not think I have made the question clear.

Mr. Cruikshank, have you heard?

Mr. CRUIKSHANK. I comment in my statement about that. In some sections of the country as high as 75 percent of the physicians are taking assignments and in other sections 25 percent. The difficulty here partly arises from the fact that any attempt to control the fees under the present setup would also probably discourage taking assignments. Hopefully if we move on the controlling of the fees we will also do something to require the physician to take these assignments. We be-

lieve he should be adequately compensated but the tradition of just considering the insurance program evidence of ability to pay and therefore making it possible for the physician to add on additional cost is something that we are going to have to face up to, and the assignment problem is an important part of it.

May I now introduce Mrs. Ruth Tucker of Pittsburgh, Pa.

STATEMENT OF MRS. TUCKER

Mrs. TUCKER. My name is Mrs. Ruth M. Tucker. I don't keep my age a secret any longer. I am 65. I am the mother of three children, grandmother of five and great grandmother of four.

I was born and raised in Swissvale, Pa., and live in the house where I was born.

I have been a housewife most of my life. For many years I served as a volunteer social worker at the Kay Boys Club, Pittsburgh, Pa.

More recently I operated a corset business of my own, but corsets have gone out of fashion.

An acquaintance, who holds a Federal position at Pittsburgh, put me in touch with the Senior Citizens Service Corps. Because of my experience as a volunteer social worker, I was employed as an area coordinator under this program.

I was desperately in need of a job because rising prices have made it very difficult for me to get by on my limited income.

Until I became associated with the Senior Citizens Service Corps, I was mainly concerned about the problems of young people, and I tell you frankly my eyes were opened when I learned of the desperate situation of so many elderly in Allegheny County.

I could go on for hours telling of the incredible hardship and deprivation of isolated, elderly men and women the Senior Citizens Services Corps AIDES have encountered in routine visits to poverty areas of the county.

Medicare, the health insurance program for those 65 or over, and medicaid, the Federal-State health program, do a wonderful job for old people who are hospitalized, but they need medication and care after getting out of the hospital and a great many have no money for this.

The drugs they need are very expensive and the price keeps going up all the time.

Here is what I mean. Senior AIDES recently visited a couple at Braddock, Pa. He is 78 and she is 74. He is a retired steel worker, but left the mill a long time ago. He has a heart condition and is barely able to get around. She has diabetes.

MONTHLY INCOME: $139

They have to make do on $139 a month income. Of that amount, $52 goes for rent. Their drugs cost them between $35 and $40 a month. So they have little left for food. As a result, they both suffer from severe malnutrition.

I read in the Washington, D.C., newspaper that Ralph Nader, the man who fights for the consumer, says large numbers of poor people eat dog food because it costs less than other food.

Let me say here the couple I have just described don't have enough left after they pay rent and buy medicine to eat dog food very often, with prices going us as they are.

The Senior Citizens Service Corps AIDES found an 87 year old man, also at Braddock, Pa., who was hospitalized twice in the past year. He had suffered a stroke and, in trying to get from his bed into a wheelchair, he broke his hip.

When we got him to the hospital, he developed other ailments. By the time he got out of the hospital, his medical and hospital bills came to around $500.

This man lives alone. He has no known relative. He cannot read or write, but he has always been self-supporting and most particular about paying his bills. So, at his request, I have arranged to pay a certain amount of his income on his medical bills. I might say his income is $123.70 a month.

His latest problem is dental care. He got false teeth. So, with the money he turns over to me, I pay $5 a week on this bill.

You might say the Senior Citizens Service Corps has all but adopted this fellow.

Not long ago, our AIDES discovered a couple—he is 76 and she is 75. He suffered a broken hip in a fall. This man had served 7 years and 8 months in the Navy prior to World War I. When his case came to my attention, my first thought was to get him admitted to the Veterans' Administration hospital in our area. So, we arranged to have an ambulance take him there. The hospital refused to take him in because he had not served in the military service during wartime. That is what they told me.

So, he had to be transferred to a general hospital where he is under care.

This man and his wife have a total income of $182 a month. However, he has been disabled since 1960 and his wife has a heart condition and is mentally deranged. As a result, doctor bills and medication account for a big part of their income and, in such a situation, $182 a month does not go very far.

The Senior Citizens Service Corps AIDES find that the condition of the elderly poor gets worse as they grow older.

39 Widows: Income $1,500 Yearly

The AIDES under my supervision have located 39 widows, all between 75 and 80, who must live on incomes of less than $1,500 a year. Nearly half this group have incomes of less than $1,000 a year.

I would like to interject here that most of these widows are of foreign extraction. During the life of their husband, the husband worked in the steel mill, they had purchased a home and paid for it. After the husband was pensioned until his death they had a good living. But with his death died the pension and they are struggling, not eating, not buying clothes, trying to pay taxes on these little homes that they have struggled a lifetime to buy.

Every one of the ones that we have documented are in serious need, not only of medical attention, they need food, they need clothes. Because of the fear of losing this home if they apply for public assistance and

a lien is placed against it, they refuse public assistance and continue to go hungry.

Mr. ORIOL. What sort of tax increases are you talking about?

Mrs. TUCKER. I am talking of property tax.

Mr. ORIOL. I mean amount. Roughly how much was it? How much is it?

Mrs. TUCKER. Well, I would say approximately on most of the homes between $200 and $300 per year. When you think in terms that many of these women have an income of only $432 per year, $630—I have it all documented, addresses and what not.

Mr. ORIOL. If it is possible for you to give us for the record, without names of course, a few of these examples, we would very much like to have them.

Mrs. TUCKER. I would be glad to give them to you and hope that something can be done.

Mr. CRUIKSHANK. Mr. Chairman, Mrs. Tucker will correct me if I am wrong but the State of Pennsylvania is one of the States that does not have an income tax, its State burdens are carried by a very heavy sales tax, I believe 6 percent, and real estate taxes. That is part of the reason this burden falls on these very poor people.

Mrs. TUCKER. That is true.

We find in these cases that the husband's pension ceased upon the husband's death and, as you know, the widow's social security benefit is reduced at the same time.

In a great many areas the elderly suffer from malnutrition and must wear rags. Many of these families once had family doctors but, with age and reduced income, they are virtually without medical attention. May I say we have the actual experience of doctors who will do nothing for them, period.

Mr. ORIOL. Do you mean that they are unavailable or that they refuse to serve?

Mrs. TUCKER. They are available, Mr. Chairman, but if a patient is on DPA they do not have time to work with him.

Mr. ORIOL. What is DPA?

Mrs. TUCKER. Department of Public Assistance.

DAILY VISITS TO CLINIC

We daily take people to the clinic. Fortunately, in Steel Valley we have a very fine relationship with the Visiting Nurses Association. We also have a very fine relationship with the hospitals within our area so that when we find a client many times is just almost to the end we are able to call and through the help of the visiting nurse and the community service worker at the hospital we are able to get these patients admitted to the hospital for service.

Mr. ORIOL. How far away is this clinic from most of the people you serve?

Mrs. TUCKER. Well, in the Braddock area within approximately 10 minutes providing——

Mr. ORIOL. By car?

Mrs. TUCKER. We are able to get an ambulance to get them there. Many of the people that we served in the several clinics, and we do

have quite a number, we have to travel a distance of approximately—well, a round trip is 26 miles.

Mr. ORIOL. How does a person without an automobile make that trip?

Mrs. TUCKER. We have been fortunate enough in hiring our Senior AIDES to have within our group three persons with cars. We prevail upon them when we can. Now since this new insurance law has gone into effect we again face another problem because some of these AIDES are unable to pay this increased insurance benefit. So what we try to do is through the department of public assistance we get books of cab tickets and this way we are able to take them.

Mr. ORIOL. Do you think that sort of thing existed before Senior AIDES came into being? How did people get to the clinic before Senior AIDES?

Mrs. TUCKER. In some cases a few ministers and priests would help them and in some cases they just didn't go. When we made the survey we found these people needing this help.

Mr. ORIOL. How long would you say some of those people had not seen a doctor?

Mrs. TUCKER. Well, I had a recent experience with a woman 86 who had not seen a doctor in 17 years.

Mr. ORIOL. Why is that?

Mrs. TUCKER. Beg pardon?

Mr. ORIOL. What reasons?

Mrs. TUCKER. She had no money. Until we found her she was not even getting public assistance, she was existing on what neighbors gave her.

Mr. ORIOL. When she finally did go, did she need hospitalization?

Mrs. TUCKER. Yes.

Mr. ORIOL. So she was eligible for medicare benefits?

Mrs. TUCKER. Yes.

Mr. ORIOL. Was she aware of it?

Mrs. TUCKER. She could not read or write and this is the problem that we have with many persons in our area.

Mr. ORIOL. Were any local officials aware of her problem?

Mrs. TUCKER. We would like to think not. We do not want to feel that they were aware and just neglected her because when we were asked to visit her a minister came to us. A couple of days later she had a neighbor bring her to the office and it was cold when she first came. The coat she had on was pinned with safety pins and the clothing underneath was indescribable. We of course keep a clothing bag. This is something we have done on our own. We got a coat for her and we got recent clothing so we could dress her to take her to the clinic. Of course we have found housing for her. She is now living in a project and is one of the most happy people you would ever want to see. But her health problems will go on. She has a heart condition, she is diabetic, and she has rheumatoid arthritis.

Mr. ORIOL. Then her health problem was compounded by all the other problems?

Mrs. TUCKER. Yes.

Mr. ORIOL. Mrs. Tucker, you mentioned malnutrition. How widespread would you say malnutrition is among the people in this area?

WIDESPREAD MALNUTRITION

Mrs. TUCKER. Well, recently some of our home senior aides were trying to be home health aides. We were concerned in getting into the real basics of malnutrition because we found so many persons in this condition. Much of it came from the fact that food stamps were available but with very limited income. The blue food stamps had to be purchased at one time and they were unable to purchase them. Many of these people lived on cereal and powdered milk and coffee. This was their diet day in, day out.

What we have actually done through this home health aid program; our women aides go into the home, help the person budget their limited income, suggest menus. In many cases, especially where the persons are heart patients or stroke victims, we try to send our Home Health Aide three times a week. Aides prepare food for the day of the visit and the next day for the disabled person and it is done on a balanced diet basis, taking into account the limited income they have.

Mr. ORIOL. The reason I pursued the question about malnutrition, Mr. Cruikshank, is the fact we are working with Senator McGovern's committee on nutrition and health needs. There is a likelihood that in the autumn there will be hearings devoted especially to this subject. I wonder whether we might work out with each of your Senior AIDES units some system for gathering the kind of information that Mrs. Tucker is giving us. I think this could be very important to that.

Mr. CRUIKSHANK. That is possible if the subcommittee would want it.

Mr. ORIOL. Thank you.

Mrs. TUCKER. What is needed is to make modern health care available without regard to their income or status in life.

Again on this problem of malnutrition, if somewhere along the line more food stamps could be made available to people who do not have the means to buy food, it would be a great help.

I thank you.

Mr. CRUIKSHANK. May I now, Mr. Chairman, present Mrs. Frances Stanislawski of Buffalo, N.Y.

STATEMENT OF MRS. STANISLAWSKI

Mrs. STANISLAWSKI. Mr. Chairman, members of the subcommittee, my name is Frances Stanislawski. I am employed by the National Council of Senior Citizens under the Senior AIDES employment project at Buffalo, N.Y. I am 57 years old. My husband died last year after a long illness and I am one of those widows that Mrs. Tucker explained about.

When my husband died, I was left without any pension whatsoever. I have a two-family house and my only source of income was $40 for the apartment which I rented out. I went to this Senior AIDES project and fortunately I have this job.

My husband had been a locomotive engineer but developed diabetes and became blind. We were under heavy medical expense for years due to his illness, and at the time of his death our savings were exhausted.

We raised and educated three children who now have families and I do not wish to be a burden on them.

My husband's death left me grief stricken and depressed, and my doctor ordered me to find employment so that I could forget my troubles. I can sew, but have no other skill and had little prospect of finding suitable employment.

One day, a Senior AIDE making a house-to-house canvass in my area came to my door and asked if any elderly persons in need of special services lived in my house. I told the Senior AIDE my age and said I was desperately in need of a job.

To my surprise, the aide told me there might be a chance to work on the Senior AIDES program. An interview was arranged, and it was my great good fortune to be employed in the Buffalo Senior AIDES program.

I love my work. To bring a ray of sunshine to someone who is sick, sad, or mentally inactive is very gratifying to me personally.

In the months I have been employed as an information and referral aide on the Senior AIDES program, I have visited hundreds of elderly persons and I can tell the distinguished Senators holding this hearing that I know from my experience on these visits that far too many of our elderly people in Buffalo, and probably in other big cities everywhere, live in a state of never-ending misery.

For the most part, they do not know there are public and private social or charitable agencies that can assist them in meeting their needs. Some know there are such agencies but are too proud to ask for assistance.

I and other Senior AIDES in Buffalo have found through our home visits that a great many elderly people are ill or disabled and that they are on the bottom rung of the medical care ladder.

Mr. ORIOL. By that do you mean in terms of interest, service, attitude? What do you mean?

Mrs. STANISLAWSKI. They are so miserable and saddened that they do not have any help whatever. They are just existing. They just gave up any hope for any help and are just going on until they finish out this life. That is the way they talk to us in Buffalo.

This is so because they lack the cash and the mobility to get the medical help they need. Now, unfortunately, the New York State Legislature has cut back funds that had been available for health care of the needy under medicaid. This means that elderly people with small incomes have less chance of getting proper medical attention.

The legislature has ordered people who ask for medicaid assistance to put up the first 20 percent of the cost of their medical expenses. It is obvious a great many elderly poor visited by the Buffalo Senior AIDES are not able to pay anything for medical care and will be disqualified from getting help under medicaid because of that 20 percent.

Take the case of a 67-year-old widow I visited. She had glaucoma which caused blindness in one eye. I received a phone call from her asking for help. She said she had gone completely blind in one eye and the other eye was becoming weak and infected.

When I answered her call I found her in the kitchen, and a pitiful sight it was. I notified my Senior AIDES supervisor of her problem. After a time, the supervisor arranged for an ambulance to take h er to Buffalo Meyer Memorial Hospital. There she underwent surgery

that saved the sight of her remaining eye. She is now recovering and can return home soon.

This woman has an income of $65 a month under social security. She has no money to pay 20 percent of her medical expense as contemplated under the New York medicaid law.

Some of the troubles Senior AIDES hear about are tragic. While making house calls, I came across a 63-year-old widow who told me that she spent 6 months being treated by a psychiatrist in a private clinic for despondency after her husband's death 3 years before. That took all her savings.

She was taken violently ill and sent word for me to visit her or she would take the remaining sleeping tablets and end it all. I arranged to have her admitted to Buffalo Meyer Memorial Hospital and, because of her record of psychiatric treatment, she was first referred to the hospital's psychiatric section. It turned out that her problem was not mental illness but a thyroid difficulty which was corrected. She is now home and in good health.

However, her only income is $125 a month in social security benefits and she cannot pay her hospital bill out of that.

The most pathetic case I have encountered is a woman, age 66, who lived with a widowed sister. This woman had a facial deformity and was a hunchback, so her family kept her secluded all her life. The parents had left the house to one sister with the understanding that she look after the deformed sister.

When I happened to call on this family, the widowed sister told me about her difficulty in caring for the deformed sister because the deformed sisted had cataracts in both eyes and was losing her sight. Through my suggestion, the deformed sister was taken to a hospital where she is undergoing treatment. Now the deformed sister had never worked and had no income whatever. She surely cannot pay anything, much less 20 percent, of her medical expense.

I appreciate this opportunity to tell about the health problems of elderly people at Buffalo. We have barely scratched the surface. In my district 70 percent of the people are retired.

Mr. ORIOL. Seventy percent?

Mrs. STANISLAWSKI. Seventy percent are senior citizens because the young people get married, stay with their parents until they save enough for a downpayment and move to the suburbs. As a result we are becoming a community of senior citizens which is bad all around.

Mr. ORIOL. Do the people own their own homes?

Mrs. STANISLAWSKI. The older people own their own homes. The homes have deteriorated because they do not have money to repair them and they do not care to move away if they have memories there. Take myself I believe I will never want to live out where I don't have familiar surroundings. I want to stay where I am and work, too, among the people.

I am glad we have a Senior AIDES project there. It is doing a magnificent job. In my opinion the Senior AIDES program is needed in every community.

Thank you very much.

Mr. ORIOL. Thank you very much. I am very glad to share this with you.

I am interested about the 20 percent medicaid. Medicaid was designed to fill gaps for people who could not afford premiums on medicare, so now we have a 20-percent charge.

Mrs. STANISLAWSKI. We have to pay and we have such a problem.

Mr. ORIOL. What sort of problems are arising because of the new rulings on medicaid?

Mrs. STANISLAWSKI. I will tell you I take forms with me when I visit these people and fill them out for the people. Otherwise, if you leave the form, they read it but never send it out. If I fill it out, almost every one of my forms go through.

So now, every one of them received a card and asking if they are still eligible in their belief. So they call me because they are afraid to put it down wrong and don't want to be refused. So I have to go to each one. I have permission from my supervisor to go to each one of them and help fill out forms.

MEDICAID PURPOSES THWARTED

Mr. CRUIKSHANK. Mr. Chairman, may I comment on that. You are quite right. It is a contradiction to the basic purposes of medicaid which is intended to help people who could not meet their medical bills. It really is kind of a contradiction in terms to set up medicaid, then put up a requirement which excludes so many in need, something the New York State Legislature came up with as a means of cutting back the costs. They are simply sweeping a part of the need under the rug and ignoring it. However, we of the National Council of Senior Citizens are trying to do something about that.

Another project that is sponsored by the National Council of Senior Citizens is a program called legal research and services for the elderly, and this operates under a grant in the Office of Economic Opportunity. Now one of the subgrant projects, the Center on Social Welfare Policy and Law, Columbia University filed suit just about 2 weeks ago in Federal Court in New York to enjoin the 20 percent medicaid cutback enacted by the Legislature and a temporary restraining order was ordered. Of course, these people like Mrs. Frances Stanislawski serves are now in limbo, they do not know whether they are actually going to have to meet the 20 percent or whether they are not. While there is a restraining order, nobody yet quite knows what the outcome will be.

Our project up there, the Legal Research and Services for the elderly project in New York, is alleging before the court that the cutback violates the constitutional rights of New York residents and is in violation of the objectives of the law as stated by Congress. We are hopeful that this restraining order will be made permanent, and of course if it is then you will run up against the fact that the Legislature appropriated money on the assumption that the restraining order would be effective. It will be a question of what response they made on that, but this does illustrate what a terrible hardship this is to these people.

Mr. ORIOL. Do you see a need for any language in any legislation that might be helpful here?

Mr. CRUIKSHANK. I think it will depend on what the decision of the court is. If the court makes the restraining order permanent on the

ground that it is in contravention of the intention of the act, we will not need any; but if we should lose, the court deciding that it is within the framework of the act as now in effect, I would think Congress would want to change that.

Mr. ORIOL. I have a few questions, but let me ask whether the minority counsel has any questions. Mr. Miller.

Mr. MILLER. No.

Mr. ORIOL. Members of the advisory committee, any points you would like to address?

Miss MCCAMMAN. I have no questions. I would just like to express appreciation for the panel's adding flesh to the bare bones of the statistics.

Mr. ORIOL. Yes, indeed. We are able to draw certain conclusions from the statistics we get; we know what the average income is, we know what the average costs of this and that is. Of course what you are doing here, as Miss McCamman said, is showing us what these statistics mean.

Dr. AXELROD. I wish to comment on something Mrs. Romero said. She pointed out her group has distributed flu vaccine, has done diabetes screening and glaucoma testing. I think it should be made clear that none of these services can be paid for through medicare.

Mr. ORIOL. Mr. Seidman.

Mr. SEIDMAN. Mr. Oriol, I would like to make a brief comment. First of all, I would certainly like to commend the National Council of Senior Citizens and President Nelson Cruikshank and the Senior AIDES who took time to come here because I think that they have made a tremendous contribution to this hearing. One of the points that it seems to me they have brought out and which you have just made is that no recitation of statistics gets at the human problems that are involved in what we are talking about.

UNEVEN IMPACT OF DEDUCTIBLES

If we say, for example, as with all good intentions Dr. Merriam did, that the deductible and the coinsurance results in the beneficiary paying only a relatively small fraction of the total cost, this means one thing when we are talking about the beneficiary, let's say, in the higher ranges of the social security benefits. But if we are talking about the individuals these representative Senior AIDES have been talking about, this clearly means a cost which these people cannot meet except by simply not getting the medical care that they need.

I think that this has been brought out very forcefully by this group, and I would hope that this would make a real contribution toward the further thought of this committee.

Thank you, Mr. Chairman.

Mr. ORIOL. Mrs. Brewster.

Mrs. BREWSTER. I want to join with my fellow widows in this and thank you very much for expressing some of the problems.

Secondly, I am sorry that we were unable to question the people from HEW because I have a distinct feeling that all of the figures they recite and which they give the averages and say what is left for the older person to pay count the $4 monthly premium as a Federal

expenditure rather than a private expenditure. Of course it is a Federal requirement so it is a semantic difference. In the situations you have been describing, $48 for a person a year for that part B benefit would be a sizable personal expenditure.

Mr. ORIOL. Mr. Glasser.

Mr. GLASSER. I want to join with the others up here in expressing our deep appreciation for making meaningful the comments that we tried to make in a broader way in the report to the committee. Certainly there is graphic evidence. We are talking about matters that are matters of life, death, and sustenance to people—they are not academic questions we are discussing.

I would like to ask either Mr. Cruikshank or the members of his National Council of Senior Citizens whether they have had any evidence of the nature of the problems created for the elderly by the arbitrary limitations on mental health benefits outside the hospital and in the hospital for elderly persons.

Mr. CRUIKSHANK. I would like to ask the AIDES if they had.

Mrs. STANISLAWSKI. As far as I know the client I told you about is being helped by medicaid for her care because I got her on medicaid. I was so afraid when she had to go to the psychiatric clinic until I visited that place. Mental hospitals are not what they used to be. It is so different now—there are no bars, no clanking keys. The atmosphere is even nicer than in a regular hospital.

Mr. CRUIKSHANK. Have you run across other people who need services, maybe had some service under medicare and then their time ran out at the clinic? Have you happened to run across any member like that?

Mrs. STANISLAWSKI. No.

Mr. CRUIKSHANK. It does not mean there are not any, but you just have not seen them?

Mrs. STANISLAWSKI. Yes.

Mr. CRUIKSHANK. How about you, Mrs. Tucker?

Mrs. TUCKER. We have two patients, one that was committed to Western Psychiatric Hospital through the efforts of the Department of Public Assistance. She remained there for 7 months and then was transferred to the county hospital. She has since been discharged. We have some very fine psychiatrists at Falk Clinic in Pittsburgh who give of their time certain days a month. This particular patient is under the care of a psychiatrist. We take her on an average of three times a month, sometimes four if we find that she is becoming very upset and disturbed.

Mr. GLASSER. May I ask who is paying for that?

Mrs. TUCKER. First she was admitted through the caseworker of the Department of Public Assistance so they must have picked up the tab.

Mr. CRUIKSHANK. It might have been medicare first.

Mrs. TUCKER. When she was first admitted she was not on medicare. At first she was only 62 when she was committed.

Now the psychiatrists who are working with these persons at Falk Clinic are giving their time. The Department of Public Assistance provides us with cab tickets to take this person back and forth to the clinic when necessary and we keep her under constant surveillance

because she lives alone. We have an AIDE who lives in the same building with her who checks on her daily because sometimes without warning she becomes disturbed and we immediately have to help her.

Mr. CRUIKSHANK. Mrs. Crook, do you have anything?

Mrs. CROOK. No.

MENTAL ILLNESS AND THE ELDERLY

Mr. GLASSER. May I simply make the observation that there is a good deal of evidence that the problems of mental ill health are probably more substantial among the elderly than among other groups in the population. The way in which the benefits here are structured with their limitations combined with the known resistance of people, particularly elderly people who are going for this kind of help, appears to be pushing more people in the direction of mental hospitals when the knowledge in the field would indicate that appropriate use of benefits would keep a great many people out of the hospital if they could be gotten to physicians on time.

Mr. ORIOL. I have just one final question and maybe we can discuss this briefly now. Perhaps this would be worth additional discussion.

One of the things that came out especially vividly in Mrs. Romero's testimony and Mrs. Crook's testimony was the sort of give-up attitude in trying to get medicare benefits. For people entitled to medicaid, it is an even tougher process to go through.

I just wonder what you think would be practical for people who are entitled to benefits but who have this give-up attitude and are not using the available benefits. Now, the Social Security Administration has made great efforts to get the information into the hands of people and to provide help. Do you think that more is needed? Do you think that maybe there should be a sort of senior AIDEs' program attached to the Social Security Administration? It might be just the thing to provide the kind of direct help which you are giving. What do you think about that?

Mr. CRUIKSHANK. I think this is very complex but I do not mean by that that we should not start doing something. We strike a very responsive chord in my heart right now. I just visited a relative of mine, very dear friend as well as a relative. He was for a long time a very, very skilled machinist. He was president of his local lodge in the machinist union for many years and always full of life and verve. He has diabetes, he has lost one limb. He got an artificial limb but the thing does not fit very well and he is discouraged. He is complaining about the price of drugs.

I told him about our drug service and his attitude was so different from that of past years. "Well, that is an awful lot of trouble, I don't think I can do that," he said. "I don't think I could go in." The man was so completely changed, so depressed and downhearted.

Now part of this comes, I think, because he is not eating right. It is a byproduct psychologically of his disability.

I would suspect that some of this depression comes from the thing that Mrs. Tucker was talking about and Mrs. Stanislawski, too—the fact that these people often do not eat right. Living alone, the temptation is to just live on snacks. My doctor friends talk about this as a very serious thing.

So the problem must be met by various approaches. These people need the encouragement that comes from people like the senior AIDES going into their homes so they know they have somebody who cares. They need improvement in their diet. They need the availability of service. They need the simplification of the procedures so that they can be manageable. They need all of these things and I think we ought to help them.

Now except for this experience with my own relative I am not as close to it as some of these folks. I suspect that Mrs. Crook maybe has comment on this, too.

Mrs. CROOK. The agencies employing our Senior AIDES are the Central Labor Council and the Urban League. The Central Labor Council has been having group meetings and seminars and pulling in all kinds of people for education with regard to medicare and medicaid. I understand the Urban League has been doing something of the same sort but more with individuals.

When we see the reports of these people, the number of contacts they have made in a month, I do not have the exact figure—yes, I do. The Urban League, for instance, during the month of June, 767 home visits; 11 workshop groups, and some of these concerned education in medicare and medicaid.

Mr. ORIOL. When you have workshop groups in places where people have to congregate together, the person most in need of this help is least likely really to come to a gathering, isn't that so?

Mrs. CROOK. Approximately true, but the people who do come are being trained to go out and find these others who cannot come.

Mr. ORIOL. I see. Did you say 767 people were contacted? Not each one of them is being trained?

Mrs. CROOK. Home visits in June totaled 767. This is apart from other activities—face-to-face interviews, workshop groups, persons referred for food stamps, and persons referred for welfare.

Mrs. STANISLAWSKI. May I comment. In the 1 year our program has been in existence in Buffalo, N.Y., we have found 150 cases of totally blind people that were not registered with the Commission for the Blind.

Mr. ORIOL. How old were these people?

Mrs. STANISLAWSKI. All senior citizens in various ages but all 60 or over.

Mr. ORIOL. And they were unaware of the help that they could receive?

Mrs. STANISLAWSKI. They were unaware. That is why in Buffalo we are called Senior Information and Referral AIDES and we refer them. Due to the experience I had with my husband, I encourage all the blind I contact to register with the Commission for the Blind and make use of the services available because this can mean a happier life. My blind husband and I went dancing. We went to Knights of Columbus parties and Lion's Club parties, indoor and outdoor picnics. There are so many services available to the blind and they don't have to sit home and just feel rejected. Also, we need a lot more recreation centers. Those are needed so badly.

Mr. ORIOL. Mrs. Tucker.

Mrs. TUCKER. Well, aside from recreation centers we need multipurpose centers where you would have certain clinic days, where doctors

would come and give services, dentist—any treatment these older people need because transporting these people in Alleghany County we have 175,000 people beyond the age of 65. That is a lot of people.

A Shortage of AIDES

We have 60 Senior AIDES which means we cannot even scratch the surface in giving service. You find so many of these people whose families—I don't like to say that children actually don't care because that is very harsh but sometimes this is what we feel because the only individuals that some of these people see are the Senior AIDES.

We practically adopt some of them to the extent that to get them to eat we go and sit while they have coffee so that they will eat their food. We try to arrange and we have been able to find a few young people who like to take them to church on Sunday. This is a very great problem, too, because many of our churches have been willing through the years to accept all the contributions that these people could give. Now that they are old and sick and cannot travel, oh, no, they do nothing at all for them.

The only thing we can ask is that hopefully you and the advisory committee and all of the persons working for our senior citizens are going to feel this way about it—today you are young, tomorrow you will be a senior citizen.

These people that we are working with are people who have given their strength, their wisdom, and their knowledge to help make America great. Now the time has come when the younger generation of which you are a part can put your strength with their wisdom and the desire to keep on living, and believe me America will have an unbeatable team and everything needed for everyone will be included and there will no longer be a generation gap. [Applause.]

Mr. Oriol. I think we just had another eloquent statement on one of the points that the task force was especially trying hard to make, that this problem is of concern to all generations.

Mrs. Romero, did you have any final words before we close this session?

Mrs. Romero. I just want to say that we are contacting slowly the nonresidents of the senior center and we are calling on all that we can contact. I have had a few since I have been on the job that have listened to me and have gone over to the job center and visited the activities that are going on and they are feeling much better.

I have some blind that have been blind from 6 years old. They are very active; all they need is transportation to the center and it comes out of there Mondays and Thursdays. I have accomplished quite a lot since I have been employed by the Senior AIDES and I have enjoyed my work very much by the help of God. It has done lots to me and I cannot express it. The things that I desired to do for years, I am doing it now and appreciate my work. Thank you.

Mr. Oriol. This is one of the themes we get time and again from people who are participating in service programs, that they benefit immensely—in fact, that there is a definite effect upon the health of people who are participating and people that they are helping. So we are very glad.

I just want to echo the words of Senator Muskie before he left, that though he had received just a part of this testimony he was tremendously moved as everyone here.

Mr. Miller.

Mr. MILLER. Mrs. Romero made reference to other people who had been blind since the age of 6 and their vigorous activity and active living. The American Foundation for the Blind has a task force that is concerned especially with the problems of the elderly blind. Of course, we have a different kind of problem for those whose blindness comes late in life, which is the more common occurrence and will undoubtedly receive much wider attention in the future. Because they have spent a lifetime as sighted persons and then in their advanced years are unable to see, they have a very special problem and a very difficult problem of which I am sure you people are very much aware.

Mr. ORIOL. I would like to thank you for coming and really extend my personal appreciation as well. Thank you, Mr. Cruikshank.

We will resume here at 3 o'clock when we will hear from Dr. Fisher.

Mr. CRUIKSHANK. Thank you very much.

(Whereupon, at 1:15 p.m., the subcommittee recessed for lunch, to reconvene at 3 p.m.)

AFTERNOON SESSION

(The subcommittee reconvened at 3:10 p.m., William E. Oriol, staff director, presiding.)

Mr. ORIOL. The hearing will come to order again.

Dean Fisher, Senator Muskie has sent word that they are still in session and he can't break away. He very much regrets that he can't be here, but he asks us to continue. And especially in view of his long working relationship with you, he is very regretful he can't be here, but he asks us to go along with the hearing.

STATEMENT OF DEAN H. FISHER, M.D., COMMISSIONER, MAINE STATE DEPARTMENT OF HEALTH AND WELFARE

Dr. FISHER. Mr. Chairman and members of the panel and of the subcommittee, first, I apologize for the lateness in getting a statement to you. This was supposed to catch up with me in Boston last night and, unfortunately, didn't do so. So I tried to recreate it this morning, and it is the best I can do under the circumstances.

I shall skip through this statement, and then I shall be more than happy to answer any questions that I may be able to answer. And should anyone choose to interrupt me as I proceed, I hope you will feel perfectly free to do so. And I am sure you will.

This is an extremely interesting subject to me, one in which I have had considerable concern and considerable involvement for a long period of time, and I know that Senator Muskie has had an equally long and sincere concern with many of these same kinds of problems.

There will be probably some additional statements submitted by people from Maine in writing to your committee, or your subcommittee, later on for inclusion in the record of your hearing. The

people from whom these statements may come are also extremely interested in the problems we are talking about. They are deeply involved with them. And through such activities as the Older Americans Act, I think there may be real contributions to solving some of these problems.

To introduce myself officially, I am Dr. Dean Fisher, a licensed physician, a former State health officer, and for some 15 years now the Commissioner of the Maine State Department of Health and Welfare. We are a rural State, of 33,000 square miles, with a population of about 1 million. We have less than 30 communities with populations over 5,000. We have about the 35th or 36th lowest average income in the United States. It is this background against which I shall talk.

I also point out that we have areas in our State, counties, for example, whose incomes must be considerably less than the average for the State at large. So we do have real problems with which to deal.

We have few sources for statistical information, but if there are any kinds of specific information that you would like to have about my particular State, I shall be more than happy to try to develop something of this nature and give it to you if you would like me to do so.

But it would seem to me that we are talking about a problem that is very broad, rather generalized, and perhaps it is not quite appropriate to dwell too much on the peculiarities of the individual State.

The problems I shall speak of are not profound and not unique. They are not necessarily peculiar to the elderly in a welfare program, although those in welfare programs do present these problems in exaggerated or extreme degrees.

The subject of your hearing will tend to focus attention on medical care, its economics, adequacy, et cetera. I shall not talk to this aspect of the problem, for I am sure others will deal adequately with it. I prefer to talk about more general and perhaps more important problem areas where there are steps to be taken that can reduce the health or medical needs of the elderly and, more importantly, enrich their lives.

Again, I prefer not to talk too much about my specific problems, but about more general, and perhaps more important problems, where there are steps to be taken that I think can reduce the health and medical needs of the elderly and, more importantly, enrich their lives. These are common, ordinary kinds of problems, and I think they tend to be lost when we talk about some of the more esoteric kinds of problems associated with the medical care program and delivery of medical care, where we are looking for means of rebuilding a whole system.

Aging, and the economics of aging, and its health aspects are not isolated phenomena unrelated to other community conditions. Therefore, I urge that we not be completely preoccupied with the problems of the aged as such. Perhaps the resolution of problems of the aged can lead to a better system in which we all may live. For example, medical care costs for a young family can be catastrophic in both immediate and long-range terms.

Obviously, the kind of system that can best deliver medical care for the elderly can probably also best deliver medical care to the young families to which I refer.

The quality and problems of aging are determined by all of the preceding experiences of the person and may be the sum of preceding deficits in health needs, earnings, housing, education, employment, place of residence, et cetera. On these, specific disabilities of age may then be superimposed.

I think this is extremely important to me as I look at our rural areas, and I see all too commonly and all too pathetically the elderly person who literally is showing all the deficiencies, all of the neglects, literally, to which he has been subjected through his entire life, and, finally, at the stage of being elderly, these are all brought together.

The qualities of aging are also shaped by the community in which the individual has lived—average incomes, ethnic background, community resources, et cetera.

Rural Disadvantages

Here, again, I point out the elderly living in the rural areas are very likely to be more disadvantageously located in terms of this previous experience with relationship to community resources, average incomes, and so forth. I think this has to be emphasized specifically. When we talk about the economics of aging, we are not talking about the wife of the local banker, and we might as well accept that fact. She probably has very few problems, she probably has very few health needs, and the main difference between her and the people we are talking about, I think, is essentially one of income, and perhaps not only income after achieving some magic number of years of age, but income during the preceding years of her life.

So I think this cannot be emphasized too much, whether we are talking about medical care, health needs, or whatever. Basically, we are talking about a group of people with low incomes.

Now, there are no specific inherent economics of aging per se. We are talking about a set of economic circumstances that we have chosen to create in the society where status and economics are largely related to the ability to produce goods and services.

The problems we see are the results of conscious and deliberate decisions on our part in our economic and social system, and I think this needs to be emphasized.

I point out to you such simple things as retirement practices at some given age. This may have had some validity years ago, but I am not sure it still has the same degree of validity.

It seems to me we have much, much more flexibility in the use of people, and I think we should accept these kinds of flexibilities and take some very serious looks at the results of so-called retirement practices.

There are no specific, inherent economics of aging per se. We are talking about a set of economic conditions we have chosen to create through "program" decisions in a society where status and economics are largely related to the ability to produce goods or services.

The aged thus do have problems of both status and economics. The economics are the economics of poverty, by and large.

Programs That Don't "Mesh"

Even in such programs as title XVIII we have chosen to complicate already complicated lives by coinsurances, deductibles, assignments, and other "fine print" that the elderly have difficulty in understanding. And I guess on that basis I must call myself "elderly," because I, too, have some difficulties in understanding them. These technicalities, incidentally, make title XIX unnecessarily costly and awkward to administer.

In OAA, I go through all the processes of "buying in," and I have developed computer lists of people, and I finally windup and pay the monthly premiums for them, and this monthly premium is about two-thirds Federal dollars. I can't see much sense in going through all this kind of falderal for little or nothing.

The social security system itself creates economic and social problems by inadequate basic retirement benefits. A great many people have as their only financial resource the retirement benefits of the social security program.

I have an OAA caseload of about 11,000. The "average" recipient is a 74-year-old widow with minimum OASI benefits. The caseload is some 10 to 12 percent of those in Maine over age 65. We are not highly industrialized. OASI benefits are low. Some 55 percent of my OAA caseload also receives OASI benefits.

It seems to me a little bit ridiculous that this should be this case. For 55 percent of the people, I must now be involved in all the processes of determining eligibility, I must have all the staff services and all these kinds of things to make a simple decision, and that is that an individual has an inadequate financial maintenance base.

By virtue of my operation, I am putting a certain amount of State money into the basic maintenance of these people. But here, again, I am putting roughly two-thirds Federal money in.

It seems to me not illogical to supplement, if necessary, the OASI program with some general tax revenue, and let just one agency send a check to my old-age assistance recipient instead of my sending one and social security sending one, with all the complications again of tying in under part (B) and all those kinds of things.

I think we should ask a serious question as to whether there is any reason at all, any justification for the operation of an old-age assistance program that in effect provides a financial supplement to the basic maintenance income.

Instead of my making out some 15,000 or 18,000 checks per month and all the rest of it, if Congress has problems finding money, I think I would probably be ahead of the game if I would write a check once a quarter and send it to you and tell you to put it in your "pot" and you send the checks to my old-age assistance recipients, only give them a little more money than you are giving them now.

I think that would save all of us a lot of trouble. What this might do, however, might be to free my resources for a much more useful endeavor, because if I were not concerned with the problems of administration, determination of eligibility, and so forth, I might then well be able to design a service program for all elderly people, with an attempt to assist with the many peculiar problems that they have.

I might well be able to provide this kind of service to elderly people purely in terms of their needs rather than in terms of any financial standard for eligibility. And I think if I were to do this, then I would be doing the kind of service that might be most appropriate for me, rather than to be involved in a financial assistance program, which is essentially supplemental to the national program designed to achieve a goal of some reasonable income floor.

Mr. ORIOL. When the old-age assistance payment is combined with the average social security benefit, what would you say is the rough average in Maine?

Dr. FISHER. Somewhere around $70 a month. I am talking about cash grants now.

Mr. ORIOL. So it is less than a thousand dollars a year.

Dr. FISHER. Considerably less.

It would seem to me that the kind of income program I am talking about could be expected to reduce health needs by providing for better food, shelter, and mobility. I think there is inequity between people in different States, and perhaps more serious problems than that, because of the general malodor in which many people hold welfare programs per se.

Next, I think we have to remember and recognize that inflation leaves the elderly person with fewer expenditure options for anything other than the barest of necessities, and such things as glasses, dental care, medications, even food, may be deferred purchases in favor of shelter and fuel.

I remind you that in the middle of the winter one can go without eating for a couple of days, but not without shelter and fuel.

These same inflationary trends force people to come to the public assistance programs. Inflation prices people out of the market for medical care, for nursing-home care, and in some instances where they are very much on the borderline, they are priced out of the market for the simple necessities of life, food and shelter.

ISOLATION AS WELL AS ECONOMICS

I think related to these economic problems are other things. The elderly have problems in isolation and loss of meaningful human contact. Isolation may be physical, social, or emotional, but, in any event, it leads to poor diets, poor medical care, accidents, and I am convinced it leads to mental deterioration.

Isolation may come from the need to accept the poorest of housing, particularly in rural or semirural areas. It may come from alienation from family by rejection, or the sense of rejection as the limited finances of the elderly force family sacrifices. Or the elderly may feel the family is being forced to make some sacrifices, and the elderly person doesn't choose to be in that situation.

General deprivation may force the elderly into situational depressions creating added health needs, or even suicide.

Economics may force resort to medical quackery or self-treatment, because they may feel this is a cheap way to solve the medical problem. And in the long run it probably means an added burden on the health-care program, rather than the opposite.

Inadequate means of transportation adds to health-care needs, or makes the use of such resources unnecessarily difficult. Some transportation is necessary to maintain what you might call normal human contacts, and to me this is an extremely important aspect of the problem I am talking about.

The kinds of problems I have mentioned are disproportionately severe in rural areas. Preceding earning histories have been low. Physical and social isolation may be severe. The elderly may be almost geographically abandoned as families become widely scattered. I emphasize that there is nothing worse than poor rural housing. There is no access to common urban resources, such as sources of medical care, social centers, et cetera.

I emphasize that when we speak of the "economics of aging" we are simply talking about a large group of people with low incomes, with infirmities, and perhaps a sense of purposeless existence. This is true, and I think this is something of a comment on all of us. They are people who have largely lost the ability or means to adapt to the deficiencies in our society, and in this way they make these deficiencies painfully clear to us, and particularly so in a rural area.

In Maine we have operated a combined health and welfare department since the mid-30's. This may have given us some broad and unique insight into our problems, and perhaps also some unique opportunities. We can bring together and to bear all of the health and welfare resources we have on the basis of conscious priority and strategic decisions related to specific problems. We can assemble a variety of resources that might not otherwise be possible. We can define broad program goals, and with both bloc grant and welfare funds, we can have a degree of fiscal flexibility that would be unlikely in separate departments. We gain added resources simply by virtue of the fact that the combination leads to a larger department and greater resources under a single administration. This kind of organization encourages us in the belief that we can contribute materially to the resolution of the problems we are talking about.

A Mobilization of Resources

The health problems of today are complex, and with large social and economic components. They require massive resources of money and skills, but any differentiation as between health and welfare has long since been lost by the nature of the problems. Mobilization of the resources of a total community, rather than the use of a specific technical device is now required for problem resolution.

Titles XVIII and XIX are obviously the largest health program we have, and they will be expanded by emphasis on the needs of children. Hopefully, if we, as State agencies, and title XIX do our jobs, the future needs of the elderly will be minimized. I hope we can make the kinds of decisions by which we can look forward to a time when we shall not need to consider the economics of aging as a special problem. I have great faith in the almost infinite capabilities of man.

There have been two times, I think, in 5,000 years of recorded history where combinations of conditions and events have challenged and inflamed men's minds and imaginations and energies to the point

where no problems seemed to be beyond his capacities, and the world was given a momentum lasting some 500 to 1,000 years or more.

The Greek of Athens grumbled about his tax load without realizing that he was building the foundations of western civilization. Queen Elizabeth's Englishmen groused about her expenditures for naval and related costs, but this was where the industrial revolution began.

Next Monday may mark the third such period in man's history. I have faith in the belief that man and his institutions can solve the troublesome, but not impossibly complex, problems we see today.

I think that is really what I would like to emphasize. The problems we see today are truly not complex problems. They are not as complex as we make them. They are relatively simple problems. They do derive from the decisions we have made very deliberately and very consciously. And if we have made decisions, it seems to me they can be changed, and I think that is where I would like to leave my statement as of the moment.

Mr. ORIOL. Thank you very much, Commissioner.

I have a few questions, and I hope that everyone here will feel free to join in.

In discussing old-age assistance, you seem to suggest that the current system, in effect, and that the money, that the supplement now given through OAA be given in the form of a direct payment possibly as an additional check in the social security envelope.

Dr. FISHER. I would hope it wouldn't be an additional check. It is easy enough to sort the money out on a balance sheet.

I am pleading for minimum social security benefits that do in truth support a level of common decency and life. That is all I am asking for.

Mr. ORIOL. There would be minimums?

Dr. FISHER. I am saying, let's do it in the cheapest and simplest and the most humane way, and that is through the social security and retirement system.

Our system of OASI has a humane device. It does not have the word "welfare" associated with it. It is coming to be looked on as an earned benefit, and by this means I think that you can serve people more easily. And I think people are more comfortably served in this way.

The individual being served in this way is really not going to be concerned about where the dollars came from that came into that social security check, whether part of it comes from trust funds and part of it from general funds. I think that is completely immaterial. I think it should be made to serve this basic purpose of guaranteeing a minimum, or a reasonable minimum, standard of decency.

Mr. ORIOL. Would you require a uniform minimum throughout the Nation? Or do you think there would be variations?

Dr. FISHER. There isn't that much difference in our communities. There is not that much difference in the needs for cash in a cash society. So I am not the least interested in trying to build into this some kind of regional differentiation, not in the least.

Mr. ORIOL. You mentioned—first, could you tell me a little bit more about your difficulties in buying into medicare part B under the existing system?

Dr. FISHER. In the first place, I have to go through the process of determining that the individual does have a social security number,

that he is properly identified, and here, again, in handling the deductions and so forth, these all have to be handled, because in my title XIX program I wind up by paying for the coinsurance, deductibles, so I have to keep score on all these types of things, quite unnecessarily.

Literally, what I do is wind up by exchanging computer tapes. There just isn't any sense in that, no sense in it at all. And there is even less when you realize that we are actually using Federal dollars to buy into a Federal program. This seems to me a little bit ridiculous, when both the Federal Government and I are splitting the cost of this 50–50.

Miss McCAMMAN. When you buy in, do you pick up the deductible coinsurance?

Dr. FISHER. When I buy in, I pay the monthly premium on behalf of the old-age assistance recipient, yes, and this is where you get into an awful lot of complicated bookkeeping.

As an example, an individual may come in on old-age assistance and may have already discharged part of his coinsurance as a deductible before he even came into the program, you see. It is just a completely unnecessary kind of mechanics. It comes only because of the sort of differences in colors of the dollars that are involved.

Mrs. BREWSTER. But you would also separately have to pay for the drugs and things that are completely outside medicare and keep records on those?

Dr. FISHER. That is right.

Mr. ORIOL. Mr. Seidman?

Mr. SEIDMAN. May I just point out that if the recommendation of our advisory committee were accepted and part A and part B were combined as a single social insurance system, then you wouldn't have this problem at all. It is because we do have the separate part B system that you have to buy——

Dr. FISHER. Yes.

Mr. SEIDMAN. You have these problems, and they are big enough problems for you as the administrator of this program, but they are also, as you stressed in your statement, very, very difficult problems for many of the elderly to handle, not only from the financial standpoint, but because they are being asked, in effect, to bear part of the administrative burden of the program, something which many of them are very ill equipped to do.

Dr. FISHER. Yes, and when you get into the whole problem of assignments—I pity elderly people, and I have seen many of them. They come to me, not receiving old-age assistance, with a handful of bills. They say, "What do I do?" Some are assigned, and some are not.

(Discussion off the record.)

Mr. ORIOL. You have a very large computerized operation in being, don't you?

Dr. FISHER. Yes. That is the only thing that saves our life.

Mr. ORIOL. What happens when you have changes in regulations and policies? Doesn't that cause you a lot of problems?

Dr. FISHER. Yes, it may. It depends on what those changes may be.

We may have some influence on the extent to which this may become a problem, because a week or 10 days ago we were one of three States selected by the Secretary of Health, Education, and Welfare to develop a model computer system, including all the programs, and

systems, to meet all necessary requirements for accounting, managerial, reporting. It is going to take about 2½ years to develop this model, and if it is successful, hopefully it will be flexible enough so that the kinds of changes you speak of can be made very easily, or the people, in writing the rules and regulations on this end of the operation, will perhaps keep in mind some of these complexities, and maybe even write simpler rules and regulations.

Combined Health, Welfare Departments

Mr. Axelrod. Dr. Fisher, Maine is, I understand, one of 12 or 14 States that now has a combined health and welfare department. I wonder what comments you have for other States where there is a separate department of health and one of social services with respect to problems of bringing together the resources of the health department with the welfare department on behalf of medicaid recipients, for example.

Dr. Fisher. Well, I must say that I feel sorry for some of my brethren in other States which do not have the same opportunities that I have for my combined department. I feel this very honestly and very sincerely, and I have for years.

I think it has given us a means of making certain that there will not be differences in priorities that will leave people caught in "cracks."

I cite you the simple example in some instances, on differences of opinions in standards for licensing certain facilities.

One agency may have funds that will permit development of standards only to a certain point at a certain time, and yet some other agency in the same State may quite unrealistically set standards considerably beyond this point.

So I think this is one of the main things that I see in our department, and that is that you determine a rate of progress. You may use health resources or health techniques to move, or you may use welfare money to push, one or the other, depending on the circumstances at the moment.

As I suggested here, the types of problems that we face now are no longer the simple kinds of problems that public health faced even up to 10 years ago. They are much more complex. They go much more deeply into our social fabric, and I think that a health program that is not aware of these kinds of characteristics can create some very real problems and can literally find itself in an academic desert someplace, or up in an ivory tower, and completely unrealistic.

We have some practical advantages of this organization in terms of utilization of manpower, or utilization of money. You can shift money around. As an example, you may use—as was pointed out this morning, where glaucoma is a problem—you can use a bloc grant. You can take your whole bloc grant and approach a problem and solve it in a given period of time. And with a department such as we have, I have even more resources that I can mobilize for what you might call a short, hard definitive campaign.

Mr. Glasser. May I ask, Dr. Fisher—I know you were here this morning—you heard testimony about the problems of getting the elderly into the mainstream of care, or into any stream of care, because of their isolation.

Dr. FISHER. Yes, sir.

Mr. GLASSER. So I have a double-barreled question, if I may.

Are there problems in getting care and understanding of the need for care because of the essentially rural nature of your State?

Second, what considerations does the committee need to give to the problems, especially, again, to a rural State, in terms of providing a continuum of care, the availability of hospitals, special services, and the like?

Dr. FISHER. I think I shall choose to interpret your question in a couple of ways.

"Rural areas" implies sparsity of population and distances. This brings problems, because hospitals and resources are distributed in general in terms of the forces of the marketplace rather than in terms of the needs of people. This is understandable in terms of the history of the development of our system.

This does mean in rural areas you literally have few, of what you might call resident resources to which you can turn. This means, to my mind, transportation, and mobility become much more important items in our program in our area than might otherwise be the case.

Secondly, aside from rurality, we do have some inadequacies in our resources. We do not have the array and variety of institutions and other related resources to which we may turn, even though we do solve the problem of mobility.

So we have both aspects of the problem. I don't know whether that answers your question or not.

Mr. GLASSER. It answers it about 70 percent. May I carry it just the other 30 percent?

Are there comments you would make on the availability of benefits under either the XVIII or XIX program that ought to take into special account the kinds of problems you are discussing?

Dr. FISHER. Yes. Here, again, when you are dealing with relatively rural areas, there is greater need, I think, for organized long term care of one kind or another.

The rural area doesn't lend itself quite as readily to the use of home care programs, for example, to the same degree that is possible in an urban area.

NEED FOR NON-MEDICAL SERVICES

There are other kinds of services, like meals-on-wheels, as a simple example, that may be feasible in an urban area, but simply are not feasible in a rural area. They may have to adopt things like a foster parent kind of relationship, a guardian kind of relationship. You may have to encourage or support people actually living in with the elderly person in order, perhaps, to permit that elderly person to continue to live in his home.

These are not the kinds of things, living in, for example, that I see coming from a medical program. This is the kind of thing that I would see States being able to do for themselves in terms of their own unique kinds of problems.

It would be this kind of problem that I would see States addressing themselves to, if we did not have, for example, to operate an old-age

assistance program, and could take the resources, the State money to be used there, and use that State money to supplement the more basic programs and develop those kinds of things that are perhaps uniquely necessary in our area, as compared with an urban area, for example.

Mr. ORIOL. Would you give us some rough estimate of the proportion of medicare beneficiaries in your State who have real access to home care services to which they are entitled under the program?

Dr. FISHER. Actual access at the present time, I think I would guess something in the neighborhood of 20 to 25 percent.

Mr. ORIOL. Even though 100 percent are entitled to this service?

Dr. FISHER. That is right. I would hope if you ask me this same question in another 6 months, I would give you between twice and 3 times the figure I just gave you, because we have three promising agencies at the moment that are in the development stage. They have taken on their first staff.

But I think that figure I gave you would be an honest guess at this time.

Mr. MILLER. Of those having access to a home-care program, how many would you consider as receiving adequate home care?

Dr. FISHER. I look on the home-health-care program as having extremely great potentials. I think that we have been obsessed with the place of the hospital in our medical care system. So I would say in answer to your question, if you wanted a sort of honest and idealistic kind of answer, I would say I doubt if any of them are getting the kind of home health services that I think deliver what I think is the potential of home health services.

Mr. ORIOL. Are there any other benefits or services to which people in Maine are entitled under medicare but do not receive perhaps because of local shortages or problems, or what have you, who are in rural areas generally? Let's put it that way.

Dr. FISHER. Probably not. They have a rather high degree of inconvenience in securing them, but I think this is the most I could say.

There are some peculiarities in the distribution of resources, extended care facilities as an example. There are some peculiarities in the distribution of certain kinds of technical skills that tend to be concentrated in the few urban areas that we have, and to this extent are relatively inaccessible to a person from, let's say, 100 miles away.

But I also point out to you here again that we are sort of talking percentages. We have some rather peculiar problem distribution because about half of the population of Maine lives within about 65 miles of the city of Portland, and this means that half of the population, then, is scattered over four-fifths of the area of the State.

So, if you want to talk in numbers and percentage of people who have reasonable access to facilities, the answer would be somewhat different.

LONG-TERM CARE

Mr. ORIOL. On extended care facilities, or long-term care facilities, a person suddenly in need of nursing home attention may find that he or she has to go perhaps a few counties away to get a nursing home bed. Is that one of the problems?

Dr. FISHER. Not nursing homes. Nursing homes in Maine—and I suppose this is true elsewhere—are privately operated and in most instances have been in business a long time. They tend to be small operations—20, 25, 30 beds—although this is changing.

Extended care facilities are the ones that create some problems. I think it is unfortunate that the "extended care facility" was ever so titled. In the act itself it is described as a nonintensive level of hospital care. And I think this should have been insisted upon.

The extended care facility shouldn't have been built under any set of circumstances if it wasn't a physical part of a hospital, and I don't believe an extended care facility can discharge the kinds of responsibilities that are assigned that kind of facility in the act, unless the extended care facility is part of the physical plant of a general hospital.

Mr. ORIOL. You are talking about an official designation under medicare, the extended care facility.

Dr. FISHER. That is right.

Mr. ORIOL. Are units of this kind being constructed, especially for the medicare recipients' benefit?

Dr. FISHER. Yes; and I am not sure that I think very highly of some of the bases for the construction. I think it is here that there is much of the unnecessary cost in the Medicare Act.

You know and I know that in any general hospital average admission, the probabilities are very good that the individual will not require the full resources of the general hospital for more than perhaps a third of the time he is in the hospital. Maybe out of a 12-day stay, he may require this level of care for perhaps 3 days. For the other 9 days, no. He needs to have access to resources and facilities, but he doesn't need the full range of services in the general hospital.

Unfortunately, in nearly all instances, he will be charged, and medicare will be charged for the full range of hospital services for the whole time of the stay.

Mr. ORIOL. Are you saying, Doctor, that a person going to a hospital under medicare now needs the intensive treatment of the full hospital for only about one-third of the time actually spent there?

Dr. FISHER. Oh, I think that is maybe not a bad average.

Mr. ORIOL. What would you say the difference in cost is between the intensive care and the recuperative care?

Dr. FISHER. A difference of about $22 a day and $65 a day.

Mr. ORIOL. Are you saying that the average cost of medicare patients in a hospital could be reduced by two-thirds if we had more of the type arrangement you speak of?

Dr. FISHER. Many of the hospitals are operating extended care facilities, but they don't call them that, or cost account them as much.

Mr. MILLER. What you are saying, Doctor, is that hospitals in general have failed to accept the concept that is sometimes described as progressive patient care.

Dr. FISHER. I think you said it very well, indeed.

Mr. ORIOL. Do you see any way in which existing legislation policy can be changed to promote the kind of arrangement you described?

Dr. FISHER. I hate to say this, but I think it is unsatisfactory for a general hospital to be certified as a provider for general hospital care when it only provides one level of care.

Mr. ORIOL. Right now we seem to be promoting one level of care. We are almost insistent upon it.

Dr. FISHER. What we have done, of course, is to let some vested interests develop, and this is unfortunate, because now we have nationwide chains with considerable vested interests, and this may create some problems.

Mr. GLASSER. May I ask apropos of that, Doctor, do you know, or can you recall from your experience in Maine the extent to which the health facility council has been able to encourage the development of extended care facilities in your State?

Dr. FISHER. Yes, our State advisory committee began about 2 years ago. Unfortunately, over a 2-year period, you don't have very much impact, because you can become involved only in those instances where the hospital is concerned with a construction project. It may well be necessary sometime that most general hospitals, when they look at themselves, will find that they have to do a reorientation of their space, and literally have to start redesigning their present plants so that they become more functional units in the sense that we are speaking of. I am not speaking simply of economies, but as a matter of fact, the patient is happier under these circumstances.

Progressive patient care is providing better care for the patient and, incidentally, more economically. The patient doesn't want to be in bed and served if he doesn't have to be. He would much rather be up and around, would much rather go out on the sun porch. He would be much happier.

Mr. MILLER. Doctor, do you feel in the development and implementation of the Hill-Burton program that regulations from Washington have tended to so freeze the program that States and communities have been impeded in an effort to experiment in the development of more sensible facilities?

Dr. FISHER. No, I don't think that this can be laid at the door of Hill-Burton. I see it as something of a failure on the part of hospital administrations, hospital trustees, to have the kind of understandings and kinds of breadths of vision that I think are necessary for these kinds of developments.

This requires a radical reorientation in the thinking of hospital people, perhaps. They have been trained for years to seek the highest possible level of quality of the individual unit of care, even though the quality or the cost of that quality may have been out of proportion to the quality itself or to the effect upon the patient.

So I think it is understandable, but I also think it is time for some changes to be taking place.

Mr. ORIOL. Mr. Seidman?

Mr. SEIDMAN. This morning when we heard from Dr. Merriam, she said the Social Security Administration was going to request broader legislative authority for experimentation in reimbursement and other aspects of the title XVIII, and I think also the title XIX programs.

As Dr. Fisher has reminded us, while it is important to get a maximum degree and the right kind of incentives into the Hill-Burton program, that program can only effect new construction and modernization—in other words, additions or replacements of the existing facilities.

But through the medicare and medicaid programs, you can operate, also, in the existing facilities. And it seems to me that it might be appropriate for the committee to request the Social Security Administration for information as to whether they are considering experimental plans relating to different types of reimbursements for progressive patient care in connection with the legislative request that they have in mind.

Regional Medical Program

Mr. Oriol. I think that is a very good suggestion.

Going back again, does the regional medical program, does that offer any assistance in dealing with some of the problems?

Dr. Fisher. No. The regional medical progam has not concerned itself very much with the process of the actual deliveries of services. It has been concerned with the quality of those services and the distribution of quality services, but not greatly concerned with the distribution system itself. As a matter of fact, I am not sure this would be consistent with the method in which they operate.

It is entirely conceivable that RMP's may become involved. The mere fact that they are concerned with the distribution of certain qualities of care, I think, will have some kind of impact on the distribution system itself.

Mr. Oriol. You mentioned several times the special problems caused by lack of mobility. How would you deal with this problem if you had resources to do it?

Dr. Fisher. Well, as far as we are concerned, we have no public transportation system in the State of Maine that is worth a "hoot." For all practical purposes, we have no public transportation system.

This leaves us with private transportation of one kind or another, like automobiles.

Now, elderly people in general, at least of the kind we are speaking of with these kinds of problems, are not likely to have either the money or the abilities to provide their own transportation. There are community groups of one kind or another that on a voluntary basis have organized transportation services, but I think this is not a very dependable type of a system, and certainly it is not universally available.

What I am saying, I guess, is that in the long run somebody is going to have to put money into the transportation system, because without being able to bring the patient and the necessary resource together, then obviously the resource is not of very much value.

I think to some extent we may even be talking ultimately of assisting elderly people to relocate so that the transportation and mobility problem no longer exist.

Mr. Oriol. Would it be possible that this kind of relocation would actually reduce Government expenditures?

Dr. Fisher. I think it would. One of the things I am talking about is adequate housing. There are a great many elderly people living in rural areas, not by choice, but by necessity. They may perhaps have some old ties to a given community, but in general they may well be living here simply because this is the only kind of shelter that they can afford.

Many of them would prefer, I am sure, to live perhaps more "in the village," rather than "out of the village," or in a suburban area rather than in the country.

But this means housing of adequate quality, and that is provided by one means or another at a price that the person can pay for.

Mr. ORIOL. You mentioned earlier that if the OAA payment systems were scrapped and replaced with a more adequate monthly income payment, that you would be very happy to use the savings that this would cause for a system of services to the elderly, services that could be related to maintenance of health.

What sort of services would you provide?

Dr. FISHER. Well, for me, this would free about 2½ million State dollars a year. This would free probably 100—I would guess 100 or more staff people.

Now, with $2½ million a year to play with, and a hundred staff people, you can imagine a lot of things that could be done, even transportation. You can subsidize, for example, the movement of services. If you can't bring patients to the facility, with enough money you can move the facility to a patient, perhaps on a mobile basis, but at least it can be done.

Mr. ORIOL. What do you do about the improvement of the services?

Dr. FISHER. Many things I spoke of, such as depression and isolation, lead to very poor dietary habits, even though the individual may have sufficient funds to purchase adequate food. I think this is the kind of area in which the health department may have some unique role to play.

In some areas, with some people, under some sets of circumstances, you may actually have to prepare and provide and perhaps even deliver food, and this is certainly not impossible.

We are operating now on a direct distribution-of-food programs, and on a food stamp program in one area. The direct distribution program has some advantages. It also has some disadvantages, because someone has to go someplace and pick up a periodic supply of food.

And, again I remind you of the problems of transportation on the part of the elderly person. So I personally would like to see very wide use of a food stamp program or something comparable to a food stamp program.

Of course, with a completely adequate financial income base, there would be no need, again, for a food or food stamp program. There would be need for guidance in the proper selection of diets. There would be need, perhaps, for the provision of foods, prepared foods and delivered foods under some sets of circumstances.

Mr. ORIOL. Doctor, I understand if we keep you here beyond 4:15, you may not get your plane, so we have 2 or 3 more minutes.

Are there other questions?

Mrs. BREWSTER. I would like to bring all of Dr. Fisher's helpful remarks back into the context of our overall committee. It seems to me that Dr. Fisher has pointed out what you might call an economist's point of view, the possibility of some real cost effectiveness in rearranging things.

You said, if incomes were more adequate, then diet and housing might be better, and there would be less health cost. This is, then, a

form of cost benefit or cost effectiveness which I think should be given a fairly serious look as your income-maintenance task force committee goes ahead with its activities. And I want to underline that in thanking Dr. Fisher for his very splendid observations.

Mr. ORIOL. Are there any other questions?

I think we would all like to join in thanking you for a statement that really does make the connection between low annual income and health problems and a statement which also showed us how things looked from the State office which the Federal Congress attempts to work with in dealing with some of these problems.

Thank you very much.

Dr. FISHER. May I thank you and your subcommittee members for the opportunity to be here. Thank you very much.

Mr. ORIOL. This hearing will resume at 10 a.m. in this room tomorrow morning.

(Whereupon, at 4:15 p.m. the subcommittee recessed, to reconvene at 10 a.m., Friday, July 18, 1969.)

ECONOMICS OF AGING: TOWARD A FULL SHARE IN ABUNDANCE

(HEALTH ASPECTS)

FRIDAY, JULY 18, 1969

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, following the recess, at 10:08 a.m., in room G308 (auditorium), Senate Office Building, Senator Edmund S. Muskie presiding.

Present: Senators Muskie, Moss, Yarborough, and Saxbe.

Also present: William E. Oriol, staff director; John Guy Miller, minority staff director.

Senator MUSKIE. As usual we have a long list of distinguished visitors and witnesses this morning so we ought to get right to work. First we have Dr. John H. Knowles, director of the Massachusetts General Hospital. It is a pleasure to welcome you, Dr. Knowles, as a fellow aluminus of Northeastern University.

Dr. KNOWLES. Thank you, Senator.

Senator MUSKIE. Senator Kennedy has sent word of his regret that he could not be here to welcome his distinguished constituent, and I would like to read this statement which he has sent. He says:

MESSAGE FROM SENATOR KENNEDY

I am sorry that it is impossible for me to be present today to introduce to this committee one of my distinguished constituents, Dr. John Knowles. Long before the American public was aware of Dr. Knowles and his work, we of the City of Boston and of Massachusetts looked to him for leadership on questions of health policy. As the Administrator of the Massachusetts General Hospital he has been an articulate advocate of new directions for the urban hospital and an administrator who wishes to bring his hospital into the community for the benefit of all rather than an institution primarily for the protection of a few.

Further in regard to good health care for the poor or the elderly, John Knowles is the voice of the future. He would have been a major contributor to the building of a more progressive national health policy in the national administration. I know that his testimony before this committee today will become a reference point for this committee's work—always sound, always to the best interests of the public, for the public is his own constituent.

I don't think I can add anything to that testimonial, Dr. Knowles. The best service I can perform at this point is to invite you to testify.

STATEMENT OF JOHN H. KNOWLES, M.D., GENERAL DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS.

Dr. KNOWLES. Thank you very much, Senator Muskie. I appreciate your comments and those of Senator Kennedy. I am particularly honored to be asked to come here to testify on this most important question before your Subcommittee on Health of the Elderly.

Due to the rush of events I have been unable to prepare extensively for publication some of my thoughts but I have roughed out some things and if I may talk spontaneously and go through what has been in the forefront of my mind for some years I would appreciate it.

I think first of all your Special Committee on Aging has produced two very excellent summaries of the problem—one entitled "Economics of Aging: Toward a Full Share in Abundance"—March 1969, and the other, which is still in galley but is being prepared, "Health Aspects of the Economics of Aging, July 1969. A careful review of these two papers presents the problem and suggested solutions in admirable fashion.

I think too often the public is not very much aware of the excellent material gathered by such Government offices. These two publications bear testimony to the good work that the Senate does.

I would like to reemphasize certain of the aspects of this problem and suggested solutions which I hope will be helpful to you as all of us struggle to improve the lot of those we call the elderly.

As all of us know there are roughly 20 million people over 65 in the United States today, and roughly half of them are 73 or older. The very dispiriting fact is that 30 percent of the people over 65 and older live in poverty and 10 percent border on poverty. In other words, 40 percent of 20 million people, or 8 million people, live essentially in at least the shadows of poverty.

Particularly distressing is the lot of widows and other elderly women living alone. In 1966 there were 3.6 million aged unrelated women of whom 2.1 million, or roughly 60 percent, lived in poverty using the Social Security Administration index of poverty. For an aged person living alone, the line was drawn at $1,565 per year in 1966. If you can imagine anybody living on that in this country today, I would like to know who can do it.

The economic position of retirees and the elderly is worsening rapidly as inflation erodes already inadequate income, assets are reduced while taxes rise, and more possibilities of cultural and recreational changes present themselves to enhance the quality of life in a consumer society. I would stress this, that, quite beyond the bare necessities of life, there is no reason that the elderly should be denied certain cultural and recreational opportunities in their advanced years.

Finally, prices for services, especially medical services, are increasing precipitously. Social security, private pensions, and other sources of income are not increasing rapidly enough to overcome this summation of factors. Total income from these sources just mentioned averages 20 to 40 percent only of the average earnings prior to retirement. The projection of these trends is dispiriting at best. Clearly, positive steps must be taken lest older age be approached with abject horror by the average American citizen.

I might say for those of us who have not reached that hallowed state when the fires are banked, something must be done if for no other reason than enlightened self-interest. From what I have learned in preparing for this subcommittee, I would certainly approach the subject with even more passion than before I was asked to testify here. These facts are awful. Improved income maintenance programs must be sought to help alleviate the special and ever-increasing problems of the health of the elderly. What with the staggering increase in health costs and benefits, we are approaching a crisis.

Compulsory Retirement Criticized

Let me say in passing that, notwithstanding the trend to earlier retirement, I believe that compulsory retirement at any age is undesirable, for nearly all men need and, indeed, want work for their own physical, mental, and social health. It is not completely fortuitous and only related to age that health may degenerate in fact with the onset of retirement.

Fruitful work and fruitful leisure must be available to all men and women, regardless of age.

The very special economic problem of the aged concerns health needs. The health expenditures of the aged person averages around $500 per year, nearly three times that of the younger individual. Physicians' visits are increased, hospital stays are longer, disability and the need for nursing home care are greater—all of which makes the position of the aged individual particularly difficult. Medicare without any question has helped to ease the financial problem considerably but again it should be emphasized that medicare covers only 46 percent of all health costs, while 41 percent remains the private responsibility of the aged and their children and includes such things as deductibles and coinsurance for hospital and physician services, nursing home care and drugs in particular.

In 1967, $9.2 billion was spent on health care for the elderly, of which $5.4 billion was from public funds. Of this, 59 percent was spent on medicare, 20 percent for largely medicaid, and 10 percent for veterans benefits.

Now hospital care consumes the lion's share of the total with $4.2 billion, and this has risen now I believe above $5 billion, of which 92 percent is from public funds, 76 percent through medicare, and 16 percent State and local.

Physicians' services in 1967 cost $1.6 billion, drugs $1.23 billion, and nursing home care $1.23 billion. These three items round out in order the largest segments of total health expenditures for the aged. Of the four main areas of costs—hospital, physician, drugs, and nursing home care—the costs of drugs borne by private sources was 93 percent—of a total of $1.23 billion spent—while nursing home care and physician services are financed from private funds to the tune of 56 and 54 percent respectively.

For both hospital care and drugs the aged person spends three times that of younger people and as much as 40 times more than people under 65 for nursing home care.

Now if one looks at plan B, for example, of the medicare amendments to the Social Security Act and finds that the present insurance policies cost the aged couple $96 per year, that drugs cost an average of $50 to $60 per capita—which rises to as much as $500 in the presence of chronic disease—and that coinsurance factors and deductibles add anywhere from $50 to $100 at least to the financial burden of the aged, then before you even get sick you have used almost one-third, or at least 8 million people have used almost one-third of that $1,565 on just their health needs, which leaves the $1,000 to buy food, have a decent roof over their head, and maybe occasionally go to a movie or buy a cigar or even have a glass of sherry. I am all for them I might add. Although I am not here on behalf of the alcohol lobby.

Now these are harsh facts. The heavy expenditures for health by the elderly make their economic plight and that of the taxpayers both employer and employee, all the more serious. Concern is heightened by the dismal figures recited endlessly to us in the health professions that hospitals' daily charges and physicians' fees have combined to make the prices of medical services rise faster than those of other consumer goods and services in the consumer price index, and these trends have accelerated since 1966.

In the most recent 3-year period, hospital daily charges have risen 52 percent and physicians' fees 21 percent.

Right here I would like to make the point that not all of this is inflation, particularly as relates to hospital charges. Three quarters of our charges go into the salaries of our employees. It was not until several years ago that the exemption from the minimum wage law was removed for voluntary hospitals and other institutions. We paid hospital workers largely in warm milk and the gratification we hoped they would receive for serving the sick, which is still important to all people who work in hospitals. We are finally catching up doing away with years of injustice to hospital workers.

I am asked at the Massachusetts General Hospital where it costs $100 a day why can't we get efficient like those hospitals down South where it only costs $40 a day? Of course you and I know that disadvantaged people down South are paid 40 cents an hour where we are paying them $2.10 an hour and in New York City by the next year I think they are going to $2.25 an hour and the union is rumbling about $2.90 an hour. Again, while in the front door we are exhorted to reduce costs, in the back door the unions frequently come exhorting us to improve our salaries, fringe benefits, and working conditions. I am absolutely for unionization of hospitals where management has been unwilling to stand up on behalf of their employees to achieve these decent wages and working conditions. In due course, some of us wonder whether many hospitals will be run by unions on one hand and Federal Government on the other.

Now on top of that there are a multiplicity of new techniques which are being evolved in hospitals which add precipitously to the cost, we are forced to buy the new technology, get new people trained, and hire more technicians.

I hope that some day we will try to develop a cost-benefit ratio that will demonstrate what we actually achieve when it costs us $1,500

to rehabilitate the young working man with a coronary. For the 3 weeks in hospital and as much as $3,000 in total costs, he now is rehabilitated for 30 years of active work—he can support his wife and his family, he can add to the gross national product and pay the taxes, and so on. That investment in an intensive care unit in the average hospital more than justifies the long-range benefit to the community.

Nonetheless, hospitals have been slow to innovate new management techniques and they have been slow to plan regionally in efforts to contain costs where they can be contained. Administrators, trustees and staff have been very slow to exercise the responsibility they should have to the public interest in the control of cost. I would not for a minute admit that completely.

It is only natural that public interest is heightened with the advent of medicare and medicaid and that the cry for public controls or at least public sanctions of one kind or another has begun. Costs and benefits will be scrutinized increasingly, coupled with demands for improved management of services and funds, and the year 1969 will see numerous congressional committees each feeling their part of the elephant. Unions will push for better salaries while Government will push for cost containment.

Senator MUSKIE. I wonder which part we have gotten.

IMPLEMENTING THE LESSONS OF MEDICARE

Dr. KNOWLES. I think you have got the head of it, Senator Muskie, I really do; for reasons I will get to shortly, you have the opportunity here with careful analysis of experience with medicare and with then improving the program of showing the way for future health insurance for all Americans. I am absolutely emphatic in my belief that health insurance must come, and the sooner the better, for all citizens of this country.

I testified at length on June 9, 1968, before the Committee on Government Operations and those hearings have been published by the Government Printing Office and are entitled "Health Care in America," dated 1969. I made the point there that the Massachusetts General Hospital after 160 years of existence improved the quality of its care and the appropriate utilization of its facilities as a result of having to set up a utilization review committee for the purpose of analyzing the needs for admission, the length of stay, the appropriate use of tests and so on, and evaluating the quality of the care that the patients receive.

The utilization review committee is improving on its practices. We should have and could have done this on our own but we had not until the medical law required that we set up such a committee.

Transfer agreements and extended care facilities have brought community facilities into the mainstream of medical care and have improved continuity and quality of care without any question. Medicare required this and we all needed the stimulus. Equal access to 20 million Americans has been assured generally in a dignified atmosphere without means testing. The old ways of charity medicine are outdated, outmoded. Largely municipal facilities have been circumvented and we no longer have the fear of financial disaster which plays

heavily on an elderly person's and a younger person's decision to seek medical care. All of this is to the good. The point is that insurance plans can improve quality and stimulate cost containment.

Finally, trust fund financing with funds separate from the general operating, tax revenues of the Government is highly desirable and separates these moneys from the tyranny of other priorities on the beleaguered tax dollar. This in no way says that management of these funds will not be responsible. We are seeing the results of financing from general tax revenues in the other program, medicaid, right now, where the only attempt so far in the improvement of medicaid has been to cut back money. There has been no effect on the system of medical care in the country so far, and no attempts to change and improve it through medicaid in contrast to medicare.

Now what are some of the undesirable aspects of medicare? First with a severe shortage of physicians and with demand mounting rapidly and far outstripping supply in a free market economy, the price of physicians' services has risen sharply. Within certain limits this was all right but this is a problem today to American physicians just as it is to our representatives who are supposed to manage tax money responsibly. Doctors have been too slow to exercise restraint and police themselves

Deductibles, Coinsurance Challenged

Second, I would like to say something about deductibles and coinsurance. How in the Lord's name we ever got the idea in this country that people will make a run on doctors and hospitals and that the average citizen really enjoys going to a hospital and fleecing and banging on doctors' doors all day, I shall never know. There are occasional neurotic patients and what have you, and shoppers who for lack of other entertainment will go from one doctor to another and have a good time of it, but most of us, 99.99 percent of us have no desire to see a doctor or go to a hospital. Deductibles and coinsurance are based on flimsy premises and compound bureaucratic redtape. It results in an unncessary expansion of the bureaucracy, it may even cost more to carry it out than it serves for the taxpayer.

Third, increased atomization and fragmentation of care has been enhanced by this act. Financial considerations have altered the best behavior of well-intentioned doctors and patients. Now the financial consideration should not determine the quality of care, the use or abuse of drugs or the accessibility of doctors or hospitals, and this act has done just that.

A fourth area which has been neglected is the development of incentives for improved management by doctors and hospital administrators. Now this is a very difficult subject. There is a high level Federal committee that has worked and discussed some 15 or 20 different types of positive sanctions to tighten up doctors and hospitals so that they will exercise prudence in the responsible management of public funds. But this is not an easy subject. Frequently the positive sanction which rewards good management will also slop over and reward bad management. The sanction which rewards full utilization of expensive facilities may result in over admission. Sanctions which reward increased use of low cost facilities may keep the wrong patients out of hospitals.

In all the discussions I have heard about the containment of hospital costs, very rarely do any of the long-winded documents ever start out with the fact that full and proper utilization of the hospital is the one single best way of containing costs.

The Massachusetts General Hospital is essentially 100-percent occupied 365 days a year as contrasted with the national average for hospitals which is about 80 percent, which means that the national average must have a 20 percent higher cost per patient today, generally, than we do. Now if we were 80-percent occupied and the community didn't need more than 80 percent of our facilities, then we should responsibly close the other 20 percent. We cannot, like the steel mill, close one of the mills and let the people out of work because we are so short of manpower that if we fired anybody or let anybody go, this would be the last time we ever saw him. We are understaffed, as it is, in most of our urban hospitals today, some areas more seriously than others.

Another area is dental coverage. I don't think really that you can cover dentistry at this point in this country. The shortage of dentists is absolutely prohibitive and it is all that any of us can do to get an appointment to see the dentist. We have to take more long-range steps to supply dentists and dental assistants before we can prime the pump, raise expectations on the part of 20 million people who need more dental care than anyone else in this room.

Let me say right off the bat that most people by the time they reach 70 or 80 have false teeth or they ought to. If their dental condition is poor, many are eating baby food and are not well nourished. The medical field has neglected the subject of nutrition.

Medicare Coverage for Drugs

Drugs, however, is another subject. The cost of drugs to individuals particularly with chronic illness may be as much as $500, $800, or $1,000 a year. I believe firmly that with the chronically ill over 65, one must extend the coverage of medicare to include drugs. Now perhaps for the isolated acute episodic illness, the cost of drugs can be covered by the majority of elderly people. But people who are chronically ill with arthritis, with heart disease, with all the degenerate diseases which require a broad array of expensive drugs, the costs cannot be covered by the majority of the elderly.

May I also say that as the Government and tax funds are used to cover drug coverage I think we can expect more responsible behavior on the part of pharmaceutical companies in terms of quality, and the use of generic names. I think this is very important.

We have had improved quality controls through utilization review committees. However, there are other quality controls that should be encouraged. Here the statement has been made that unnecessary surgery or surgery done by not fully qualified people has occurred and that the elderly who have no way of judging the professional competence of the expert professional should be protected from such practices. We have a wonderful opportunity to improve quality, which all of us deserve.

The Medicare Act continues to drive people into higher cost hospitals without any question. For example, to qualify for extended care

you have got to come to the high cost hospital for an acute episode of illness before you can go to extended care facility and stay there for the 30 or 90 days as a result of your hospitalization. You cannot obtain the benefits of extended care unless hospitalized first.

Now that is not intelligent use of tax money. It would be much easier to allow patients—nursing home care is not covered adequately at the present time by medicare but must be in due course—to go direct to these extended care facilities from home rather than come by the acute care hospital. It is very hard to be admitted to a hospital for just 3 days anyway and if the stay was this short, we should seriously question whether extended care was needed. On top of all this, because of a general lack of adequate extended care facilities, there may be long delays in discharging the now admitted patients to the appropriate facilities. For example, 10 days at $100 a day is $1,000 per patient that could be saved were they to go directly to the extended care facility where it might be $20 a day for the same 10 days, or $200. This is a very large issue.

At the Massachusetts General Hospital in the month of June 1969, we had an extra $60,000 of "day delays" to get into extended care facilities. This is as much as a half million dollars a year that could have been saved the taxpayers if we could have gone direct to nursing homes. I will get back to that subject again because here is a major difference between medicare and medicaid, which makes it difficult for us to discharge patients to extended care facilities. The homes won't take them if they are on medicaid because they either don't get paid, or they get paid less than they get for medicare patients. A chronically ill patient exhausts his medicare benefits and is shifted to medicaid—at which point the proprietor of the extended care facility either throws him out, sends him back to the hospital, or denies him admission.

Finally, there are no provisions for specific medication measures as relates to quality, quantity, cost, and so forth. Health maintenance or requirements for evidence of responsible regional planning by hospitals and doctors have been neglected. Here again if the utilization review committee has been so successful—at least at one hospital in Boston—and if I can sit here on behalf of one of the very good hospitals in this country and say the medicare requirement of utilization review has improved our quality and our responsible management, certainly the same thing can be done by requiring evidence of regional planning, for example before reimbursement is allowed. I think it must be done, for regional planning can improve quality of care and contain costs.

Medicaid: Perpetuating Problems

Now No. 2, medicaid. Medicaid is very important to the elderly because after they get through their medicare benefits they are shifted to medicaid. A very large part of medicaid concerns itself with the elderly patient. Medicaid is a poor program with no standards and no quality controls. It is implemented largely by State welfare departments which are overworked, understaffed, and almost totally unable to plan the medical aspects of these programs.

Medicaid has degenerated into merely a financing mechanism for the existing system of welfare medicine which is not adequate and must

be changed in this country. The present law and the present implementation guarantee that it will not be changed. It perpetuates the very costly, highly inefficient, inhuman, and undignified means test in the stale atmosphere of charity medicine carried out in many instances by marginal practitioners in marginal facilities, largely municipal facilities in most of the urban locations of our country.

Senator MUSKIE. Why do you describe means test as very costly? You are speaking not in money terms, I take it?

Dr. KNOWLES. We estimated in the State of Massachusetts it cost between $200 and $300 to conduct a means test, and that is an awful lot of money trying to find out whether a person qualifies for welfare or not. In this country we constantly set out to catch the occasional chiseler. Most people in this country are not chiselers. To have somebody come into our house, look under the bed, look in the closet for the television set, see if you can find the old man's pants out in the garage and so on, is inhuman, undignified, and an insult to the human condition. I think it is absolutely wrong. Just on the basis of the prudent use of my tax money—I pay taxes too—it is expensive, $200 to $300 to conduct an exhaustive means test. Meanwhile, the welfare agent goes through the community and finds out if you paid your bill at the grocery store, which automatically signals to the grocer that you are out of cash. In our country when you are out of cash, it means something is the matter with you, and I don't think that is fair. I don't think most of the people of this country are chiselers or deadbeats. I think we all have the same American philosophy, which values hard work and self-reliance. The whole welfare situation is deplorable and the laws must be changed.

Nearly $5 billion total annually is poured into this same old inadequate system with no improvement sought nor gained. The leverage of $5 billion is not being used to alter the system and it should be. Medicaid is financed from general tax revenues and with the usual recurrent waves of taxpayers' revolts—and I am a part of that as much as anybody else today in this country—the medicaid program as many of us anticipated is cut back by both Federal and State legislatures thereby depriving in many instances, particularly in the State of Massachusetts, children of much needed services.

So the only way we have tried to improve this program so far is to cut the money back. The program must be improved. You can also save money in certain areas. However, if you improve this program you are going to ultimately have to spend more money without any question. Only the acute part of the medicaid program has been implemented, that is, that portion devoted to acute diagnosis and therapy while the other desirable parts of the legislation which cover prevention have been largely neglected. The difference, as I said before, between State reimbursement nursing home care and Federal reimbursement favors medicare over the medicaid patient and this leads to decisions which do not favor the best interests of the patient.

When a medicare patient runs out of his benefits and his facility he may be sent back to our hospital, he may be sent somewhere else or he may be transferred to another and less adequate nursing home facility. This gets expensive. It is inhuman and not in the best interest of the patient or the doctor. These financial considerations should not be

the prime determinant of whether you and I are able to obtain health care, and without health there is little enjoyment in life.

In summary, the medicaid program must establish quality controls and standards at least to the level of medicare and beyond. Secondly, it must be turned over to State public health departments in terms of medical care and public health programs.

Trust Funds for Health Programs

Third, I believe it must have trust fund financing and be separate from general tax revenues.

I was trying to find out before I came down here where would this money come from in fact? That is a very difficult question, and I am sure that you, Senator Muskie, and others, have much more experience and better ideas of where this might come from. I was trying to find out how much money we spend on alcohol and cigarettes in this country—it is a staggering amount—each year. There might be a special tax on that to set up a separate trust fund under medicaid, or it might be lumped with the social security program itself. I don't think anybody in this country in his right mind would say the social security concept is a mistake at this juncture.

Fourth, good health clinics or neighborhood clinics should be developed which are easily accessible to the people, particularly in the case of the aged, where they can get advice on their nutritional needs and where they can get a comprehensive and realistic advocacy of their particular needs. The use of public health nurses and other health advocates in the community for health counseling which elderly people in particular need.

Many things relate to the health of the elderly—not just the medicine, the doctor, or the hospital. The aged have got to have knowledge of legal services, they have got to know which services are available to them, they must have help in finding at least part-time jobs.

In the State of Massachusetts, for example, the elderly people are bussed to a school in a State institution for mentally retarded children where elderly people act as mother surrogates to these children. You would not believe what this does for both the child and the aged person. Furthermore they are paid for it. There aren't other people to do this.

Finally, the requirement for recreation for elderly people. All of these things could be made available in good health clinics or neighborhood centers in the local communities. It is not a lot of money we are talking about. Aged people could almost run these things themselves with men who could show them how to run it.

Finally, just a few general observations. As I have said just now, I think we should have a comprehensive and holistic view of health which must include considerations of recreational, social, cultural and religious activities, jobs, all of which are needed as much by the elderly person as the young person.

Problems of transportation and housing and easy access to family, friends, and young people must be considered. The most touching sight in the world in the Massachusetts General Hospital is to see an 18-year-old student nurse giving a little love to an 80-year-old tooth-

less man who has arrived at the end of the life cycle. It is a great thing that does them both good, the recipient as well as the person giving it. It is good for both of them.

A Voice for Consumers

Consumers must participate in improving the system of health services. The guy who eats the meals is a better judge of the feast than the fellow who cooks it, without any question. The consumers have the right to tell us what they want rather than suffering our beneficial offerings which may or may not relate to what they need. This applies to rich and poor alike, black or white, red or yellow. This has nothing to do with the hassle we have had over "maximal feasible participation." We must develop utilization review and quality controls for medicaid and we must expand these controls for medicare. This will help us to improve the system and none of us fear this, doctors or hospital administrators alike. We must develop effective sanctions for good management. This is absolutely necessary.

I might say in that regard I think there ought to be a special sanction for the boards of trustees who work in the 7,000 hospitals of this country because I don't think most of them are working hard enough. I don't think you can have a trusteeship of the hospital where you run an executive committee for 1 hour a month and effectively run an institution where the same people go downtown and have a whole different set of values in their successful businesses. I think the whole business of trusteeship is anachronistic. Our own trustees meet two and three times each week for an hour and even they have difficulty understanding the whole issues surrounding the complexity called a large hospital.

We must develop sanctioning for doctors. We have got to stimulate group practices and comprehensive prepaid medical care plans. This is not socialism, it is not communism, it is not economically depriving doctors, it does not jeopardize their freedom, they have nothing to fear and this has been proven time and time again.

I was called by a man from Jackson, Tenn., just yesterday who said, "I agree, I don't like all that Government stuff but what I am doing down here is a bunch of us have gotten together in a group and we are treating rich and poor alike. We put an ad in the paper. We are going to train people in the community to help us so we don't have to do all the work ourselves. It will not increase the cost."

I said, "That is what made America great, voluntary activity." The price of freedom from central control is responsibility to the public interest and it has been since the country was founded. The majority of the doctors in this country want to do these things, I am convinced.

Now, finally, we have got to develop the better use of home health services, ambulatory clinics of hospitals and finally the good neighborhood health center for all social and economic classes. We make the mistake today thinking we can only develop these community health centers for the poor people, the very old people, the very young people or some other special group. The fact of the matter is that the 60 million people living out in the suburbs are the ones that have the political and economic oomph. They are the ones who can and should complain

and force constructive change. However, where the poor ultimately perceive health and its services as a right, we may suffer the confrontation that we have seen in the Ocean Hill-Brownsville area of New York where the poor people perceived that their educational system was not in fact meeting their needs. What happened? A destructive confrontation occurred where everybody lost. Two million children were out of school for 2 months and all kinds of extraneous issues were used to fan the flames, waste time, and dispirit a harassed citizenry.

Sooner or later health will be perceived as what you and I firmly believe it should be—a right of all Americans to good health. After all, without health you cannot go to school, you cannot work, nor enjoy the quality of life, and you cannot raise your family or serve your country.

Neighborhood Health Centers

The neighborhood health center is accessible to people in their local communities. It will diminish the fragmentation of care by enhancing continuity of care and will reduce costs by establishing preventive medicine and rehabilitation. It will make better use of scarce manpower. It will allow us to experiment with new methods of care which is what we are doing for example, over in Charlestown, Mass., a community of 16,000 people. It took us 3 years to establish ourselves there but they have accepted us now and we have seen 3,000 patients in the last 4 months. Their needs are staggering.

We have reduced the same people's hospitalization at the Massachusetts General Hospital by as much as 50 percent in 3 or 4 months. Those same people who crawled over to our hospital for the 10-day stay at the rate of $1,000 are now being treated in home and clinic in Charlestown. It will therefore contain the cost, and that has been the experience of many of the neighborhood health center developments in this country to date.

Neighborhood health centers are essentially a prepaid group medical practice and we know from the experience of the HIP in New York that this does work in the public interest. It does not work against the interest of doctors or hospital administrators or nurses or what have you.

Finally, I would make the special plea, and I am sure there is not an elderly person sitting in this crowd today who would not agree with this, that while we improve the conditions under which the aged lived, I don't think that any of us can forget the other end of the life cycle.

We are deploying many of our resources to the elderly today and well we might. On the other hand, we are not deploying the necessary resources to what you and I look to do for the future of this country, and there are even more than 20 million people involved in that. Developing of infant and children and adolescent programs and the support of the Children's Bureau is a very crucial issue and will not cost all that much money in this present dispirited era of the taxpayer revolt.

I believe that the circuitous and often tortuous route to the promised land passes in anywhere from 4- to 8- to 16-year cycles between honest conservatism and honest liberalism, individualism versus

statism or federalism, public versus private, Democrat versus Republican. I hope that we can retain the virtues of both and not indulge ourselves in the hollow comfort of ideological absolutes, and I must confess I have been treated to quite a bundle of them over the past months. [Laughter.] I believe in practical, well-intentioned men and recognize that there are problems such as the ones that your committee is concerning itself with. We must move to solve these problems—and their solution will involve cooperative and coordinated public and private efforts.

Clearly the resolution of the promise surrounding the help to the elderly will apply to other parts of the system. You have a magnificent opportunity to improve medicare for 20 million Americans, and use that experience to develop fine programs which will protect the ruggedly individualistic doctor and the hospital director and the nurse and all those people, 3 million and more who work in the health sector and who by 1970 will form the largest single employee group in this country.

Finally, total health involves all aspects of a community's life—housing, urban development, transportation, recreation, jobs, and so on—which I know you are all very much aware of, and I have been made more aware of it in the last 8 years. One cannot prime the pump and build up expectations when we are beset with short manpower. Here I would hope that the Congress when concerning itself with the programs of the Department of Health, Education, and Welfare will not cut the domestic budget in this area because it will accentuate the manpower shortage. It will not allow us to rejuvenate our facilities and recruit, train and retain needed manpower. We need our help and your support at this time. This is not the time to let the pendulum swing too far to the right, but at the same time the public has every right to ask all of us to use tax money responsibly and to cut the fuzz off loose programs where required.

Thank you very much.

(The prepared statement of Dr. Knowles follows:)

PREPARED STATEMENT OF JOHN H. KNOWLES, M.D.

The U.S. Senate Special Committee on Aging has produced two excellent summaries of the problem—one entitled "Economics of Aging: Towards a Full Share in Abundance"—March, 1969; and the other, "Health Aspects of the Economics of Aging"—July, 1969. A careful review of these two papers presents the problem and suggested solutions in admirable fashion. I would like to re-emphasize some of the points made and offer some of my own views which I hope will be of help to you in your efforts to improve the lot of those we call elderly.

Of the 20 million people over 65 in the United States, roughly half are 73 or older. Thirty per cent of people 65 and older live in poverty and 10 per cent border on poverty. Widows and other elderly women living alone have a particularly bad situation. In 1966, there were 3.6 million aged, unrelated women of whom 2.1 million or roughly 60 percent lived in poverty (Social Security Administration "index of poverty" line was $1,565 in 1966). The economic position of retirees and the elderly is worsening rapidly as inflation erodes already inadequate income, assets are reduced while taxes rise, and prices for services (especially medical) increase (and Social Security, private pensions and other sources of income are *not* increasing rapidly enough to overcome these factors—and total income from these sources averages 20–40 per cent of average earnings prior to retirement). The projection of these trends is dis-spiriting at best. Clearly, positive steps must be taken lest older age be approached with abject horror by the average American citizen. Improved income maintenance programs must be sought and a review of health benefits must be sought.

Notwithstanding the trend to earlier retirement, I believe that compulsory retirement at any set age is undesirable, for nearly all men need and indeed want work for their own physical, mental and social health. It is not completely fortuitous and only related to age that health may degenerate with the onset of retirement.

The very special economic problem of the aged concerns their health needs. The health expenditure of the aged person averages around $500 per year—nearly three times that of the younger individual. Medicare has helped to ease the financial problem considerably, *but* it covers only 46 per cent of all health costs, while 41 per cent remains the "private responsibility of the aged and their children" (and includes deductibles and co-insurance for hospital and physician services). In 1967, 9.2 billion dollars was spent on health care for the elderly of which 5.4 billion was from public funds (Medicare 59%, public assistance vendor payments 20%, Veterans 10%, and "other" 11%—and only 11.5% of the total is derived from State and local funds). Hospital care consumes the lions share of the total with 4.2 billion dollars of which 92% is from public funds (76% Medicare and 16% State and local). Physicians' services at 1.6 billion, drugs at 1.23 billion and nursing home care at 1.2 billion round out in order the largest segments of total health expenditures for the aged. Of all four, the costs of drugs is borne by "private" sources (93%) while nursing home care and physicians' services are financed from private funds, 56 and 54% respectively. For both hospital care and drugs, the aged person spends three times that of younger people and 30–40 times more for nursing home care.

These are harsh facts and the heavy expenditures for health by the elderly make their economic plight (and that of the taxpayers, both employer and employee) all the more serious. Concern is heightened by the dismal figures recited endlessly to us in the health professions, that hospital daily charges and physicians' fees have combined to make the prices of medical services rise faster than those of other consumer goods and services in the Consumer Price Index; and these trends have accelerated since 1966. In the most recent three year period, hospital daily charges have risen 52% and physicians' fees 21%.

It is only natural that public interest has heightened with the advent of Medicare and Medicaid and that the cry for public controls (or at least sanctions) has begun. Costs and benefits will be scrutinized increasingly, coupled with demands for improved management of services and funds (by both public and private sector)—and the year 1969 will see numerous congressional committees each feeling their part of the elephant.

Permit me to make some random observations.

1) *Medicare.*—generally a good program with quality and utilization controls in hospitals (Utilization Review Committee) which have worked in the public interest (see testimony on July 9, 1968 before the Committee on Government Operations, U.S. Senate, entitled Health Care in America, U.S. G.P.O., 1969, pages 683–725). Transfer agreements and extended care facilities have brought community facilities into the mainstream of medical care and have improved continuity and quality of care . . . Trust Fund financing—separate from general operating, tax revenues is highly desirable.

Undesirable aspects—deductibles and co-insurance; atomization and fragmentation of care enhanced; no positive sanctions for good management, full (and proper) utilization; dental and drug coverage (particularly for chronically ill) lacking and should be reviewed; continues to drive people into high cost hospitals (e.g. to qualify for extended care, hospital admission for acute episode of illness necessary); no provision for health education, specific preventive medicine measures, or requirements for evidence of regional planning.

2) *Medicaid.*—a poor program with no standards, no quality controls, *implemented* largely by State Welfare Departments overworked, understaffed and unable to plan medical aspects of programs; *perpetuating* the very costly, highly inefficient, inhuman and undignified means test in the stale atmosphere of charity medicine carried out in many instances by marginal practitioners in marginal facilities; nearly 5 billion dollars annually poured into the same old inadequate system—wasteful, expensive and with no improvements sought or gained; financed from general tax revenues and is anticipated with the usual recurrent waves of tax-payers revolt, the Medicaid program is cut back by both Federal and State legislatures thereby depriving (in many instances) children of much needed services; only the "acute" part of the program has been implemented (i.e. diagnosis and therapy) while the other desirable parts of the

legislation—prevention of disease, health maintenance and follow up care and rehabilitation—have been largely neglected; difference between State reimbursement for extended care facility nursing home and Federal favors Medicare over Medicaid patient and this leads to decisions which do not always favor the best interests of the patient.

GENERAL OBSERVATIONS

1) A comprehensive holistic view of health must include recreation, social, cultural and relgious activities; jobs and useful activity; transportation; housing; and access to family, friends and young people.

2) Improve cost: benefit and the system of health services for hospitals (regional planning; utilization review; sanctions for good management and full utilization) and doctors (group practices; development and use of other health professionals) or both (better use and development of home health services, ambulatory clinics and neighborhood health centers for *all* social and economic classes).

3) While improving the conditions under which the aged live, don't forget the other end of the life cycle, i.e. infants, children and adolescents.

4) The circuitous and often tortuous route to the promised land passes between conservatism and liberalism, individualism and statism (or Federalism), private and public. I hope we can foster and retain the virtues of both and not indulge ourselves in the hollow comfort of ideological absolutes, but be practical, well-intentioned men—but *do* something while always moving to solve the problems.

5) Clearly, the resolutions of the problems surrounding the health of the elderly will apply to the other parts of the system—and ultimate solutions will depend on all component parts—manpower, facilities, financing and programs—to say nothing of the larger field of health and social welfare.

Senator MUSKIE. Thank you very much, Dr. Knowles, for your excellent testimony. If I were to label your ideological thrust there I would describe it as New England pragmatism. I understand better now why you have generated opposition in certain circles and I say that in that confrontation you have won.

I have a number of questions but I am conscious of the fact that we have a list of distinguished witnesses which presses us for time. So I am going to yield initially to my colleagues and perhaps inject some questions of mine after they have an opportunity to question you, bearing in mind that we have some other distinguished witnesses we also need to hear before 12:30 this morning.

Senator Moss.

Senator Moss. Thank you, Mr. Chairman.

Unfortunately, I was a little late in arriving and heard only the latter part of the doctor's testimony, and it really was excellent, the part that I got to hear.

I should like to forego my questions, then, and simply continue to listen because I may not have heard the full import of all that he had to say. I can say that what I did hear was delivered with conviction and I can understand why the doctor enjoys the great reputation he does.

Dr. KNOWLES. Thank you.

Senator MUSKIE. I didn't identify the reputation. [Laughter.]

Senator Moss. I said great.

Senator MUSKIE. Senator Saxbe.

Senator SAXBE. Dr. Knowles, I would like to compliment you on your excellent presentation and certainly the interest that you have expressed.

The satisfied doctor is the key to any health center or any kind of a service put together. I am seriously disturbed about how we are going

to accomplish this. I have a son in Boston, his second year residency at Peter Brent. He has been going to school since God knows when [laughter]—Harvard Medical School and internship, now in residency. He is performing four or five operations a week minimum. He is drawing $8,000 a year, which the older doctors say, "this is great for nothing."

He is not married but many of his fellow residents are married and they live in extreme circumstances. They have families and their wives have to work. Isn't there some way that we can arrange this so we don't starve this guy until he is 35 years old? Because my son after 3 more years of residency will come out as a surgeon. He will spend 2 years in the Army and he will be 35 years old before he ever really is out to make a living.

Now isn't there some way that we can build this man up so that he does not feel he is fighting the hospital, that he does not feel that, "Well, I have got to get mine now," that he does not maybe drive himself to exhaustion as you know many of your friends do, to feel he has to make it in 10 years? This is the type of thing that results from an educational system that admittedly turns out a fine surgeon, or an internist or allergist, or what have you, but is not supplying that neighborhood center. It is not performing the function to the elderly that we are discussing here today and is not, I feel, satisfying the needs of the health in this country.

Dr. KNOWLES. There is no question about that, Senator. For all the reasons you have listed the surgeon's life is a relatively short earning life, and there is this attitude of "getting it all back fast" among some surgeons and it is generated by the system.

When I started interning at the Massachusetts General I was paid $300 a year and the assistant director asked if I wanted it in war bonds or cash [laughter]. Fortunately my father had the wherewithal to pay for my education.

MEDICAL AND TEACHING HOSPITALS

One of the first things we have got to do is expand the output of medical schools and teaching hospitals. In this era of the tight budget, the expansion of existing medical and teaching hospitals can be done at one-quarter the cost of building new schools and new facilities. That has got to be done and there have got to be ways of subsidizing through scholarships entry into the medical profession for all social and economic classes rather than for just the higher social and economic classes.

If we can double the output of schools, and give access to medical training to people of all socioeconomic classes—these people I feel will go back to areas in the inner city, not inevitably but they will—and education gives upward mobility to disadvantaged groups.

Now second, the country has always valued the highly trained specialist such as your son who, you and I, when we have our gall bladder taken out, that is the man we want. At the same time, through curricular changes and through more emphasis on the utilization of the existing knowledge in the medical field we have got to reset priorities in this country so that we don't give quite as much of the tax dollar to further acquisition of scientific knowledge. We have got to

give more dollars to the utilization of existing knowledge and develop sanctions so that these people will find it to their advantage, their self-interest, to practice medicine and to go out into communities. However, many of them want to but they follow the leaders and stay in the ivory tower on nice fat research grants, while shortages of practicing physicians are accentuated.

Third, I have done an extensive review of the physician specialty boards in this country. Unfortunately, now most specialty boards have not tried to answer the question of how to relieve manpower shortages. I gave a speech in Houston to all the deans and hospital directors in the United States last November (1968) on this subject. Many of the surgical specialty boards are now trying to tailor their programs to shorten the period of training and to give more close supervision to people like your son and maybe shorten his period of required training because he got their faster technically and is more proficient than others. I think you are going to find specialty boards applying themselves to this problem. I think you are going to see improvement. I think you are going to see a shortening of the period required.

At the same time there are experiments where the college time is cut down to 2½ years, medical school to 3 years, go right into surgery for 3 or 4 years, and you have cut 3 or 4 years off this period.

Now we don't want to end up with a bunch of idiots who don't have the broad view afforded by a liberal education and we have to constantly guard against that. We want our doctors to be broadly educated people.

Now also in the last 3 or 4 months a new specialty board in the area of general practice has been developed. They now have a specialty certification, taking several years to develop this kind of person who has enough surgery, enough psychiatry, enough pediatrics, enough general knowledge to care for the community at all ages as the first point of contact. He will also know when to refer the patient to our specialists and your son in the high cost urban hospital.

Senator SAXBE. Do you believe that we can accomplish this job of putting doctors into neighborhood health centers and welfare centers and geriatric centers serving old people without putting them on the Government payroll?

Dr. KNOWLES. Yes, I think you can. It makes it much more difficult, quite frankly, because it organizationally makes it a less manageable situation to continue piecework in what is now an impoverished community where you have a multiplicity of reimbursement arrangements, and so on. It makes it much more difficult to handle on a highly individualistic basis. I think you can do this, although, bear in mind, a considerable amount of medical care is now financed by Government.

The point I would make about the health center is that if we can make a go of it in the impoverished intercity, we hope to be able to transpose what we learn to suburbia. That same system should be transposable to the middle class, the blue- and the white-collar workers and the very well to do out in suburbia so that they will have easy accessability to medical care, of personal and continuing nature and at reasonable cost. I see no reason why a doctor should not, like all the rest of us, have incentives to do his work well. I see nothing the matter with financial incentive. If he does a good job, he will get more referred

patients; or if he is in group practice and salaried by governmental funds he will have incentives that give him extra money if he does a better job and gets more referrals and so on.

Senator SAXBE. One of the areas that I just can't help but feel is overlooked is the loss of dignity to older people when they are sick. If you go into these clinics, especially the so-called free clinics, piled up in there, standing in the corners, sitting on boxes and they are getting shoved around by a lot of cheap help, and as a result they don't go.

Dr. KNOWLES. That is true.

Senator SAXBE. Because this is something that a great many older people hold very dearly, is their self-respect and their dignity. They say, "I am not going down there and be pushed around, I just would rather not go."

Dr. KNOWLES. Precisely.

Senator SAXBE. And you know this happens.

Dr. KNOWLES. Yes, sir.

Senator SAXBE. And the overworked doctor in the back room some place really should not permit this but there is no help.

HOSPITAL ADMINISTRATORS AND TRUSTEES

Dr. KNOWLES. Here is where the finger should be put on hospital administrators and trustees. I talk about the Massachusetts General as much as any other institution. For 160 years we had an open cattle car in the clinics; long, hard benches; completely undignified, no privacy and nobody cared. Now what we did with that clinic was to break it up into private areas and put some decent furniture out there and air conditioned it for the people. All of a sudden the old people started coming on time, they took baths, they put on neckties, their own dignity meant something to them. Our doctors started to get there on time. In our Charlestown health center, our Ladies Visiting Committee is over these hanging pictures and painting that place so it is going to look just like the best part of the Massachusetts General Hospital. These things can be done, they don't cost a lot of money. You must maintain a person's dignity when he is sick in particular because when a man is sick or has a fever all his sensory areas are heightened. The psychologist will tell you this. You are more attuned to the look on a person's face, you smell more odors than you usually do—you hear things louder, you are more sensitized to the environment you are in and it must be a dignified, comforting environment, it is all part of your treatment. I could not agree with you more. When you do that you will find that people respond in kind—and everybody feels better and enjoys the visit. We have heard comments of people sitting in our clinic, one old person will say to another, "Where is Bill today?" And the other person says, "He could not get here, must have gotten sick." [Laughter].

They come because the environment is good, they like to see each other and they are getting some therapy by merely being in the environment. And that is therepy, it really is. Your point is a very good one and we have got to do these things. We are generally doing them. Doctors have tried to do these things but we have not done them as we should. We are doing them now, though.

Senator MUSKIE. We are delighted to have with us this morning Senator Yarborough, who is chairman of the Committee on Labor and Welfare, and also chairman of the Subcommittee on Health.

Senator YARBOROUGH. Thank you, Mr. Chairman.

STATEMENT BY SENATOR YARBOROUGH

I want to congratulate you on the hearings of this subcommittee of the Committee on Aging. I am proud to be a member of your subcommittee, your hearings in the field of aging, and I shall limit my questions to that field.

I took the chairmanship of the Health Subcommittee this year hoping to make it a national objective that we have health care for all the American people. I don't think we have health care now except in the limited field of medicare and medicaid for elderly people.

We have proprietary medicine, spend $53 billion a year on health care. We call it that because it is broader than medicine but it is not really health care except for these elderly.

I congratulate you, Dr. Knowles, on your statement. I have read all of it. I regret your discussion was much broader and more perspective and I missed most of that.

Your third point you said is improve the conditions under which the aged live. While we do that, don't forget the other end of the life cycle, infant and adolescence falls under malnutrition and hunger. The special committee on which I serve also heard the testimony of pediatricians and child psychologists. This work has been this year but by the time the child is 4 years of age it's potential for intelligence development is 90 percent already formed. The malnourished mother of the child of four, if they are malnourished in those years badly it will be either mentally retarded, a slow learner or drop out of school, or have other problems. So I am glad to see that you brought that in as the overall comprehension.

Just as 8 years ago we made a national goal of landing a man on the moon in 10 years, I think we ought to make a national goal of health care—not in 10 years but 2, 3, or 5.

I am chairman of the committee with that goal in mind.

Now back to this area stimulated by the discussion of Senator Saxbe. A few years ago I had the privilege of serving on the health committee for 11½ years under the chairmanship of Senator Lister Hill. We passed a bill to create 2,000 medical schools in the United States, which was not enough but it was a beginning. As you know, there have been slowdowns and lack of willingness on the part of the health professions to see them created. I think my own State is probably typical. This past fall—we have four medical schools in my State—they made it with 400 new medical students but they had 1,300 applicants in the medical profession.

Their entrance board was certified as having accredited premed training to be entitled to enter medical school but only 400 were accepted.

Now the University of Guadalajara accepted 1,500 first-year medical students in medical school last September; 600 of them from the United States. I know they just didn't take anybody that paid a fee

because I had people from my State calling on me to help them go down there. They had to have affidavits, something almost like a deposition to prove their college credentials.

That school was afraid they might be put upon by forged credentials and they went to great care with Americans to see that they actually had these credentials from American universities before going there.

We know they cannot get a medical education, 1,500 in the first-year class, as in an American class with 100 in that first class, but we know, too, that with the great shortage of doctors, when they finish that 600 will be admitted to practice medicine in the United States because 20 percent of our interns are in foreign medical schools, including those as far away as India, Iran, Pakistan, the United Arab Republic, and South America. Over 30 percent of the residents as graduates of foreign medical schools have such a great shortage we will welcome that and especially those 600 from the United States.

Now in your knowledge, how many more students do you think the American medical schools could take as first-year students from the numbers they accept now? Could they double their numbers without impairing the level of education they get?

Limitations of Medical Schools

Dr. Knowles. I think it would be very difficult to double them, Senator Yarborough, with present facilities they have. You see, one other thing which I know you are well aware of is as much as 70 percent of the budget of medical schools today comes via Federal funds, support for research that the faculty members do and this support also provides for teaching the students at the same time.

You can increase, and many medical schools have done this, by as much as 10, 20, or even 50 percent the size of the class. The teaching hospitals which are located generally in urban centers close to medical schools can certainly absorb that without much of any increase in their facilities.

I don't think you can get a doubling of that. Present capacity is 90-plus medical schools but you can get 10, 20, percent—or even 50 percent and of course that means at least the output of another thousand doctors each year. However, we need at least 50,000 more doctors by 1975—and this may be a conservative estimate.

Senator Yarborough. Now as you point out, for every applicant that is admitted there is another applicant that was not admitted in this country and they are very well qualified people.

Dr. Knowles. Exactly. I think you can both serve the public interests in being prudent with the use of tax moneys but don't hold back on the training grant money from the HEW, don't hold back on the improvement or expansion of existing facilities which will allow medical faculties to increase their enrollment. I think that over a short period of time for minimal expenditure of money you can at least increase the output by 20 percent across the board in existing schools and I think that is absolutely essential.

This is a very interesting subject. There is resistance. Sometimes you get the argument that you dilute the quality of individual pedagogy

when you have one teacher and one student and then increase the class so that you have 10 students and one teacher. It is argued that the quality of the educational experience falls. I know of no evidence whatsoever that says that is so. I think you have to exhort the existing medical schools by appropriate sanctions to enlarge their classes considerably.

Senator YARBOROUGH. It would decrease the quality of instruction, it seems to me, which is more of an argument for monopoly than an argument for education.

Dr. KNOWLES. That is a good point, Senator.

Senator YARBOROUGH. I want to commend you on your leadership toward health care for the American people.

Dr. KNOWLES. Thank you.

Senator YARBOROUGH. I commend you on your testimony. Due to the fact that there are many other witnesses to testify, I will not ask other questions that I would like to ask a person of your knowledge. We hope to have you back before the full health committee in the future as we move into hearings on this comprehensive question of health care for the American people. I think this is the most important field of American endeavor, the overall welfare of the American people.

I have been on the educational subcommittee for 11½ years too, and I have chosen this health subcommittee rather than health education because I believe that we are first in all this world in education. Seven and six-tenths people in poverty, nearly 1 out of 25, but on the data that we have for infant mortality and morbidity and length of life in the male and female in America vis-a-vis Europe and Japan and other civilized nations, I don't think we are first. We are first in medical expertise and knowledge but not in the health care of the people in this country. I think that is the neglected field that needs the thinking now in this country very bad.

Dr. KNOWLES. I agree with you, Senator; I am happy to hear you say that, very happy.

Senator YARBOROUGH. Thank you.

Senator MUSKIE. Thank you very much, Dr. Knowles. I have several questions relating to positions taken by the American Medical Association on your views, which are of interest. I suspect your views will not be new, but I think that I must restrain myself in order to leave some time for our other witnesses.

May I again thank you for coming. I hope that we may find the opportunity to bring you down again.

Dr. KNOWLES. I would appreciate that.

Senator MUSKIE. The advisory committee, I am sure, may have questions to submit to you which will be included in the record if you can find the time to respond to them.

Dr. KNOWLES. Be happy to. Thank you very much.

Senator MUSKIE. Thank you very much, sir.

(Subsequent to the hearing, the following questions were addressed to the witness:)

1. Recognizing that in the interest of saving time you doubtless shortened your statement of what went into the rehabilitation of the young man with the coronary, would you elaborate on how the health facilities and services outside

the hospital could or should have participated in contributing to his recovery and rehabilitation.

2. The Committee has had testimony from one witness that on any given day as many as 25% of the hospital beds in acute general hospitals are occupied by persons who do not require this expensive care. You testified that the Medicare requirement of 3 days prior hospitalization for nursing home placements is one factor. Would you comment on other steps the Congress and the hospitals might take to reduce inappropriate hospitalization.

3. In your discussion of trust funds for health programs, you suggested that taxes on liquor and cigarettes might be sources of revenue; and you also expressed great faith in the ability of the Senate to discover other likely funding mechanisms. Nevertheless, I would welcome any other thoughts you might have on the subject.

(The following reply was received:)

THE MASSACHUSETTS GENERAL HOSPITAL,
Boston, August 25, 1969.

DEAR SENATOR MUSKIE: Thank you very much for your letter of August 12. Let me answer the questions you have asked in your letter.

1. Health facilities and services outside the hospital which can speed the recovery and enhance the rehabilitation of people with acute disease such as coronary occlusions include home health services, visiting nurse associations, half way houses and extended care facilities. I feel very strongly that such individuals, organizations and services have not had the necessary stimulus from Federal legislation over the years while acute curative services—science and technological devices in high cost hospitals have received undue emphasis. If and when we have adequate numbers of visiting nurses, homemakers services, half way houses, custodial and extended care facilities, we can then very measurably shorten the period of hospitalization necessary for acute illness. With this shortening we can reduce the cost per day from something over $100 to something under 20 or 30 dollars. At the present time, the individual with acute coronary thrombosis may spend anywhere from 3 to 6 weeks in the hospital, and I firmly believe this could be cut in half to a maximum of 3 weeks in the hospital if such individuals, organizations and facilities were available outside the hospital or in the home.

2. Your statement about the misuse of expensive hospital beds is true. There are many factors and ways in which we might reduce inappropriate hospitalization. First of all, the present form of most health insurance including Medicare drive patient and doctor into the hospital. Incentives and sanctions should be built into health insurance policies which will foster the use of lower cost facilities, out of hospital. Secondly, all forms of health insurance should require utilization review and quality controls which, outside of Medicare, are not provided for at the present time. Medicare, by requiring a Utilization Review Committee with recorded notes does much to enhance the proper utilization of the hospital and to improve the quality of the patient's care. Another area is to stimulate the private sector to build more ambulatory facilities and extended care facilities and here we come full circle to the development of the neighborhood health center. We have shown time and time again, both in our own project in Charlestown as well as those run by the Kaiser Permanente in California and the HIP in New York and the Columbia Point Project of Tufts University in Boston that such neighborhood health centers can reduce the use of expensive hospital facilities by at least 50 per cent. The neighborhood health center by stressing preventive medicine and enhancing rehabilitation services locally available to the community will measurably decrease the need for trips to the high-cost hospital. Once the patient arrives at the door of the high-cost hospital, both doctor and patient are driven to use in-patient facilities by insurance programs as well as mutual convenience. These tendencies can be done away with by resetting Federal and Private priorities to the development of neighborhood health centers designed to maintain health and to detect disease in its incipiency before it becomes acute or chronic and requires high-cost hospital facilities. Finally one should stress the development of larger and more adequate and economically run nursing homes for those over 65 years. In this case a very basic change in the Medicare law would pay for nursing home facilities because at the present time such patients are driven into the hospital under the guise of having

an acute illness so that they may then qualify for extended care in the nursing home, all of which raises the cost of medical care.

3. I suggested that separate trust funds be developed for the Medicaid program similar to Medicare and Social Security trust funds for the reasons outlined in my testimony. I made the initial suggestion that taxes on liquor and cigarettes might be good sources of such revenue—only because it is known that both when used in anything but moderation can lead to poor health. Other sources I suppose, might be taxes from the incredible amount of wagering and betting that goes on in everything from race tracks to footbal games around the country. Here again, I am way over my head and I recognize that it is a very difficult problem.

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Absolutely any time that I can be of any help to you or to your subcommittee I do hope you will let me know. In the meantime, I send my very best wishes as always.

Sincerely yours,

JOHN H. KNOWLES, M.D.,
General Director.

Senator MUSKIE. The next two witnesses will appear as a panel, Dr. Frank F. Furstenberg, associate director for program development, Sinai Hospital, Baltimore, and Dr. James G. Haughton, first deputy administrator, New York City Health Services Administration.

I express my appreciation to both of you gentlemen to have agreed to come here to enlighten us.

STATEMENTS OF FRANK F. FURSTENBERG, M.D., ASSOCIATE DIRECTOR FOR PROGRAM DEVELOPMENT, SINAI HOSPITAL, BALTIMORE, AND JAMES G. HAUGHTON, M.D., FIRST DEPUTY ADMINISTRATOR, NEW YORK CITY HEALTH SERVICES ADMINISTRATION

Dr. FURSTENBERG. Senator Muskie and Senator Moss and Senator Yarborough, we are glad to be here. It is a little difficult to follow our distinguished colleague. Since he covered so many of the problems society faces obtaining adequate health services we will necessarily repeat him somewhat in our 15- to 20-minute presentations. I am going to limit myself to some technical problems the committee faces in broadening medicare and medicaid and in making health services for the aged a model for developing the health care system we need.

We certainly thank you for the opportunity to testify. The committee has already heard about the need——

Senator MUSKIE. Do not overlook the point that repetition is a good way to educate a Senator.

Dr. FURSTENBERG. Also a way to tire him too, I am afraid.

You have heard so much testimony concerning the many difficulties of older persons, especially older poor persons in coping with the rapidly rising costs of medical services as well as their problems in obtaining prompt access to health care.

My experience as an administrator and a practicing physician documents their problems. Both medicare and medicaid have left gaps in health services for older poor sick persons which fall in a number of areas. Medicare does not cover payment for drugs, a major concern. Second, for many older persons there is a simple lack of money for the 20-percent coinsurance under part B; and many also have

difficulty paying the fees of physicians who are unwilling to accept assignment, approximately 50 percent of the doctors.

The income criteria for medicaid are too low, and much too low for many needy older persons who have not gravitated to public assistance. These examples simply emphasize the fundamental need of all poor people. They need more money.

The aged poor sick patients are not being placed in skilled nursing homes promptly; nor do they obtain home health services under medicare part A, because 3 days of hospitalization are required for eligibility. They really cannot afford the services under part B because then they must pay 20 percent of the fees and most of the aged poor do not qualify for medicaid.

Now I am not here to disparage the Social Security Amendments of 1965 which are doing much for older Americans. However, I must emphasize that payment alone does not provide access to care for many older persons who are in desperate need of personal physicians interested in their welfare.

Neither medicare nor medicaid is doing much more than paying providers for services rendered. The hospitals, nursing homes, physicians, appliance houses, and ambulance services are simply paid for services rendered. The defect in the legislation is the lack of emphasis on coordination of health services to promote the prevention of illness and rehabilitation. Hospitals do not ask what care the patient received prior to hospitalization, nor are they interested in what happens to the patient after he leaves.

In general, the health profession has shown little interest in the socioeconomic problems of older persons; nor has it felt a responsibility for bringing health resources to them so that they may live in their communities and not be institutionalized. Our health services generally do not reach out for the isolated, depressed, lonely oldster. Society is now making the health services of the country a whipping boy, and while implementation of controls is laudable and necessary, such controls may simply aggravate the problems for the poor. The providers may well turn away from the elderly and poor and devote their services to the middle class.

I would like to elaborate on some of these statements and make a few recommendations. Medicare did signal a new era in health care for the aged, and indeed for all Americans. Payment for services, now a right, brought dignity to many aged persons who previously gravitated to charity when ill. Many older persons can now cope with both the cost of catastrophic illness as well as day-to-day medical needs. However, that large group which is on fixed minimal income or dependent upon social security for basic income is often unable to cope. They have little money to purchase the drugs which are essential in health care.

Drug costs are often the major health expense for those older persons suffering with chronic illness requiring constant use of medication. Costly drugs for these persons are as necessary to them as food, and without the drugs they cannot maintain their physical and emotional integrity and live independently.

Medications to which I refer are those that are used in the treatment of such common illnesses as cardiac disease, chronic lung disease,

arthritis, diabetes, mental and neurological conditions. Just this week in my office I saw two patients who typify the kind of problems older persons have in meeting drug costs. One patient is a 62-year-old secretary, an anxious depressed person with smoker's emphysema. She has been on necessary drugs and I have been following her for 3 years, and for 10 years she has had an immense drug bill. "Last year I spent $235," she spontaneously told me.

I said, "What will you do when you retire?" and she answered, "I don't know what I'm going to do." She has a marginal income at best. She must work and she should work for emotional reasons. But when she finally retires, $235 a year for drugs, paid out of social security benefits and savings will be a major problem.

The other patient is a hard working butcher who just reached 65, and retired. He has asthma, emphysema, and recurrent respiratory illnesses. This year while under my care he spent $250 for drugs—also necessary drugs, I want to assure you.

Medicaid in some States pays for drugs but many needy aged persons have incomes above the State medicaid levels and with the restrictive Social Security Amendments of 1967 many, many millions of aged persons are being denied the opportunity to become eligible for medicaid. In addition many aged persons refuse to go through what is for them a demeaning means tests required for medicaid.

Maryland has a $1,800 limit for eligibility for a single person for medicaid. If the income per year is $1,900, one is not eligible; $150 a month is the maximum income allowed. Anything above that makes one ineligible for medicaid.

700 Receive Comprehensive Care

We at Sinai Hospital of Baltimore have a comprehensive health service for 700 aged persons requiring continuity of care for chronic illness. All necessary care and the resources of our hospital are brought to these patients 7 days a week, around the clock, in the outpatient department, their homes, the hospital bed or nursing homes by a team of physicians and other health personnel, working in group practice.

With the knowledge we have obtained from these patients and from others seeking aid at our Information Service for the Aged, we are aware of the difficulties that many older persons have in meeting coinsurance payments. With the general increase in fees for services in the last 3 years, the 20 percent copayment may be more than the total payment was prior to medicare. Such has been the escalation of fees. In addition, as emphasized by the committee's reports, real income for the elderly poor has decreased in the last 3 years and this emphasizes the retirement crises faced by older persons.

Poor patients experience a real economic hazard in Baltimore when they need ambulance service for transportation to and from the hospital, if they cannot use public transportation, ambulance services in our area insist upon immediate payment, and do not take assignment. They charge $30 for a single trip, and $60 for the round trip to the hospital outpatient department. Ready cash for ambulance service is not manageable by many of the poor despite reimbursement by medicare of all but 20 percent of the cost.

Patients in our hospital home care program often require home health aides while convalescing. Here, too, unless the patient is eligible for part A, which then pays the entire fee for home health services, near-poor persons cannot afford it. Home health aides are a necessary service for patients who otherwise might have to enter nursing homes and be improperly placed for best care.

Medicare requires 3 days of hospitalization prior to eligibility for extended care services. The intent of Congress was clear that patients were not to be shunted into nursing homes without proper study in hospitals. In addition, the requirement was intended to protect the fund against paying for custodial nursing-home care under medicare.

This requirement really works to the detriment of the medically indigent aged. These people do not have access to hospitals. Physicians treating older persons with mild strokes or recurrent cardiac failure would often prefer to place the patient in a skilled nursing home for convalescent care without prior hospitalization. Since payment for nursing home is dependent on prior hospitalization, the patient must first suffer acute illness requiring immediate hospitalization which often occurs through a hospital emergency service.

Access to Care for Elderly Poor

Our new health legislation for the aged has done little to make access to ordinary health care easier for the elderly poor. Payment for care does not equal access to care. It is true that when the aged sick finally reach the hospital they are now admitted with less resistance than they encountered formerly since payment for hospitalization is authorized. However, older persons need primary physicians—personal family doctors—interested in their welfare to become responsible for the maintenance of their health. The facts are that these patients are not being cared for by such physicians. The few remaining general practitioners have almost disappeared from ghetto areas where many of the aged poor live. The well-being of the aged would be much improved by more frontline practitioners of medicine.

In addition to finding physicians to care for them, many of the elderly with limited income are in real trouble in their relationship to doctors who are unwilling to accept assignment and insist that full fees be paid to them with the patient then waiting for reimbursement from the intermediary. I would expect under controls now contemplated that doctors will become more hesitant to accept assignment.

However, the aged need much more than mere physician services. They need the reorganization of our health services in the interest of the consumer rather than primarily that of the provider. What this means is group practice of medicine with a rationale use of health manpower and the development of health care teams to meet patient needs. In addition, individual incentives, that is, payment to providers for performing fragmented care must be changed into group incentives for the providers who then effectively become responsible to the consumer for comprehensive care—a total health package.

There is also the need for a new health service, consumers review boards at the local level, to monitor the effectiveness of health services. Professional peer review of health services, necessary as they are, will not meet the needs of the consumers who are primarily interested in

the sensitivity and the dignity with which care is given. Consumers have become alienated from the providers by the latter's apparent indifference to patient needs. The providers have not educated the patients in the use of our present health care system nor have they involved them in the development of new necessary health services, unmet needs, so that patients can be better served.

Recommendations

Now some recommendations. Though our society is faced with inflationary costs of health services, it is not proper to punish the poor and elderly, and especially the elderly poor, because cost controls were not effectively structured originally in medicare and medicaid, and are also being implemented.

(1) Drugs should now be included as benefits in new legislative proposals. Emphasis on generic prescribing is of course indicated. No drug program should be mandated by Congress without including well-thought-out controls on the quality of prescribing and the maluse of drugs.

(2) The coinsurance features, the deductibles in the present medicare legislation, warrant a second look. They are wrong in principle, for it is the doctor who orders the health services and it is he that should become responsible for the proper use of health resources. From observation of patient difficulties as well as those of providers, the administration of this program may cost the fund as much as it is said to save. Coinsurance has certainly not prevented overuse of service.

(3) The mandatory 3-day hospitalization required to obtain post-hospitalization benefits also merits review. Any alteration of this provision, however, should not encourage movement of patients into nursing homes without considering alternative methods of care. I am certain that Dr. Haughton will speak to this problem. A good, hard look needs to be taken at this time at the accelerated placement of patients in nursing homes because such care is funded. The nursing-home provisions of medicare and medicaid may have slowed the development of more socially useful modalities of care for the aged. I refer to such necessary health resources for the elderly as protective housing, visiting housekeepers, meals-on-wheels and a variety of other services which would be included.

Finally, I want to digress and emphasize a point that has already been made in previous testimony; and that is that you should consider appropriate funding to pay for more teachers in the medical schools, more scholarships for medical students. Some of the medical schools are dragging their feet, not radically increasing their enrollment of qualified medical students. We need a crash program now in our present medical school facilities, and we need to keep these medical schools open year around. Then we might rapidly approach a student body double the present enrollment in the medical schools.

Senator Yarborough. Would the doctor yield? About how long do you think, Doctor, if we had the will to do it, we could double the enrollment in medical schools?

Dr. Fürstenberg. I think it could be accomplished in 3 to 5 years with appropriate incentives. Such incentives would divert some pri-

mary research funds into funds for medical school teachers which is society's need at this time. I do not mean to downgrade research but at this point society needs not 9,000 medical graduates a year but 18,000 a year.

Senator YARBOROUGH. Senator Saxbe pointed out the great cost to the student that is a terrible drain on him and his family, wherever he gets the resources, but despite that in my State we have three times as many students qualified applying as can be admitted or as they do admit. We know that this problem is not in the failure of people who have the will to go and meet this terrifically high cost and the very rigid standards, it is a failure to furnish the facilities to let them be educated to help meet the great need in American society.

Dr. FURSTENBERG. I certainly agree with you, Senator Yarborough. We should not, and I might say that it is a national disgrace for us to be an importer nation of physicians at this time, draining physicians, as you well put it, from underdeveloped nations which need their doctors so desperately. More than 3,000 foreign physicians permanently immigrate to this country each year. We should be exporting American physicians to supply the needs of less affluent nations.

Senator YARBOROUGH. We deny our own young men and women the chance for education and we bleed the rest of the world when we ought to be educating enough doctors to let many who have the will to be medical missionaries, not in a religious sense but they want to serve the underdeveloped nations. We should be educating thousands more than we are, the richest, most affluent nation on earth. I think it is a national disgrace and national scandal that we will not open the medical schools to educated young men and women of America who are dedicated and have the service and intellectual capacity to enter those schools.

Dr. FURSTENBERG. Much is now happening in this area because medical schools are really shaken up by recent events and sometimes by their own medical students who are challenging their goals.

Senator YARBOROUGH. The AMA was shaken up some by their own members last week.

CHANGES IN CURRICULUM

Dr. FURSTENBERG. We also need an appropriately changed medical curriculum to encourage the practice of primary medicine rather than just research and medical specialization, otherwise we will be left with the two-class health system. The middle class will continue to be served by physicians and the poor largely served by other health personnel.

At this time there is almost no competition in medicine, there is no free market. Patients desperately seek personal physicians. With the limited number of graduates, this monopoly by the providers, the physicians, will continue. Even were Congress to act now to increase the number of physician graduates decidedly, its impact in the practice of medicine would not become effective for nearly a decade.

Senator YARBOROUGH. You mean because there is such a great shortage?

Dr. FURSTENBERG. Yes.

Senator YARBOROUGH. It would take a decade to fill the gap even if we found out at this time?

Dr. FURSTENBERG. Yes, that is right.

Senator YARBOROUGH. And we have a greater population?

Dr. FURSTENBERG. Yes.

Senator YARBOROUGH. And a greater affluence, more people able to pay for medicine?

Dr. FURSTENBERG. Yes.

Senator MOSS. Even if we doubled the input, it would take 4 or 5 or 7 years before they began to come out and practice?

Dr. FURSTENBERG. We could probably restructure the curriculum and design it to graduate qualified physicians in less than the standard 4 years.

Senator YARBOROUGH. Doctor, this is something rather personal, but I have a nephew in the Green Berets and in each squadron of eight they assign one as medic. He had no medical leanings, he is a fighter, too. One out of every eight of a squadron has to be the medic to treat the others. They sent him down to Fort Bragg and pretty soon he was engaged in vivisection of animals and amputating legs and things, and now he sews people up and works on them. When they are out there on the combat line, if a man's stomach is blown open with a grenade, he sews him up. He has to amputate sometimes if they are out where they cannot get helicopters. I was astonished to learn this was common practice in the Green Berets. He has his fighting gear, his submachinegun; he fights and shoots. The ones cut to pieces by fire, he sews them up until they get back. He learned that down at Fort Bragg. One out of every eight in the squadron is a medic.

SHORTAGES IN NURSING

Dr. FURSTENBERG. I am not for downgrading medical training, but society's need for accelerated training of physicians is paramount now.

We also need to greatly increase the number of professional nurse graduates. They are key personal in health care in the chronic disease field, especially for the aged. Our health establishment cannot be manned with quality bedside nursing in the hospital, the nursing home, or in the community without a large increase in the number of competent nurses. We suffer from a tremendous shortage of nurses in our country at this time. Here, too, special incentives must be developed to increase the flow of nursing students into their training schools. They are not under such stress at this time. I think there was only a 4-percent increase in nursing enrollment last year. Special attention should be given to this problem.

Minority groups are not entering nursing, there are few men in the nursing field. There has not been any real change in the percentage of minority groups in the last 6 or 8 years. We must, without putting any more money into the system, reorganize——

Senator YARBOROUGH. Mr. Chairman, this doctor is so knowledgeable on this and I have been listening to testimony for at least 11½ years with Senator Lister Hill. We have now in addition to the registered nurses practical or vocational nurses in this country—in some States called practical nurses and in some States called vocational nurses. In my State they must take a year or a year and a half of schooling to get this license. The two together are not enough.

Many hospitals in my State have just women sitters. They had no practical nurse training. You cannot even hire vocational nurses. To what do you attribute the great opposition of the registered nurses to the vocational nurses? When you add the two together they do not even fill the hospital needs.

Dr. FURSTENBERG. Professions all maintain rigid criteria for certification. There is a certain rigidity in all professions.

Senator YARBOROUGH. The social security has put up such regulations on hospitals that your practical and vocational nurses cannot qualify under social security for payments if they are using certain vocational or practical nurses.

Mr. Chairman, I think this is a question some of our committees need to explore because practical nurses do not attempt to be registered nurses even in their limited field but they want to improve the hospital for payment. In my State you cannot get either one.

Senator MUSKIE. You have sitters.

Senator YARBOROUGH. They call them sitters. They thank you for being somebody with any nurse's training.

Dr. FURSTENBERG. There are real shortages of the entire nursing team and we have a lot to do in this area with new methods of delivering nursing services. We need professionally qualified personnel to direct nursing services or quality of care suffers. One must have competent, intelligent professionals with leadership capacities at the head of any health care team, and nursing is one of the areas of professional service which is mandatory in health care.

Senator YARBOROUGH. We agree with that, Doctor, but of course the practical nurse has limited scope; she cannot give injections and things like that. They all know that their duties are limited. But it seems to me that when you point out only 4-percent enrollment in registered nurses, the vast increase in hospitalization going on, that you should write regulations over in social security. That we cannot even keep those hospitals open with practical nurses is a folly.

REORGANIZING SERVICES AROUND PATIENTS

Dr. FURSTENBERG. Furthermore, we have to develop the health services so that they are reorganized around the patients as they live in the community. This means the development of group practice in hospital-based or neighborhood health centers. Such groups then will become effective by including social workers and other personnel to become responsible for the socioeconomic factors in health care and housing and work and recreation, all of which are very necessary in the adjustment of the aged in the community. Then the health professions could properly become the consumer's ombudsman and press to maintain the elderly in the community by services in the home, be they visiting homemakers or meals-on-wheels or other resources.

Furthermore, we cannot continue to authorize payment for more of what we now have without a definite change both in the delivery system and the method of payment. Under medicare and medicaid, we have simply paid individual and institutional health entrepreneurs for fragmented care by usual and customary fees or cost. For the elderly poor this has to often resulted in bad care by emphasizing

crisis medicine with admission to hospitals through emergency services. Again I say we should alter individual provider payment to prepayment for total health services with financial incentives for improved services shared by all health personnel.

However sensitive the providers become to the necessary health services, health is too important to be monitored by the professionals alone. Your committee should now consider consumer review boards for health services to work at the local level. Such consumer boards should be funded and staffed. Consumer participation is necessary in judging the effectiveness of any delivery system, the one we have now, "our nonsystem," and any new program for delivery care.

I have just read the advisory committee's fine new report on Health Aspects of the Economics of Aging. I conclude by saying I agree with its findings and I endorse its formulation for public policy.

Thank you.

(The prepared statement of Dr. Furstenberg follows:)

PREPARED STATEMENT OF FRANK F. FURSTENBERG, M.D., ASSOCIATE DIRECTOR FOR PROGRAM DEVELOPMENT, SINAI HOSPITAL, BALTIMORE, MD.

Thank you for the opportunity to testify on some of the health problems of the elderly with limited income. Your committee, in earlier hearings, has received much testimony documenting the many difficulties older persons, especially older poor persons, are having in coping with the rapidly rising costs of medical services as well as the problems they meet in obtaining prompt access to health care.

Both medicare and medicaid have left major problems in health services for older poor sick persons which fall into a number of areas. Money to pay for drugs is a major concern. They also lack money for the 20 percent coinsurance under part B of medicare, and many find it difficult to pay the fees of physicians unwilling to accept assignment. Income criteria for eligibility for medicaid are too low for many needy older persons. These examples merely emphasize the fundamental need of all the poor; their need for more money.

Often the aged poor sick patients are not placed in skilled nursing homes nor do they obtain home health services under medicare part A, because 3 days of hospitalization is required for eligibility. They really can't afford these services under part B, for then they must pay 20 percent of the fees if they do not qualify for medicaid.

It is not my intention to disparage the Social Security Amendments of 1965 which are doing much for the older Americans, however, payment did not solve access to care for many elderly poor in desperate need of personal family doctors interested in their total welfare.

Neither medicare nor medicaid are doing much more than simply paying providers for the services rendered. There is very little emphasis on coordination of services to promote prevention of illness and rehabilitation. The health profession has shown little interest in the socio-economic problems of older persons nor felt a responsibility for bringing health resources to them so that they may live in the community and not be institutionalized. Our health services generally do not reach out for the isolated, depressed, lonely oldster. Society is making the health services of the Country a whipping-boy—and cost controls developed in the last few weeks are laudable and necessary, but these controls will not necessarily improve services. I'd like to elaborate on some of my statements and make a few recommendations.

Medicare signalled a new era in health care for the aged—indeed, for all Americans! Payment for services now a right—brought dignity to many aged persons who previously gravitated to charity when ill. Now, perhaps, two-thirds of all older persons can cope with the costs of both catastrophic illness as well as day-to-day medical needs. However, that third on fixed minimal incomes or dependent upon Social Security for basic income are often unable to purchase the drugs essential in health care. Drug costs are often the major health expense for those older persons suffering chronic illnesses requiring constant use of medication. Costly drugs are as necessary to them as food and without which they cannot maintain physical and emotional integrity and live independently.

Medications to which I refer are those used in the treatment of cardiac disease, chronic lung disease, diabetes, mental and neurological conditions. While medicaid in some states pays for these drugs, many needy aged persons are above the State medicaid levels, and with the restrictive Social Security amendments of 1967, many medically-indigent persons are denied the opportunity to become eligible for medicaid. In addition, many aged persons refuse to go through the demanding means test required for eligibility for medicaid.

We, at Sniai Hospital of Baltimore, have a comprehensive health service for 700 aged persons requiring continuity of care for chronic illness. All necessary care and the resources of our hospital are brought to these patients seven days a week—around-the-clock—in the outpatient department, their homes, the hospital bed or nursing homes by a team of physicians and other health personnel, working in group practice. Each patient has his own personal physician. With the knowledge we've obtained from these patients and from others seeking aid in our Information Service for the Aged, we are aware of the difficulties that many older persons have in paying the co-insurance features under part B, of medicare. With the general increase in fees for services in the last three years, this 20% payment may be more than the total payment was *prior to medicare.* In addition, the real income of the elderly poor is decreasing in the last three years emphasized so well in your committee's paper, "Economics of Aging: Toward a full share in abundance."

Another economic hazard is ambulance service to and from the hospital for persons unable to use ordinary transportation. Ambulance services in our area insist upon immediate payment, $30 for a single trip—$60 for the round trip to the Hospital Outpatient Department. Ready cash for ambulance service is not maneageable by many of the poor despite reimbursement by medicare of the 80% of the fee.

Patients in our hospital home care program often require home health aides for convalescence. Here, too, unless the patient is eligible for part A. which pays the entire fee for home health services, near-poor persons not eligible for medicaid cannot afford to pay 20% of the fees for home health aides necessary for 20 hours or more a week for several weeks after hospitalization. I am not referring here to the many thousands of aged widows and feeble couples living independently who should have visiting housekeepers on a long-term basis.

Medicare requires 3 days hospitalization prior to the placement in nursing homes. The intent was clear—to insure that patients were not routed to nursing homes without proper studies as well as the protection of the Fund against paying for custodial nursing-home care under Medicare. This requirement works to the detriment of the medically-indigent aged. These patients do not have easy access to hospitals crowded with acute illness. Physicians treating older persons with mild strokes, recurrent cardiac failure, would often prefer to place such elderly patient must first suffer acute illness requiring immediate hospitalization which Since payment for nursing home is dependent on prior hospitalization, the patient must first suffer acute illness rquiring immediate hospitalization which often occurs through a hospital emergency service.

Our new health legislation for the aged has done little to make access to ordinary health care easier for the elderly poor. Payment for care does not equal access to care! It is true that when the aged sick finally reach the hospital they are now admitted with less resistance than they encountered formerly since payment for hospitalization is authorized. However, older persons need primary physicians—personal family doctors—interested in their welfare become responsible for the maintenance of their health. The facts are that these patients are not being cared for by such physicians. The few remaining general practitioners have almost disappeared from the ghetto areas where many of the aged poor live. The well being of the aged would be much improved by more front-line practitioners of medicine.

In addition to finding physicians to care for them, many of the elderly with limited income are in real trouble in their relationship to doctors who are unwilling to accept assignment and insist that full fees be paid to them with the patient then waiting for reimbursement from the intermediary. With few schedules imminent physicians may become more reluctant to accept assignment.

However, the aged need much more than mere physician services. They need the reorganization of our health services in the interest of the consumer rather than primarily that of the provider. This means the group practice of medicine with a rational use of health manpower and the development of health-care

teams to meet patient needs. In addition, individual incentives, that is, payment to providers for performing fragmented care (the norm today) must be changed into group incentives for the providers who then become responsible to the consumer for comprehensive care—total health services.

There is now the need for a new health service, consumers' review boards at the local level, to monitor the effectiveness of health services. Professional peer review of health services, necessary as they are, will not meet the needs of the consumers who are primarily interested in the sensitivity and the dignity with which care is given. Consumers have become alienated from the providers by the latter's apparent indifference to patient needs. The providers have not educated the patients in the use of our present health care system nor have they involved them in the development of new necessary health services, unmet needs, so that patients can be better served.

RECOMMENDATIONS

Some recommendations flow from my remarks: Though society is faced with inflationary costs of health services, it is not proper to punish the elderly poor because cost controls were not effectively structured into Medicare and Medicaid legislation.

(1) Drugs should now be included as benefits in new legislative proposals. A formulary with emphasis on generic prescribing is of course indicated. No drug program should be mandated by Congress without including well-thought-out controls on the quality of prescribing and the maluse of drugs.

(2) The co-insurance features, the deductibles in the present Medicare legislation, warrant a second look. They are wrong in principle, for it is the doctor who orders the health services and it is he that should become responsible for the proper use of health resources. From observation of patient difficulties as well as those of providers, the administration of this program may cost the fund as much as it is said to save. Co-insurance has certainly not prevented overuse of service.

(3) The mandatory 3-day hospitalization required to obtain post-hospitalization benefits also merits review. Any alteration of this provision, however, should not encourage movement of patients into nursing homes without considering alternative methods of care. Indeed, a good hard look needs to be taken at this time at the accelerated placement of patients in nursing homes because such care is now funded. The nursing-home provisions of Medicare and Medicaid may have slowed the development of more socially-useful modalities of care for the aged. I refer to such necessary health resources for the elderly as protective housing, visiting housekeepers and Meals-On-Wheels.

(4) I urge this committee to consider appropriate funding to pay for *more teachers* in the medical schools and *more scholarships* for *medical students*. A crash program to keep medical schools open year 'round could rapidly double their enrollment. We need twice as many medical graduates educated in an appropriately changed medical curriculum to encourage the practice of primary medicine rather than research or specialization, otherwise we will be left with the two-class health system we now have. The middle class will continue to be served by physicians and the poor largely served by other health personnel. At this time, there is almost no competition in medicine. Patients desperately seek personal physicians. With the limited number of graduates, this monopoly by the providers—the physicians—will continue. Even were Congress to act now to increase the number of physician graduates decidedly, its impact in the practice of medicine would not become effective for nearly a decade.

(5) We must also train a greatly increased number of professional nurses. Our health establishment cannot be manned with quality bedside nursing in the hospital, nursing home or the community without a large increase of competent nurses. With the tremendous shortage of nurses, special efforts and special appropriations are necessary to meet society's mounting need for nurses by increased student enrollment at all levels of professional nurses training.

(6) Health services must be reorganized around the needs of patients as they live in the community. This means development of group practice with all health practitioners working together in hospital-based or neighborhood health centers. Such groups then become competent to include in their responsibility such socio-economic factors as adequate housing, work, recreation—all of which are necessary in adjustment of the aged in the community. Then the health professions could become consumers ombudsmen and press for adequate health re-

sources to maintain the elderly in the community by services at home—be they visiting homemakes, Meals-On-Wheels or transportation.

(7) Furthermore, we cannot continue to authorize payment for more of what we now have without a definite change both in the delivery system and the method of payment. Under Medicare and Medicaid, we have simply paid individual and institutional health entrepreneurs for fragmented care by usual and customary fees or cost. For the elderly poor this has too often resulted in bad care by emphasizing crisis medicine with admission to hospitals through emergency services. We should then alter individual provider payment to prepayment for total health services with financial incentives for improved services shared by all health personnel.

(8) However sensitive the providers become to the necessary health services, health is too important to be monitored alone by the professionals. Your committee should now consider consumer review boards for health services to work at the local level. Such consumer boards should be funded and staffed. Consumer participation is necessary in judging the effectiveness of any delivery system, the one we have now, "our non-system," and any new programs for delivery of care.

I am certain a hard-headed budget officer would and should ask, "Will the services proposed be less expensive to society?" Obviously, one cannot predict that they will—but we can be certain that the answer is not more of what we are doing at present—paying for fragmented care and developing more and more institutional care for many of the sick elderly persons in chronic disease facilities, nursing homes and mental institutions. We are late in realigning priorities in our society. We need both intent and money to treat the elderly with dignity and to give them the health services they need to keep them independent. "Does our society owe all persons a good life?" My answer is, of course, "Yes." And I add that any society can be measured by the sensitivity of its treatment of the older citizens who deserve both financial and health security.

Senator MUSKIE. Thank you very much, Dr. Furstenberg, for your excellent testimony.

May I ask Dr. Haughton now to present his statement.

I am sorry the questioning period is necessarily limited. We are not going to do justice to you gentlemen.

STATEMENT OF DR. HAUGHTON

Dr. HAUGHTON. I am Dr. James G. Haughton, first deputy administrator of New York City's Health Services Administration.

Mr. Chairman and members of the committee, I welcome the opportunity to speak on the subject of "Health Aspects of the Economics of Aging." For the past 7 years, first on assignment by the New York City Health Department to administer and direct the medical programs of the New York City Welfare Department, and more recently in my present position I have been constantly faced with the health problems of the aging and their economic consequences.

Our over 65 population carry an economic burden due to health care costs that would be difficult even for a younger working population, and they carry it at a time in life when they are living on reduced, fixed and sometimes almost nonexistent incomes.

The social security system conceived in a period of national financial crisis has not kept pace with the Nation's financial recovery and transformation into an affluent society. Our dedication to the principles of individual initiative has caused us to misjudge human nature and has deterred us from realistically establishing national priorities which might have lead to more realistic social insurance programs for retirement income and health care coverage. As a result, large groups of our population supposedly protected from poverty and the

costs of health care by social insurance programs find themselves on public assistance and medical assistance.

Mr. Chairman, people do not, as a rule, willingly plan for illness and old age. These are not subjects on which people like to dwell, and furthermore, the advent of illness is quite unpredictable. I don't know whether it is common knowledge that more than 50 percent of the 55,000 persons receiving old age assistance in New York City are simultaneously receiving social security benefits which are so low that they must be subsidized by these welfare payments. Neither am I sure whether it is commonly known that 41 percent of the persons receiving medicaid assistance nationally are over 65 and that expenditures on their behalf represent 45 percent of medicaid costs.

Social Insurance Programs: Inadequate

All this tells me that our social insurance programs are inadequate and that we are using a notably inefficient and administratively costly welfare system to subsidize what is generally recognized as a very efficient but financially inadequate social insurance system. That somehow seems a bit foolish from a purely managerial point of view.

It has been established by careful studies that most persons over 65 can be expected to have one or more chronic ailments requiring continuing treatment. The drug costs relating to these disorders may be sufficient to spell the difference between a social security beneficiary's financial independence and his need for public assistance. This is so since drugs are not a medicare benefit and since some States do not provide all drugs in their medicaid (title XIX) program and some States have not yet implemented title XIX for the medically needy.

Institutional care for the aging has been and continues to be under both titles XVIII and XIX, a major element of expenditure. Much of this expenditure is inappropriate and related to our serious lack of appropriate social alternatives for the care of the aging. It is estimated that at least 10 percent of the nursing home residents in New York City are unnecessarily institutionalized for this reason. Many of them could be discharged to their homes, and many hospital stays could be reduced by days and sometimes weeks if homemaker services could be provided.

Although it is true that homemakers are not always available, even when they are, neither medicare, medicaid, nor voluntary or private insurance will pay for their services. As a result, aging persons remain expensively institutionalized in nursing homes and hospitals at public expense.

In both Federal programs, home health aides are provided for, but frequently their availability is so hedged in by administrative barriers that the service is not accessible to the needy beneficiary.

In this connection it is important to note that a bill now numbered H.R. 10296 introduced on April 21, 1969, by Congressman Jacob H. Gilbert, of New York City, proposes to amend title XVIII of Public Law 89–97 (medicare) to authorize payment for what he calls home maintenance services. He defines home maintenance service includes housecleaning, laundry, cooking, and shopping and under this amendment would be furnished to an individual in his own home by a certified home health agency as part of a home health service plan.

The medicare law as it now reads permits these services only when personal care (such as bathing and toileting) is necessary. The amendment would permit home maintenance services without personal care or in addition to it. This is an important piece of legislation and should be supported because frequently an older person is under medical supervision at home and is unable to perform these services for himself, even though he may not need personal care. Frequently these persons are institutionalized at great expense because these services are not available to them as a medicare benefit.

Long-Term Institutional Care

Long-term institutional care has always been a problem to the elderly and to their families because in most parts of the country where there is high population density, nursing homes and homes for the aged do not exist in adequate numbers. Since most nursing homes are profit-making institutions, the circumstances of supply and demand in this seller's market have put the price of nursing home care out of the reach of most families and most of the cost of such services therefore becomes a burden upon the community and the Nation. Anything we can do to appropriately decrease this demand should therefore be considered a worthwhile investment both socially and financially.

Under the heading of "worthwhile investment" should come great emphasis on preventive services, and I mean this in its broadest sense. One of the major mistakes in title XVIII (medicare) is the exclusion of routine physical examinations in a population which is known to suffer from ailments, some of which begin insidiously and in which disability can be prevented or at least delayed if diagnosis is made early. When amendments to the law are considered, this defect should be corrected.

But an equally important area for prevention is social in nature with health implications. There is a growing number of the elderly aged, those over 75, who become progressively feebler and are therefore less able to move about. In New York City alone it is estimated that there are about 50,000 persons over 80 years of age. Some of these are in nursing homes and homes for the aged, but the preponderant majority are still in their own homes, and some, of course, live with relatives.

This large number living alone represents a serious problem in almost every metropolitan center. They rapidly become isolated, lonely, and depressed when they reach the point where it is no longer possible for them to get about easily. This isolation soon leads to fear, alienation, and disorientation. We have frequently had cases in which such older persons were so alienated and fearful of the outside world that they have refused homemaker or housekeeper assistance even when they obviously needed it. Many of them live in single room occupancy dwellings and have become a hazard to themselves and to their neighbors because they sometimes forget to turn off gas-burning stoves and so on.

In such instances we have been forced to seek police assistance to remove them from the premises and to conduct them to an emergency psychiatric hospital for observation or evaluation. Sometimes this

solves the problem because the hospital after brief treatment will discharge them to a nursing home or a home for the aged where, if the care is good, such patients will begin the process of resocialization and live out their remaining years under acceptable circumstances.

Frequently, however, the admission to a receiving psychiatric hospital is only the beginning of a long and frustrating process in which the patient may be discharged back to his single room only to begin the process of alienation and disorientation again with predictable results, or in which he may be sent to a State psychiatric hospital which may refuse him as "not amenable" to treatment or may accept him for very brief treatment. In both instances he is soon back in an inappropriate living circumstance which is destructive.

While it is true that many of the elderly aged who become actors in these depressing dramas have physical causes for their problems, such as cerebral arteriosclerosis (hardening of the arteries), which are irreversible and perhaps not preventable, it is equally true that there is another large number whose deterioration can be prevented if we take the necessary steps to keep them involved in the process of living.

"Visiting Companion Service"

In New York City the Citizens' Committee on Aging of the Community Council of Greater New York in cooperation with the Association for Homemaker Service and several health agencies have recently inaugurated a, "Visiting Companion Service." This is a paid friendly visiting and escort service. These friendly visitors are younger aged persons who empathize with their older neighbors. They visit as needed, escort to church, clinic or other place of service, and are supervised by a person to whom they can relay the needs of their charges and who can then attempt to use the community's resources to meet those needs. Some say this is a paid buddy system, and this is precisely what it is. This is a preventive service not only for the shut-ins who are being visited, but also for the visitors who benefit from the sense of being needed and who are helped by those earnings to maintain their own financial independence. We believe that this will be a successful program and hope that funds will become available for its expansion.

Isolates on "Skid Row"

Another group of aging persons whom I want to mention briefly are the old men who live on the skid rows of every large American city. There is a tendency to mark these off as alcoholic derelicts whom no one can help. Our experience in New York City is that a sizable number of these old men are neither alcoholics nor derelicts, but when your only income is a social security pension of $60 per month and you are too proud to accept welfare assistance because you consider it charity, where else can you get a meal for 50 or 75 cents and where else can you get a bed and a roof over your head for 25 cents per night? Many of these persons do become a health concern because the circumstances of their lives do expose them and make them more susceptible to disease such as tuberculosis, and they respond poorly to treatment because frequently they suffer from malnutrition.

I would like to mention briefly a crisis which has been created in New York State by a recent directive of the State department of mental hygiene. In June 1968 that department, without any prior consultation with local health and welfare agencies, issued a memorandum to directors of all State psychiatric hospitals reminding them of their responsibility under the law to admit only those patients who were clearly amenable to "psychiatric care and treatment." The memorandum went on to stress the admissions of older patients, "where we believe most abuse of this principle occurs."

The interpretation given this directive by some hospital directors has lead to the exclusion of many older people with chronic psychiatric disorders and arteriosclerotic brain syndromes from these hospitals. In New York City alone we anticipate that this policy will affect 2,000 persons per year who will then either remain in very expensive acute hospital beds, the very few nursing homes or homes for the aged which will accept such patients, or return to their own homes to continue through the revolving door process.

We do not argue with the principle that psychiatric hospitals should be primarily for the care of those who can benefit from treatment, but what is to become of those older chronically ill persons who require a psychiatrically oriented environment? The State psychiatric hospital is presently the only logical available resource, and if these are to be closed to this population we are indeed faced with a crisis.

We have accepted the assumption that this is not totally a health problem, but that long before these unfortunate persons reach the doors of a State hospital from which they are turned away, we as a community have made a number of social mistakes. We have, therefore, organized a task force in the city's office of aging composed of representatives of public and private agencies to plan alternatives to State hospital admissions of aging perons. The charge to this task force is to plan short-range solutions which can be implemented immediately and to make long-range recommendations which may prevent the cases which are preventable. This task force has already developed an interim report which is being put into final form and can be made available to your subcommittee when it is completed since it may contain legislative proposals.

Gaps in Medicare, Medicaid Fee Arrangements

Finally, I would like to bring to this committee's attention the problem of the medicare beneficiary in States which have not implemented medicaid for the medically needy, and the beneficiary whose income is above the State's eligibility level. As you no doubt know, payments to private practitioners in the medicare program are based on the customary charges of the practitioner and on the prevailing fees in the service area.

Social Security Administration guidelines provide that the fiscal intermediary may pay as a maximum fee for any given service an amount equal to about the 83d percentile of the range of prevailing charges for that service in that area. The beneficiary, of course, does not know what the maximum fee is and therefore pays whatever the practitioner charges with the full expectation of being reimbursed 80 percent of what he has paid.

He is frequently disappointed and outraged to find that the fee he paid is considerably above the Federal maximum, and that he is reimbursed against that maximum instead of against what he actually paid.

For example, my own mother visited two specialists during the past 3 months. On both occasions she was charged $25 and was reimbursed 80 percent of $15, so that although the Federal contribution in each case was $12, she still paid $13 for each visit—a considerable outlay for an older person living on limited income.

In view of the fact that the principle of "usual and customary charges" is written into the medicare law and is now being applied in some medicaid programs as well, I am not sure what the Congress can do to help the elderly deal with this problem, but I think you should at least be aware that this is happening.

In conclusion, it might be appropriate to point out that while it is laudable that this committee should address itself to the subject matter it has been assigned, there is a much more serious issue to which both the Congress as a whole and the Nation must address themselves.

The principle of "health care as an individual right of every American" has been piously mouthed by many in and out of Government in recent years, but so far it has merely been rhetoric and sloganeering. The passage of Public Law 89-97 led many of us to believe that finally the Nation had recognized the primacy of health and health services as an important national priority, but none of the subsequent actions of the Congress and of State legislatures have supported that belief. My own State legislature in New York in two rounds of absolutely insane legislation has cut the heart out of our medicaid program.

The issue therefore is whether or not health is to be an important national priority. If it is to be, then we must address ourselves not only to the financial aspects of the problem but to the proper organization of our resources for the delivery of health care. Our present system is antiquated, inefficient, discriminatory, and unworkable. There are those who will vigorously oppose change because the status quo has been good to them, but responsible government and leadership demand that the executive and legislative branches of our Nation's Government address themselves to the resolution of these problems even when to do so may mean attacking and overturning powerful vested private interests in favor of the public good.

This is the challenge you face, gentlemen, and I and millions of our citizens pray that your courage and wisdom may be equal to the task before you, because the health-related problems of the aging will never be solved except within the framework of solutions for all our people.

Thank you.

Senator MUSKIE. Thank you, Dr. Haughton.

May I say that the insights which you and Dr. Fürstenberg and the other witnesses have given us are respected, and the testimony of practicing physicians has been tremendously helpful to us. I especially appreciate these two papers that you two gentlemen have given us because you have shed light on the other side of the problem which we see from the financial end. As important as those two elements are, we cannot really grasp the impact of what we do with the problem unless we see it through the eyes which they give us.

The report you mention on page 8 of your testimony about the task force is welcome.

Dr. HAUGHTON. I will see that you receive it.

Senator MUSKIE. We will appreciate getting it.

Dr. Furstenberg, on page 3 of your testimony there appears to be a very unusual service which you provide in the Sinai Hospital in comprehensive health service for 700 aged persons requiring continuity of care for chronic illness.

Is there any way which you could supplement the comments you made with respect to that program to give us further insights? We would appreciate receiving it.

I repeat, I especially enjoyed your testimony; it has given us the other side of this problem. Whether or not we can put together the financial resources necessary to do the job, I am not sure at this point. You give us tremendous motivation, at least, to work in that direction.

Dr. FURSTENBERG. Thank you.

Senator MUSKIE. The advisory committee will submit questions to you on the material which you have given us this morning.

(Subsequent to the hearing, the chairman submitted the following question to the witness:)

From your experience would you tell us what can be done to safeguard the quality of medical care given in the Medicaid and Medicare programs—particularly out-of-hospital services?

(The following reply was received:)

THE CITY OF NEW YORK
HEALTH SERVICES ADMINISTRATION,
August 25, 1969.

DEAR SENATOR MUSKIE: This is in reply to your letter of August 12, 1969.

It was indeed a pleasure to testify before your Subcommittee on Health of the Elderly and although time did not permit further exploration of some of the matters I presented, I am pleased that you found my testimony helpful and will be happy to participate in any future hearings in which some of these points can be developed.

The question raised with regard to safeguarding the quality of medical care given in the Medicaid and Medicare programs is one of the most pressing problems facing the field of health care today. A number of leaders in the organized professions have taken the position that the question is inappropriate since no one has know-how to define what is quality care; furthermore, they take the position that professional people in the health field are people of integrity and make a constant effort to maintain the quality of services they provide. Thus, no outside surveillance is necessary.

My own experience as a health administrator in the past seven years, plus my fifteen years of experience as a private practitioner, leads me to the conclusion that it would be irresponsible for those who are responsible for the expenditure of large sums of public funds to ignore the questions, since as purchasers of health care we must exercise some responsibility for the quality of the product we purchase. The real question, therefore, is not whether there should be surveillance, but how the surveillance should be exercised.

The major problem is how to establish norms against which care can be measured. Establishing such norms is sometimes difficult since there are frequently honest differences of opinion between health experts with regard to what is appropriate for adequate care in any given situation. The most competent health professionals frequently are loathe to participate in the activities of committees which attempt to establish such norms, since they wish to avoid the kinds of disputes and confrontations which frequently ensue when these attempts are made.

Here in New York City we have had some measure of success in monitoring the quality of the care we purchase. We began our program by routinely reviewing the cases of providers who submitted claims of $4,000. or more. This review

was fiscal, as well as medical. As we gained experience we expanded our review process to include a sample of all claims regardless of amounts. We have tried to carry out this procedure as an educational activity rather than as a police action. We have found most private practitioners willing to have their cases reviewed and have encountered very few instances of medical or financial abuses. We believe that the knowledge that this monitoring activity is being carried out has in itself been a deterrent to abuses.

One of our major tools in our attempts to safeguard the quality of care we purchase from private practitioners has been the establishment of standards for the participation of such practitioners. All professional participants in our program are required to meet standards for continuing education. General practitioners in all of the professions are required to meet the continuing education requirements of their appropriate academies of general practice. Specialists must be either board eligible or board certified in their specialties. A medical general practitioner may also qualify by having a staff appointment in a teaching hospital and by participating in the educational activities of his hospital. While the State Health Department, which is responsible for the supervision of that part of our program, has been less than vigorous in the implementation of these standards, we feel that the existence of such standards has in itself improved the quality of the program.

We are now in the process of developing utilization review procedures which, we believe, will further strengthen our attempts to upgrade the quality of the care which the beneficiaries of these public programs receive. It should not be overlooked that these attempts to improve and safeguard the quality of services received by those whose care is financed by government, have a fallout effect by improving the care received by those who pay privately for their care, since it is difficult for a private practitioner to do less for his private paying patient than his public patient.

We find it very heartening that one state medical association in the State of Oregon has passed a resolution requiring continuing education as a condition of membership in the association. If other professional organizations in the health field will follow that example, it will make the job of those of us who work in government much simpler. Pending the arrival of that millennium, however, we must continue our efforts to safeguard the quality of care. One way to speed the arrival of that day would be for federal regulations to require that in states where such standards are not a requirement for membership in the state association that the state agency administering a federal program be required to establish such standards.

One of the impediments to improvement of the quality of health services is the archaic delivery system which we persist in using. Our present pattern of private practice has not met the health needs of our nation adequately and yet we persist in stating in each piece of federal legislation that there should be no interference with existing patterns of private medical practice. Comprehensive Health Planning under Public Law 89–749, for example, will always be an empty exercise as long as that proscription remains in the law. Hardly anything in our lives has remained unchanged in the last fifty years, and why we consider existing patterns of private practice to be sacrosanct and unchangeable, is something I cannot understand.

After my many years of private practice, I am absolutely convinced that we will never be able to address ourselves rationally to the health needs of our nation until we begin to look dispassionately and objectively at our existing pattern of practice with a view to making adjustments for the good of the broadest public interest.

I hope that you will find these few comments useful.

Best wishes.

Sincerely yours,

JAMES G. HAUGHTON, M.D.,
First Deputy Administrator.

Senator MUSKIE. Our next witness is Dr. Elaine M. Brody, director of the department of social work, Philadelphia Geriatric Center.

Dr. Brody, it is a pleasure to welcome you.

Mrs. BRODY. Thank you, Senator.

STATEMENT OF ELAINE M. BRODY, DIRECTOR, DEPARTMENT OF SOCIAL WORK, PHILADELPHIA GERIATRIC CENTER

Mrs. BRODY. My name is Elaine Brody and I represent the Philadelphia Geriatric Center. I wish first to thank you for the privilege of appearing before this committee.

The Philadelphia Geriatric Center is a voluntary agency in which almost a thousand aged people live in a variety of arrangements, including an institution, a hospital, and apartment buildings. We see additional hundreds of the elderly each year whose need for health care is creating problems for them and their families, and therefore have an intimate knowledge of how governmental policies and funding mechanisms affect people on a day-to-day basis. I will speak specifically to the issue of the impact of health care costs on the younger generations which help pay such expenses.

Many older people are deprived of health services because of the lack of income for nonacute long-term care or because of their unwillingness to impose financial hardships on children and grandchildren. When long-term care is unavailable, as is often the case, or when offspring do pay health costs for the elderly, families are often subjected to severe financial, physical and emotional stress.

In considering any aspect of health care for the elderly it is essential to look at the needs of the total family which has elderly members rather than solely at the older person. The misconception that modern families neglect or abandon their aged has been so thoroughly disproved that it is no longer an issue in gerontology. Broad studies have shown that ties between the generations continue to be strong and that families willingly assume responsibility for old people in health crises. It has also been shown that the provision of health services to the aged by public or voluntary agencies does not undermine family feeling and responsibility. The services reach those who have no family, and those whose families lack the physical or economic capacity to take care of the old person. When services are not available, as is often the case, there is a high social and economic cost to all generations.

The most severe impact on offspring occurs when the aged parent requires long-term health care, either in an institution or in the community. Such needs arise primarily among the very old. Physical and mental incapacity and poverty are more likely to occur with advanced old age. About half of those in institutions are over 80. Conservative estimates indicate that a minimum of another 8 percent who are not in institutions are so incapacitated that they are either bedfast or housebound. When these figures are translated into human terms, they represent about 2½ million individuals.

The adult children of the very old are themselves approaching or already engaged in the aging phase of life. This fact was recently made more graphic by a study which found that in the United States 40 percent of old people with children have great-grandchildren. At the Philadelphia Geriatric Center, about 40 percent of the applicants for institutional care have at least one child over the age of 60 and the ages of these children range as high as 76. The problem is acute for adult children struggling to meet obligations to themselves and

their own children. It is catastrophic for elderly "children" on the brink of retirement or already retired, who may be existing in marginal economic situations, and who themselves are experiencing the interpersonal losses and ailments of old age.

Medicare was a major achievement, but it has not helped those who require long-term care whether in or out of institutions and there is tremendous inequity from State to State in the public funding of such care. Both Dr. Knowles and Dr. Haughton presented testimony about the limitations on extended care and gaps in continuity so I will not go into that at this point. What they did point up is that the fragile elderly person is moved from square to square on the checkerboard even though research evidence indicates the hazards to health and even survival of relocating the elderly. The family is in a state of constant upheaval and stress.

The problem is compounded by the various streams of public funds. To use Pennsylvania as an example, a nursing home is paid "reasonable cost" while the patient's medicare ECF benefits last. However, long-term care is funded through the public assistance program which pays a maximum of $285 monthly. Since proprietary homes understandably prefer the higher "reasonable cost" fee, medicare has boomeranged in areas such as Philadelphia.

Long-term nursing homes have become almost completely unavailable to those who need it most, the indigent impaired aged whose families cannot afford to pay upward of $5,000 yearly for nursing home care. What actually happens is that the laws require that children do not have to pay the costs while the parents are receiving 100 days of care but that they must pay perhaps for years if they need long-term institutional care.

Support by Adult Children

The overwhelming majority of States still have legislation requiring support by adult children. I will give you just one case example, Senator, of the impact of this. The full testimony I submitted contains several cases.

A 59-year-old post office clerk's wife was in a psychiatric hospital. There were three young children. The oldest daughter was 14 years old. The elderly grandfather was in a nursing home. After the post office clerk exhausted his own savings to maintain his father in a nursing home, he also exhausted his borrowing power and was required to take the old gentleman home. Because of a lack of community-based services and institutional care—both were unavailable—the 14 year old granddaughter was compelled to lose time from school in order to take care of the elderly man. He has brain damage—that is chronic brain syndrome—and someone had to be around constantly to watch him. The 14-year-old was responsible to see to it that the two younger children in the family got to school.

The father in this family is just on the verge of a nervous breakdown and we do not know what will happen if something is not done to alleviate that situation.

Some sick old people are fortunate enough to be in long-term facilities which accept public assistance recipients. In Pennsylvania their

adult children need to contribute according to a sliding scale. A man with a gross income of $9,240 a year on which to support his own family of four is required to contribute $50 monthly for his parent's care.

To my knowledge, no coherent body of national data exists with respect to the cost in dollars paid by the younger generations for health care for the elderly. Some figures could probably be unearthed from the States as to the direct outlay by those adult children whose parents are also receiving some public aid under the public assistance nursing home care programs. It should be noted in this connection that there are wide variations from State to State and even from county to county in the amounts of the contributions required of adult children. Additional inequities result because of the latitude allowed individual public assistance workers in the administration of support regulations.

However, even if the information as to dollar contributions for public assistance recipients were readily available, it would represent only a small part of the total picture. There are no easily accessible records of the amounts contributed by adult children who by necessity are carrying total or partial costs for parents not receiving public aid whether they are in the community or in institutions.

Further, if costs are to be computed, other factors should be included such as the effect on family income due to loss of time from work and health costs for the adult children which are incurred because of the physical and emotional strain of caring for the elderly.

Related questions are: To what extent will current costs to adult children contribute to their own future dependency? What deprivations are caused to the younger generation; that is grandchildren? What are the social costs in terms of family inability to engage in normal social and recreational activities or to take an occasional vacation?

While observations and experience thoroughly document the distress of these old people and their families, research is needed to objectify and quantify that information so that it can serve the purpose of coherent planning and policy. It is even more important for the known facts concerning intergenerational relationships to be communicated to legislators, professionals, and the public so that judgmental attitudes do not perpetuate punitive legislation and practices.

Support laws in this country, which stem from the Elizabeth poor law, are archaic carryovers and are not consonant with the current situation. In 1900, for example, life expectancy was 47 years. A large aging population simply did not exist at any previous time in history. Laws directed at the occasional "neglectful" child of the occasional elderly parent are no longer appropriate. We now have a mass problem.

As Alvin Schorr stated:

> The consequences of support requirements are to impose on some old people a standard of living lower than public assistance levels; where support is procured the deprivation is shifted to the adult child and his family and handicaps him and his children in their own struggle for a better standard of living.

These statements certainly apply to the crushing costs of long-term health care. It has been proven that most adult children give generously of themselves in time and effort in helping their ill aged parents. Money is not the only way to demonstrate affection and loyalty.

Need for Social Services

Your committee has expressed interest in the relationship between the rise of health costs for the elderly and the availability of social services. This points to the question of services and resources which could prevent the neglect of old people which often results in hospitalization, could shorten the length of stay in hospitals, and play a supportive role after hospitalization so that the elderly do not return to the same conditions of neglect which in cyclical fashion result in rehospitalization. Hospitals currently are plagued by their inability to discharge old people for social rather than medical reasons. As a result hospital beds cannot be freed to treat acutely ill people who need them.

The community-based services needed include home nursing care, homemakers, mobile meals, day-care for mentally and physically impaired elderly, adequate outpatient services, temporary inpatient care to permit family vacations or to relieve families in time of emergency, and, of course, institutional care which would be available regardless of race or ability to pay.

Community care has been badly neglected in this country. A recent study of the United States, Denmark, and England by Ethel Shanas & Associates found the percentages of elderly people served by public or nonprofit home help services were 4.2 percent in England, 3.6 percent in Denmark but less than 0.1 percent in the United States. The study stated that—

> The number of old people actually helped in their housework, provision of meals, and care during illness is dwarfed by the numbers . . . helped . . . by relatives.

The overwhelming majority of those ill in bed with temporary illnesses are helped by family members. Of an estimated 350,000 bedfast persons in the community, between 80 and 90 percent depend mainly on the family.

Thus, when families are able to do so, they care for old people at home. I do not believe, Senator, that love and morality can be legislated. Yet it is a paradox that funding mechanisms often put a premium on separating old people from families. For example, in Pennsylvania an indigent sick older person is entitled to a maximum monthly grant of $121 while he lives in the community, but may receive a maximum grant of $285 in a nursing home. Why cannot the very same tax dollar, the differential of $164, be used to pay for homemaker or other services which would enable the family to maintain the old person in the community?

The over-riding paradox is the priority given in our society which stresses concern for the young at the sacrifice of the aged. The personal and economic well-being of all the generations are interlocked. If the well-being of the younger generations is to be fostered and family ties with the elderly encouraged, they must be relieved of the overwhelming burden of costly health care for the elderly.

The staff of the center wishes to express its appreciation of this opportunity to express these views.

Senator Muskie. Thank you very much for your excellent testimony. This is one area where the young find themselves afflicted with

the problem. I think that too many citizens are unaware of this side of the cost.

Does the advisory committee want to submit questions to Dr. Brody?

Mr. GLASSER. Yes.

Senator MUSKIE. They will submit questions, and will you send us your answer subsequently.

Thank you very much.

Mrs. BRODY. Thank you.

(Subsequent to the hearing, the chairman in a letter addressed to the witness, asked the following question:)

AUGUST 12, 1969.

DEAR MRS. BRODY:

It seems to me, too, that the Committee should look further into the point you made about the lack of a "coherent body of national data . . . with respect to the cost in dollars paid by the younger generations for health care for the elderly." You gave specific suggestions in your testimony as to what should be included in that body of data, but I would very much like to have additional thoughts from you on the federal role in compiling such information.

Will it be possible for you to send on additional suggestions?

With kind regards,

Sincerely,

EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

(The following reply was received:)

PHILADELPHIA GERIATRIC CENTER,
August 22, 1969.

DEAR SENATOR MUSKIE: I am writing in response to your letter of August 12th requesting additional thoughts about the federal role in compiling national information with respect to the cost paid by the younger generations for health care for the elderly.

While the federal government could probably tap several sources (such as Internal Revenue Service, available statistics from the various states and possibly census information) the information garnered would be most inadequate. The reporting systems utilized by the states would vary greatly, the data therefore would not be comparable, and the picture would be fragmentary at best for the reasons stated in my testimony.

It is my opinion that there are two ways in which the federal government could aid in collecting the necessary information:

First, a uniform reporting system could be instituted requiring the states to provide the information about contributions of adult children to elderly recipients of health services which are financed by public assistance programs. This, of course, would be a very partial representation of the total picture.

Secondly—(and I think this would be more effective and reliable)—the government could finance careful research investigations. Such studies would need to be planned and coordinated nationally to obtain consistent and reliable data. However, they would need to be carried out in selected representative areas on a regional basis because of the wide variations in different parts of the country.

Several years ago, Dr. M. Powell Lawton and I carried out a small preliminary study in a related subject area at the Philadelphia Geriatric Center. The study was called the "Social Cost of Care for the Elderly." The content of the study concerned institutionalization of the elderly rather than the costs of health care to adult children, but it does illustrate the sort of approach which might be used in a national study. To quote from Dr. Lawton's proposal:

"Specific Aims—The immediate aim of the present proposal is to explore the area of measuring the *social cost* and the *social gain* of community and institutional management of elderly people. We define social cost to mean the total expenditure of effort by society to maintain the aged person in an institution or in the community. This "cost" has elements of (a) emotional stress, (b) time, and (c) money, as expended by (1) the subject, (2) the family and/or significant

others, and (3) the community. "Social gain" refers to (a) relief from stresses noted above; (b) contributions made by subject and family to each other and/or to the community, and (c) positive satisfactions which accrue to subject, family, and community by virtue of the older persons' being in the community."

In studying health care costs, it would probably be advantageous to utilize a cost/benefit approach in the research. Dr. Robert Morris of Brandeis University would be a good resource person in that regard.

If there is any additional information you require, the staff at the Center would consider it a privilege to be of service.

Sincerely yours,

(Mrs.) ELAINE M. BRODY,
Director, Department of Social Work.

Senator MUSKIE. Our next witness is Dr. Frederick C. Shwartz, American Medical Association, chairman of the committee on aging.

Mr. Swartz, I will have to leave at 12:30 for a prior committment. Senator Saxbe will remain and hear you and the other witnesses.

STATEMENT OF FREDERICK C. SWARTZ, M.D., AMERICAN MEDICAL ASSOCIATION, CHAIRMAN, COMMITTEE ON AGING; ACCOMPANIED BY PAUL R. M. DONELAN, LEGISLATIVE ATTORNEY ON THE STAFF OF THE AMA

Dr. SWARTZ. Mr. Chairman and members of the committee, I am Dr. Frederick C. Swartz of Lansing, Mich., in the active practice of internal medicine and chairman of the committee on aging of the council on medical service of the American Medical Association. With me is Mr. Paul R. M. Donelan, legislative attorney on the staff of the AMA.

Generally, in speaking of the economics of aging, we think of the adverse effects which aging has upon the income-producing capabilities of an individual. From our point of view, a major way of reducing the impact of the economics of aging is to lessen the health hazards, to eliminate the concept that after 65 one is over the hill, and to provide the employment and motivation necessary so that the oldster feels wanted and useful.

In addition, we need an educational program for older people that would place proper emphasis on physical and mental exercise, on adequate but not overnutrition, and on elimination of unphysiologic habits such as smoking. Further, the educational program should be supplemented by a positive health program for the healthy as well as for those with chronic conditions. This, then, would reduce the incidence of chronic conditions and improve life expectancy.

To support the above, let me present our thinking on the subject matter of "aging" as we see it in the year 1969.

Let me ask: What does "aging" mean to you?

How precise are your concepts of the changes which are so-called wrought by time?

Have you ever stopped to think of the difference that exists between those people whom you called old when you were a youngster and those whom you call old now?

Has it not occurred to you that the concept of "aging" that existed 100 years ago when the life expectancy was 40 years must have been quite different from the concept of "aging" as it exists today?

When the geologist talks about the aging rock on the hill, he is not referring simply to the passage of time. He uses this term to include

those effects wrought by changing temperature, by the wind, by the rain, and by the heat of the sun. This usage, therefore, includes with the effects of the passage of time—if there be any such effects—also those changes wrought by the impact of other environmental forces. This concept of the aging process admits that many of the observed results are produced by forces other than the passage of time. This is so very important that we shall emphasize it from time to time. This concept gives us hope. This concept gives us an area that we can attack in order to change the "process of aging." All we have to do is modify those environmental factors which have contributed certain effects.

Many people from ancient times to the very present speak about the signs and symptoms such as the tottering gait, the shaking hand, the white hair, the bald pate, the shrunken shank, the piping voice, the store teeth, the thickening glasses, the forgetful mind, the narrowed mental horizons and the lack of motivation, the creaking joints, the stiffness and aching, as if these all were a part of a great syndrome which would lead to a diagnosis of the "aging process."

The big question of the moment then is, "Are all these characteristics and many others alluded to by various writers the result of the passage of time?" If so, then at any stated age we should all have some of the characteristics, and as time goes on we should expect to acquire all of them.

If these stigmata of "aging" are considered to result from the passage of time, then there is no possible way for us to modify the final picture of old age. This idea is supported by some professionals and some nonprofessionals. I am happy to report, however, that in the past few years more people in the health field are beginning to realize that all the signs and symptoms witnessed among the aging represent some functional aberration related to the presence of a chronic condition or the lack of proper physical and mental exercise. These people believe, moreover, that such departures from a "normal" state can be corrected by the methods of modern medicine.

In many medical articles the terms "aging" and "aging process" are used interchangeably with the term "degeneration." There is a growing concept that these terms need more specific definition and some separation. When the busy scientist writes an article and arrives in the middle or end of the paper, he usually has a few odds and ends that are unexplained. All too frequently he sweeps them under the rug and says they are due to the "aging process." More critical minds, however, are commencing to examine these odds and ends and have observed that they occur at any time in life.

One of the latest books in medicine dealing with the older patients, "Clinical Features of the Older Patient," by Joseph T. Freeman, points out the growing tendency to identify changes with the appropriate ecological factors. It also emphasizes that some changes which are usually associated with the older individual are more frequently found in younger age groups.

Dr. Warren Andrew on page 72 of this textbook says, "The characteristic of an aging muscular apparatus is the picture of an atrophy of disuse."

On page 91, Dr. Frederick T. Zugibe says:

The failure to date, to define biologic aging adequately resides in the controversy whether ostensible, morphological, biochemical or physiological changes are related primarily to aging or to disease. For many years arteriosclerosis was believed to be a part of old age. More recent investigations have shown the invalidity of the thesis that a man is as old as his arteries. Some septuagenarians and octogenarians have been found at autopsy to have coronary arteries relatively free of plaque formations whereas individuals who die before the age of thirty have shown occlusive atheromatous lesions. Major William Enos of the United States Army Medical Corps revealed that about 77 percent of a group of American soldiers in their early twenties who were killed in Korea had atheromatous deposits in their coronary arteries. These were heavy in over 40 percent. Such observations are prima facie evidence that arterosclerosis is not an inevitable product of chronologic age alone . . .

Dr. Andrew Fuller says on page 109 of the same book: "The general management of elderly cardiac patients should differ little from that planned for younger individuals."

And finally in this incomplete list of examples where the weight of testimony indicates that age is probably not a factor in the production of a symptomotology or architectural change, we have a quotation from the latest book on emphysema and bronchitis by Drs. Petty and Nette who say simply: "Age itself does not damage the lungs."

We would like to ask each of you: How old are you? It doesn't matter whether you are 20 or 70. What part of you is 70 years old? You all know that in all living structures the cells are growing and changing and being decimated and destroyed and reutilized. But to make this thing simple, the red cell in the adult human individual is supposed to have a life span of about 120 days. The lifespan of other cell groups in the body probably ranges from shorter to longer periods of time. Certainly none run for 20 years. Accordingly, what part of you can be said to be as old as your chronologic years?

We don't expect at this time to have all or part of the answers. We would merely like to raise in your minds some definite questions about some of the concepts that represent the past and the present climates of opinion. We would ask you to be wary of the uncritical acceptance of terms such as degeneration, aging, and the aging process. We hope that you will become completely liberated from chronological snobbery.

"Aging" Not a Disease

The Committee on Aging of the American Medical Association has studied this whole area for 15 years and has come to the conclusion that there are no disease entity or physical or mental conditions that result from the passage of time. We firmly believe, moreover, that no one can foretell that a specific condition could reasonably be expected to occur in anyone after the passage of a specific amount of time.

Although the term "geriatrics," which means the study of the diseases of aging, is used frequently, we have been unable to find any disease entity that was of necessity related to the passage of time. Arteriosclerotic heart disease, high blood pressure, arthritis and cancer are found in the youngster, and measles, mumps, chickenpox, and poliomyelitis are found in the oldster. The clinical picture under these circumstances varies only as the seed and the soil vary.

The diseases of chronic illness and long term care cases which constitute the major problem in medicine today result from the recurring and irritating effects of environment over a long period of time.

Chronic conditions are the results of these irritants and do not result from the passage of time.

In addition to the recurring and irritating effects of environment, which he lives. The pot belly and flabby muscles that result from the which he lives. The pot belly and flabby muscles that result from the lack of exercise, the loss of habits of study, the forgetfulness that comes when the mind is not used, and the painful knees and flat feet that come from longtime pounding by too much weight, present a picture of dilapidation that represents longtime lack of care and is not due to the passage of hours.

A few years back it was not uncommon to hear the physician say to the patient, "Well, what do you want, a new machine made from all these old parts?" This remark is rarely heard in our present-day medicine.

Age is no bar to good medical or surgical treatment, including open-heart surgery, so long as the patient presents himself as a reasonably physiologically functioning unit to the physician.

May we emphasize again at this point that many of the so-called infirmities of age stem directly from lack of conditioning. Great numbers of individuals after leaving high school or college settle down to a routine of breadwinning which uses only a small portion of their muscular or physical equipment. Under these circumstances it is easy to understand why the physical horizons become cramped, why the hand shakes and why the gait becomes uncertain and tottery. Accordingly, it behooves the young and old to continue some type of physical development and exercise throughout life instead of neglecting these important duties after leaving school.

Forgetfulness and mental retardation result largely from lack of attention, failure to concentrate, and loss of motivation. This can largely be prevented if we will continue to encourage people of all ages to maintain the habits of study learned in school. We can prevent mental deterioration by helping older people to continue in employment. Some serious reading and thinking should be a part of each man's daily life. The muscles are strengthened and the wits are sharpened only by proper physical exercise and mental activity.

Our whole program aimed at retarding the so-called aging process by improvement of physical and mental activity would fall short of accomplishment if we did not at the same time strike a blow for moderation in the use of alcohol, tobacco, and food.

Much propaganda has been directed to the already brainwashed oldster and increasing efforts must be made to prevent the brainwashing of those coming behind him. The fatal concept that debilities come with age and at 65 one is "over the hill" condemns the oldster to a period of ever-narrowing horizons until the final sparks of living are the psychoneurotic concerns with the workings of his own body.

Disease, Not Prevention, in Spotlight

Thus far, our thinking has been largely disease oriented. If we persist in thinking along this line, there will be millions of well oldsters and well youngsters that will fail to get the attention they need to prevent them from falling heir some day to a chronic condition.

Lack of symptoms and multiphasic screening programs are going to isolate a great number of older and younger people from the attention of the health professionals.

There is a general tendency to turn these people away from the doctor's office with the statement, "You do not have any organic disease—you are well." We are shocked on occasion when one of these patients says:

Doctor, I sort of thought I was well when I came in to see you, since I had no symptoms and was able to do my work. But, how well am I? Am I well enough to run a block? Am I well enough to run a mile? Am I well enough to ride with the astronauts next week?

These are indeed questions that cannot be answered at the moment, but certainly provide a challenge that will keep the medical minds and facilities busy for ages to come. And, the answers will provide better health and happiness for the people of the Nation, and lead to a reduction in the number of people who have chronic conditions.

We, therefore, must recognize that when we see patients, old or young, and have examined them and find that they do not have any organic disease, and we classify them as "well," that there are degrees of "wellness."

All items checked under the original examination will have to be reconsidered in the light of what would happen if the patient's respective organ systems were tested with a challenge of its function so one could grade the individual as a living organism under stress rather than a quiet piece of protoplasm on the doctor's examining table.

We are devising and using, and we must devise and use, more tests of organ function and acquire enough data in these areas so that they have predictive significance. Then at the conclusion of the original examination, when we have arrived at the point of evaluating the presence or absence of chronic conditions and their significance, we can apply functional tests and further categorize the so-called well into various areas of wellness.

We might then arrive at a point where we could say to the individual involved:

You are now in such a category, and at this point in our knowledge, we have so many hundred thousand people listed in this group and not one of them have had a coronary in 5 years.

This type of information would be of extreme interest to the busy executive, to his wife and family, and to his company. In fact, this type of information would be of extreme value and interest to most everyone.

It is strange indeed, that as we delve into the physiology and anatomy and pathology of the human organism, to note how we go back to some of the basic principles of Hippocrates that was written 400 years before Christ. The validity of the concept that muscular and mental inactivity produces wasting and that exercise produces strength and that you lose what you do not use has been proven times without number. Implementation of this concept calls for ambulation, rehabilitation and reeducation for positive health.

Aging is really living, growing and developing, so that the final days and contributions should be far different in the future than they seem to be today.

Mr. Chairman and members of the committee, in concluding let me say that I hope we have shattered the present concept of an "aging process." What we see instead is a hereditary package buffeted by the wind and wave and weather of environment. This package is not like a sailless, rudderless ship. It is the most magnificant creation in the universe. Overlay this with emotional veneer which does not seem to be based on chemistry or physiology but is equally capable of influencing the destiny, and you get some idea of the composite picture of man, none of which is dependent on the "aging process."

The oldster, with his problems of health and disease, can look to the future with hope. The generally considered unchangeable, incurable, etiologic factor "aging process" has been eliminated. The oldster has become as treatable as any other age group and often responds as well.

Mr. Chairman, the American Medical Association is pleased to have had this opportunity to present to your subcommittee the foregoing views. If I can, I will be happy to answer any questions on my statement which the members of the subcommittee may have.

Thank you.

Senator SAXBE. Dr. Swartz, you have given a very encouraging view of the future of medicine but it seems hardly appropriate in that what we are talking about is that people are old and they are sick. I am sure that we are interested in seeing that in the future we can solve the ecological reasons for human deterioration and that we can educate people. The difficulty, it seems to me, is the here-and-now problem that we have people who are old, they are sick. Maybe they have neglected the things that they should have been doing or perhaps they have no intention of following the health rules that are quite common, or it could be that a lifetime of work under which they had no control such as we have seen under the black lung cases in a hearing before the full Labor Committee have put them in a category where they are a serious problem.

They pile up in the clinics and in the doctor's office. We have heard substantial testimony that medicare and medicaid have not made as significant an impact on this health problem. I was hoping that the American Medical Association would have more concrete recommendations, not on preventative aging but rather on the problem of how are we going to supply adequate medical assistance to people in economic levels where they are distressed and they feel that in many cases they are abandoned?

Dr. SWARTZ. When you have heard the great numbers of people who are more competent than I am talk about the economics the burden of this testimony is merely simply this. In the area of treating people, and this is where I live and work, we have a certain number of things that we know about from preventive medicine, all the health items that at the moment are not being applied, that if we could apply to one generation we would improve life without any question.

In the area where we have sick people who are now sick we have to treat them, but in our study of these older sick people we have learned certain things—the benefits, certainly, of physical activity.

Just briefly for 1 minute, osteroarthritis is the bone disease. This is the sort of thing that comes from a bump in a car and a fractured

vertebra or the female falls and has a fractured hip. This is the only time that the male as a result of action has less sickness than the female. There are certain reasons, the basic one is the stress and strain at the several levels of the bones which keeps the bone structure.

We can take a kid 13 years old and put him in a cast and in a week you can show definite bone restruction; but if you are active physically, you can prevent this physically. These are the things we have learned.

So when we treat the older people in my office, and in my contact with nursing homes, I try to emphasize the need for physical activity to prevent this softening of the bone from occuring. I even demonstrate to the women what kind of shoes they wear, how they should get up and put their feet forward and not walk like this [indicating] as they do with their high heels, et cetera. This is the type of preventative program which will prevent broken hips, prevent bills in hopsital centers, et cetera, et cetera.

So this is what we are trying to say. We think this needs emphasis because this is so simple.

The same thing is true of mental activity. Dr. Osler told the medical students so many years ago, "If you do not want to become senile, spend adequate time in your medical library." This is our approach, and I think it should pay off.

We have so far in medical history wiped out diptheria, typhoid fever and polio. There is no sense, as far as I can see, for a patient to come to the office with bursitis because all you have to do is this [indicating] a half dozen times each day and you will never get it unless you get a bump on the shoulder. The same thing is true of arteriosclerosis.

We have to take the things we learn from the oldsters back to the youngsters. In our meeting with the American Geriatrics Association, we told the oldster to bring a youngster with him because what we learn here is applicable over there. We have never established a geriatric center in a medical school because we think all people who are sick should be cared for in the mainstream.

As I say, there was a time at the University of Michigan back in the twenties when there was big placards on the operating room door "If this patient is over 55, you will not be able to operate; if he is over 65 we will not do this or that," and so forth. There is nothing like this any more.

I would guess that probably 50 to 75 percent of the surgery in any major center is in the geriatric age group. In my own practice, two patients have new aortic valves.

A lot of things we see as doctors could well be prevented with 15 or 20 minutes of physical activity each day. I always tell them, "You are not a Christian just because you go to church on Sunday because you have to live like a Christian the rest of the week," so I tell them after they do their physical exercise, "When you walk, walk with exertion; pull these muscles up tight so you do not block circulation because you can spoil your exercise in the morning if you just slump down the rest of the day."

So there is the program. The failure to produce inroads in cigarette smoking is one of the areas that we like to emphasize because we are seeing more and more people with lung failure these days on the

basis of cigarette smoking. I really do not have the answer to this area but I realize the need.

Senator SAXBE. Thank you very much, Doctor.

(Subsequent to the hearing, the following question was addressed to the witness:)

August 12, 1969.

FREDERICK C. SWARTZ, M.D.,
Chairman, Committee on Aging,
American Medical Association,
535 Dearborn, Street,
Chicago, Ill.

DEAR DR. SWARTZ:

* * * * * * *

In your testimony you stated, "Lack of symptoms and multiphasic screening programs are going to isolate a great number of older and younger people from the attention of health professionals."

Would you explain the basis for this statement?

With kind regards,

Sincerely,

EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

(The following reply was received:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., August 20, 1969.

DEAR SENATOR MUSKIE: Dr. Frederick C. Swartz, Chairman of the AMA Committee on Aging, has asked me to respond to your request for an explanation of a statement in his testimony of July 18, 1969. Perhaps the paragraph in which the statement appears should have read:

"Thus far, our thinking has been largely disease oriented. If we persist in thinking along this line, there will be millions of well oldsters and well youngsters that will fail to get the attention they need to prevent them from falling heir some day to a chronic condition. Patients usually do not seek medical consultation unless they are experiencing pain or discomfort, or recognize that they have symptoms of disease. Lack of symptoms and lack of multiphasic screening programs designed to detect a symptomatic disease are going to isolate a great number of older and younger people from the attention of the health professionals. Periodic health examination including appropriate multiphasic screening programs would bring these people to their physicians' attention."

If you still have a question, please let me know.

Sincerely,

HERMAN W. GRUBER, *Assistant Director.*

Senator SAXBE. American Association of Retired Persons and National Retired Teachers Association. The members of the panel will be introduced by Mr. Peter Hughes.

Mr. Hughes.

Mr. HUGHES. Thank you, Mr. Chairman. My name is Peter Hughes and I am legislative representative for the National Teachers Association and the American Association of Retired Persons. We appreciate this opportunity of appearing before the subcommittee and the opportunity to continue our associations' participation in whatever small way we can contribute to the overall study being done by the full committee.

Because time is short and I know that the Senator is rushed and needed elsewhere I would like at this time to introduce the two

gentlemen who will represent our associations this morning at the hearing and let them proceed as they see fit.

Dr. Michael Lynch on my far left and Dr. Noel Edelson will testify for the association.

STATEMENTS OF MICHAEL LYNCH AND NOEL EDELSON, AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION

Mr. LYNCH. Thank you.

Mr. Chairman and members of the subcommittee, my name is Michael Lynch. I am assistant professor of economics at the Wharton School of Finance and a staff member of the Leonard Davis Institute of Health Economics at the University of Pennsylvania. I am accompanied today by Noel Edelson, who is also an assistant professor of economics at the Wharton School of Finance and a staff member of the Leonard Davis Institute of Health Economics at the University of Pennsylvania.

We appreciate this opportunity to appear before the committee today as representatives of both the Leonard Davis Institute of Health Economics and the National Retired Teachers Association and American Association for Retired Persons. Our prepared testimony is a joint effort of both myself and Dr. Edelson.

I have been asked that rather than to read the whole testimony to summarize it very briefly which I will try to do.

Senator SAXBE. The entire statement will be printed in the record. (See p. 634.)

Mr. LYNCH. Thank you, sir.

It is a little difficult to summarize. I think I will just try and hit one of the points which the committee may find interesting.

Between fiscal year 1966 and fiscal 1967 expenditures on all personal health services increased by 13 percent. This of course does not mean that the amount of health services received by Americans increased by the same percentages. If the supply of health care services is relatively fixed, then the actual increase in health care services will be smaller than 13 percent and prices will rise. As we all know, prices did rise so that the 13 percent increase in expenditure only purchased about 5 percent more health care per capita for Americans during that period.

The large increases in public spending were mainly on behalf of the aged and so we would expect that the aged would gain a more than proportionate share of that increase. Our studies show that in fact it was true that, for example, the persons over 65 gained in real per capita terms 12.6 percent in physician services during that time. In contrast, persons under 65, the statistics indicated they actually lost 2.1 percent in physicians' services for the same period. That is, physicians' fees rose more rapidly than expenditures by persons under 65.

The same sort of thing is true with regard to hospital care. Our statistics indicate that the persons over 65 gained 3.2 percent in the real per capita hospital care services. On the other hand, persons under 65 actually lost some 4 percent in hospital care services. These, of course, are very crude sort of measures of real output but they are

suggested and they do show that in fact if one looks at the medicare and medicaid program as being designed to increase the amount of health care services for the aged that the program was more successful in attaining that role than one would gather from looking at the aggregates; that is, the persons over 65 actually get more than the public at large.

Unfortunately, it is also true that part of this gain of persons over 65 was at the expense of people under 65. On equity grounds I think that is the way it should be in a sense but nevertheless it is said that part of their gain had to be at the expense of those under 65.

Shortage of Health Care Services

In order to get more health care for all Americans, the thing that must be done is to somehow increase the supply of health care services, and here we would echo and implore the testimony of earlier witnesses here this morning. I am presently engaged in a study of physicians' incomes so I found myself very strongly supporting the comments made here by yourself, Senator Saxbe, by Senator Yarborough and by Drs. Knowles and Furstenberg particularly with regard to increasing the number of students in medical schools.

If one looked at producing physicians as a kind of business and if I could sell a physician, for example, my preliminary results indicate that I could make something on the order of $200,000 profit per unit—that is, per physician if we could really sell a physician. I am not suggesting that we should sell a physician.

Senator Saxbe. Talking about a lifetime?

Mr. Lynch. Talking about physicians really as a capital good, looking upon them as a machine where they use a lot of income over their whole life. You could either rent a computer or you could buy one. If you look at a physician this way and assume that you could actually sell a physician as you could sell computers, then my figures indicate that you know it would be very profitable to go into the business of selling physicians. I thought the committee might find that interesting. If the staff would like a copy of the paper, I would be happy to introduce it.

Let me now turn the microphone over to my colleague, Dr. Edelson, who might like to make some comments about the staff committee report.

Mr. Edelson. Yes. The comments we have now are not part of our prepared testimony, they come as a consequence of our having to abbreviate that testimony. We find the report of the advisory committee extremely useful and interesting. We are struck by what is an inevitable conflict between providing high quality medical care or indeed providing any high quality service of anything, whether it is education or medical care, and the cost of doing that.

Clearly we could consider producing less qualified medical personnel at a presumably lower cost. One might expect a lower quality of medical care services. This whole question of how much one saves in terms of educating less qualified medical practitioners and the reduction, if any, in the quality of medical services rendered is the most understudied aspect of the supply side of the medical industry. After all,

one of the real horror stories in the committee report was that of an elderly individual going from one specialist to another with absolutely no coordination. There was an example given of an ophthalmologist who was treating him with a drug procedure which evidently was causing some internal problems. He had seen an internist but the internist did not detect his problem, not because that internist did not receive a very fine education but had he known he received a notice to the effect that this drug was being prescribed he would have known not to prescribe some of his own. That did not require a man to go to school for 15 years; a clerk earning $2.50 an hour could have received that information and made it known to him. This is not the loss in adequate medical care, it was not by any means due to an adequate education on the part of the internist, it was simply not having available manpower to perform low order kinds of tasks.

The whole question, as I say a tradeout between quality and numbers, is an understudied problem as it is understandably an empirical one. One cannot talk about high cost of medical care and be confident that is surely a long medical education. One really has to get some imperical studies to see what effect, if any, occurs with the production and quality as mated by inputs. Years of education pertain.

There seems to be no evidence like this other than instances of crash medical programs in the military which apparently allow people to perform at a very, very high level for certain tasks with a very, very small income of educational services, and in that sense we are obsessed, I would say, by some of the recommendations in the report: for example, that all surgical procedures be performed by "qualified" individuals. We should not delude ourselves that qualified means more higher priced, and that based upon the evidence that we have seen in the report of the gains in surgical procedures does not seem obviously justified by the increase in educational service required.

We should not delude ourselves that trying to insure quality by granting monopolies, and that is what they are, to have specialized procedures which are done only by individuals qualified by certain educational programs. We should not delude ourselves in thinking that will do anything but create monopolies and inhibit any adequate supplies of medical facilities.

Senator SAXBE. Do you believe that we could accomplish the staffing of these medical centers for the elderly and the welfare staffing of neighborhood health centers, the problems that were discussed during New York City? Do you think that could be accomplished without having Government paid physicians?

Mr. EDELSON. I would have to say emphatically yes to that. There were long waiting lists for people, as you well know, very eager to undergo all the privations of inadequate earnings during the medical training in order to get the rewards that justly come with practice of medical care. The fact that there seems to be no shortage of people willing to undergo this, the fact that programs which have been instituted to try to train paramedical personnel have met with resistance on the part of other supplies, a suppy of people willing to undergo that training seems to me to indicate——

Senator SAXBE. The minimum requirement for a general practitioner at the present time from the time he leaves high school is 9 years, I believe. That is the minimum time.

Mr. EDELSON. Yes.

Senator SAXBE. I know of none that achieve it in that time. That is, 4 years of college, 4 years of medical, 1 year of internship, practically all of them have at least 1 year of residency even in general practition. Now do you think that is realistic in view of the present pressures that we have?

Mr. EDELSON. I dislike giving simple minded answers to very difficult questions. If you are asking for a personal opinion or reaction, yes.

Senator SAXBE. Opinion.

Mr. EDELSON. Yes, you could do it. That length of training seems to me to be excessive in terms of the majority of problems that doctors face. After all, doctors taking care of children report that 70 percent of their time is spent in well baby care. Now surely a less trained individual could examine children and separate those who are sick from those who are healthy and then refer those who appear to be ill and in need of treatment to a person of higher qualifications.

Senator SAXBE. Well, in your treatment of the elderly which we are discussing here today and the economic factors it has been pointed out by Dr. Swartz and others that preventative medicine can accomplish a great deal even though, of course, surgery and things like that have contributed very little to the increase in the life expectancy in this country. I think that all the surgery combined amounts to about 6 months and the preventative medicine has added the balance—health care, environmental care, and so on.

Now obviously there is a great deal to be done in this area of training because as has been pointed out here, there are a lot of psychological problems here of losing the will to live and losing the will to compete really.

Now is this a medical problem or can this be handled adequately otherwise? I mean should we in our neighborhood centers place greater emphasis on environmental and on counseling, or is it really a medical problem to be handled by a physician or a registered nurse?

Mr. EDELSON. This is a topic which is currently undergoing research by the National Bureau of Research. There is a study right now trying to separate those aspects of enhanced mortality and reduced morbidity which could be properly ascribed to environmental as opposed to procedures. It seems that environment is infinitely more important to medical care in terms of reducing morbidity and enchancing mortality.

Senator SAXBE. You are concerned with this and the people you are associated with are vitally concerned; there seems to be a great difference of opinion on whether the elderly should be separated. Should they be separated or should they live in communities, either in housing units where there are young, old, children or should they be in a golden age village so-called?

Mr. EDELSON. I would feel personally unqualified to answer that particular question. Rather than give a flippant answer I would have to say I honestly don't know. I think there are various ways of forcing people to take a position which saves the community at large some sums. Whether one should force people to that mode of treatment I think is very questionable.

Senator SAXBE. Now you represent the Retired Teachers Association, I believe.

Mr. EDELSON. Right.

Senator SAXBE. You have done economic work on this, Doctor. Retired teachers are a notoriously low paid class, is that right?

Mr. LYNCH. That is certainly true.

Senator SAXBE. Those are under State programs that were not set up at times of inflationary pressure.

Mr. LYNCH. That is right. The real value of their pensions has been very, very small.

Senator SAXBE. What percentage of these people become public charges under 70 years old?

Mr. LYNCH. That I am afraid I do not know.

Senator SAXBE. But there is a substantial number, isn't there, because of inflationary pressures? Teachers' retirement and the social security together is a wasting operation; in other words, if they live long enough they have used it all up. Now this has been my personal experience with this class.

Mr. HUGHES. I would like to comment. Mr. Gettings of our staff has done a study of teachers' pensions in the 50 States and I think it might be valuable for the committee to take a look at this. I would be more than happy to make it available to you.*

Senator SAXBE. Yes. As I understand it, too, most of the teachers are not covered by social security unless they secured coverage after their teaching, in summer employment or something like that.

Mr. HUGHES. Yes.

Senator SAXBE. Because membership in the teachers public employed retirement system did not include social security.

Mr. HUGHES. That is correct. It was based on the state pension plan in most instances, or I would say in all instances. We found that it can range anywhere from $300 per year to amounts upward.

Senator SAXBE. Yes. I recall $25 a month minimum was passed in Ohio and this was a great boon because you had teachers getting $10 a month.

Mr. HUGHES. Right. Of course you have teachers who retired 10, 15, 20 years ago and their pension was based on what they were earning at that time.

Senator SAXBE. And they received $90 a month when they were teaching.

Mr. HUGHES. In some instances, yes. Besides being based on their earnings of twenty years ago they are based on the pension system generally that was set up 20, 25, or 30 years ago and they have just not kept in tune with the inflationary pressures and what have you.

We also have examples of letters from individuals who are members of our association. Deleting names, of course, we would be happy to make them available to the committee,* outlining the problems the teachers have living on $300, $400, $800 a year.

Senator SAXBE. I appreciate your understanding because of the pressures of the day, busy time on the floor and they are in session. I assure you that all of your statements will appear in full in the record. I would appreciate it if you would also forward this research that you refer to in regard to teachers' retirement because I think this is a very critical area of people who have made an effort and have served well.

*Retained in committee files.

Thank you very much.

Mr. HUGHES. Thank you.

Mr. EDELSON. Thank you.

(The prepared statement of Michael Lynch and Noel Edelson follows:)

PREPARED STATEMENT OF MICHAEL LYNCH AND NOEL EDELSON, ASSISTANT PROFESSORS OF ECONOMICS AT THE WHARTON SCHOOL OF FINANCE AND STAFF MEMBERS OF THE LEONARD DAVIS INSTITUTE OF HEALTH ECONOMICS AT THE UNIVERSITY OF PENNSYLVANIA

Mr. Chairman, Members of the Committee: My name is Michael Lynch. I am assistant professor of Economics at the Wharton School of Finance and a staff member of the Leonard Davis Institute of Health Economics at the University of Pennsylvania. I am accompanied today by Noel Edelson, who is also an assistant professor of Economics at the Wharton School of Finance and a staff member of the Leonard Davis Institute of Health Economics at the University of Pennsylvania.

We appreciate this opportunity to appear before the Committee today as representatives of both the Leonard Davis Institute of Health Economics and the National Retired Teachers' Association and American Association for Retired Persons. Our prepared testimony is a joint effort of both myself and Dr. Edelson.

I would like, at this time, to present our testimony to the Committee. I would like to point out that we are both available for quesions from the Committee at your pleasure, Mr. Chairman.

Beginning in 1960 the price index for medical care services, which in the previous decade had increased at roughly the same rate as the price index for all services, began to increase at a substantially higher rate. This increase has been particularly marked in the last four years, and has become an object of serious concern, especially for the elderly.

Some investigators, in attempting to explain this relatively high rate of inflation, have blamed it on inefficiency on the part of hospitals, inadequate use of paramedical personnel, and monopolistic practices of physicians and drug companies. While we believe these factors are important in explaining the high level of medical prices, they cannot by themselves explain a rapid rate of price inflation or an *increase* in that rate.

It is our contention that the rapid increase in demand for medical services, associated to a great extent with Medicare and vendor payments through public assistance programs, is crucial to an understanding of the rise in medical care prices. In this sense medical care behaves like any other commodity: one should expect rapid price increases from substantially increasing demand for a product whose output increases slowly in response to that demand. Our analysis suggest that, besides increasing demand and rigid supply, the method by which added demand is financed is important.

It is clear that increases in medical care prices cause special hardships for the aged, insofar as these expenses are not covered by Medicare; this inflation also adversely affects taxpayers in general, since they must finance the Medicare program. Since the aged spent roughly 2¾ times as much per capita on medical care as the non-aged in fiscal 1967 out of a (median) income only 45% as large, medical care expenditures relative to income are roughly six times higher for the aged than the non-aged. (12% of income for over-65 vs. 2% of income for under 65.) Public programs covered a greater share of elderly persons' medical care outlays, however, (60% vs. 22% for the non-aged); this means that persons under 65 spent about 1.6% of their (pre-tax) incomes on medical care compared with 4.8% for the aged.

Because of the ratio of out of pocket medical costs to income is three times higher for the aged, a 20% rise in medical prices would cause a 1% fall in real income for the aged and a 0.30% fall for the non-aged. In money terms the aged would need an additional $40 per capita to compensate for a 20% price rise and the non-aged $29. Note that since taxes fall more heavily on the non-aged the distribution of the burden of inflation is not quite so inequitable as the above example might indicate.

Economists have generally been reluctant to apply their usual tools of analysis to the health industry because medical care is clearly not an ordinary economic service like haircuts or restaurant meals. Because enhanced capacity for prevention and treatment of disease entails complicated medical procedures, the consumer is generally unable to evaluate the quality of care even after he has received it (but how different is this from automobile repair?) This uncertainty leads to a greater role for tradition and trust rather than informed and rational consumer choice. Furthermore since many institutions in the health industry are non-proprietary, e.g., hospitals, the opportunity for using models based on profit maximization is correspondingly diminished.

Our presentation abstracts from these complications in order to perform a mental experiment: supposing that medical care were sufficiently like ordinary economic services to apply some simple economic reasoning, would the predictions from such a model accord with reality? In particular, what would happen to the price of output and the incomes of participants in our industry which received substantial infusions of purchasing power?

Our analysis will consider three factors: (1) the extent to which increases in medical care prices induce increased output; (2) the responsiveness of demand for medical care to changes in prices and income; and (3) the form of payment scheme by which the government assists purchasers of medical care. For simplicity, consider two commodities differing completely with respect to supply conditions: genuine Rembrandts and bricks. The known supply of genuine Rembrandts cannot be augmented by any price increase, however large, whereas bricks can be produced in varying quantities at roughly constant unit cost.

An equilibrium price is one which equates supply and demand. Suppose that the government decides to assist purchasers of Rembrandts and bricks by subsidizing the cost of their acquisition. If the payment scheme is one in which the government pays a fraction of market price, the customer will perceive as his effective purchase price the market price times one minus the fraction subsidized by the government.

Consider first the market for Rembrandts. If the government offers to reimburse all costs of acquiring Rembrandts what will be the size of the Rembrandt support program? The answer is that it has no definite limit because at a virtually zero price people continually try to purchase more Rembrandts than there are in existence. If the government offers to reimburse only 80% of costs, the price of Rembrandts will rise to something less than five times its previous level. Suppose the initial price of a Rembrandt was $1,000; people now perceive the price to be $200, and many people who were unwilling to pay $1,000 for a Rembrandt may be quite willing to pay $200 or more. The perceived price will have to rise to about $1,000 and therefore the market price to $5,000, in order to make people content to hold the existing number of Rembrandts. Thus, the ultimate size of the Rembrandt support program will be nearly four times the initial market value for Rembrandts.

What is the outcome of applying a similar offer to brick-buyers? Even if the government offers to reimburse all costs there will be a definite limit to the support program. Since the demand for bricks at a perceived price of zero, is finite, reimbursing the costs of brick purchases leads to an increase in output but not price. This is true only if the brick industry is competitive, however; if brick sellers could conclude and raise prices this would increase their profits, since consumer demand would not be affected by a rise in market price. If the government reimbursed purchasers for only a fraction of their brick expenditures a rise in price would reduce demand.

By way of contrast, suppose that the government simply gives individuals 10% of the initial value of Rembrandts on the condition that they spend it only on Rembrandts. If people do not reduce their initial spending on Rembrandts then the only effect of this program will be to raise Rembrandt prices by 10%. It is quite possible, however, that private spending on Rembrandts would be reduced as much as 10% and thus the price rise may actually be anywhere from zero to 10%. The price rise is limited because, unlike the previous case, the increase in price is perceived by the consumer and this inhibits his demand. The lesson is that the mode of reimbursement in a subsidy program may affect the extent of the price rise induced by such a program. The same program applied to the brick industry, would again result in no change in brick prices and in a larger quantity of bricks produced. The lesson should be amended to add that the more responsive the supply the less will be the increase in price.

We now apply our simple analogy to medical care expenditures and see whether they resemble Rembrandts, bricks or something in between. The table below summarizes the changes in expenditures and prices of various components of medical care by age category for fiscal years 1966 and 1967. This shows that while total personal health care expenditures increased by about 13% overall, the medical care component of the Consumer Price Index increased by about 7% and population grew about 1%. Hence, very crudely speaking, by spending 13% more on medical care, consumers managed to increase by 5% the real per capita amount received. Thus medical care seems to lie a bit closer to the Rembrandt end of the spectrum than to the brick, but nevertheless the figures show a substantial increase in output.

PERCENTAGE CHANGES IN EXPENDITURES, PRICES, AND REAL PER-CAPITA SERVICES, BY AGE CLASSIFICATION, BETWEEN FISCAL YEARS 1966–67

Type of service	Percent increase in expenditure	Percent increase in price	Percent increase in real per-capita services received
All personal health services	13.0	7.0	5.0
Hospital care:			
Over 65	24.4	20.2	3.2
Under 65	16.8	20.2	−4.4
Physicians' services:			
Over 65	20.7	7.1	12.6
Under 65	5.2	7.1	−2.1
Other professional services:			
Over 65	10.7	5.0	5.7
Under 65	5.0	5.0	−1.0
Drugs:			
Over 65	6.3	−.01	5.2
Under 65	7.4	−.01	6.3

Source: "Personal Health Care Expenditures of the Aged and Nonaged," by Dorothy P. Rice, Arne Anderson, and Barbara S. Cooper, Social Security Bulletin, August 1968, table 2, p. 21. Price indexes taken from Social Security Bulletin, January 1968.

Our simple analogy can be pushed further. If the infusion of money goes mainly to the aged, then the predictions would be that: (a) prices of medical care services that are relatively more important to the aged, i.e., those that comprise larger proportions of their budgets, will rise more quickly than medical care prices in general; and (b) that the increase in real per capita medical care will be greater for the aged than for the non-aged. The aged spend relatively less on physician's services and relatively more on hospital care, drugs and nursing home care than do the non-aged. Thus, other things equal, we would expect that physician's fees would rise by a smaller percentage than hospital care costs (which is confirmed), drug costs (which is not confirmed), and nursing home prices (for which data is not available). Our analogy reminds us, however, that it is not just the change in expenditures that determines the change in prices, but also whether we are dealing with bricks or with Rembrandts. The drug industry resembles bricks more than it resembles the Dutch master's portraits. It is likely that the presence or absence of a monetary incentive to minimize costs for any given level of output also affects the supply response. Physicians and drug manaufacturers, if they are interested in profits, have an incentive to keep their own costs low, while the hospital industry is essentially a cost plus industry with few rewards for efficiency and few penalties for inefficiency. All the factors mentioned imply that hospital care prices should rise more rapidly than physicians' fees. This is, in fact, the case. We should also note that fees for physicians' services that are specialized to the aged did rise faster than the average[1] as we would have predicted.

The second prediction made above was that the increase in real medical care received would be greater for the aged than for the non-aged. This prediction

[1] The data refer to "customary fees" rather than the actual prices charged. There is evidence that doctors often charge poor individuals less than the customary fee. If, as a result of reimbursement through Medicare, physicians began to charge the elderly "customary fee," actual fees paid by the elderly could have risen rapidly despite only a modest rise in "customary fees."

is not only confirmed, but the statistics indicate that the real per capita amount of hospital care services and physicians' services received by persons under 65 actually fell in spite of the substantial increases in expenditure in these two categories.

Has the Rembrandt-brick analogy helped in understanding the facts about medical care prices? One of the conclusions suggested by the analogy is that only for a brick-like industry would it be possible to divert large sums of money to that industry without inducing a rise in the price of that industry's service. It would have been very surprising if Medicare had not caused some price rise. The changes in the share of total medical services going to the elderly and in the relative prices of services used more intensively by the elderly were about what one would expect to occur in any "normal" industry. Given that some changes in both the absolute level and relative structure of prices is inevitable, is there anything that can be done to keep this change as small as possible?

The analysis suggests that we examine two broad areas for an aswer. First, the mode of payment or reimbursement may have an impact on the extent of the price rise. Prices will go up more, the greater the percentage increase in services demanded as the perceived price falls toward zero. For example, if the average person would attempt to see a physician ten times more often when the perceived price is zero rather than $5 per visit, then the pressure of prices to rise will be very great. We know of no study that even attempts to measure how much, if any, medical care prices have risen because of the mode of reimbursement adopted. The general presumption, and it accords with casual evidence, is that the mode of payment does not have much impact on prices. Instead, it is the second broad area, supply response, that is thought to have had the largest impact on prices and which holds the greatest promise for moderating the rise in prices.

The many policies that have been suggested to increase supply response are probably familiar to this committee and we have time only to mention them here. Group practice prepayment plans may provide incentive to physicians, hospitals and patients to allocate more resources to preventive medicine, to avoid excessive hospitalization, unnecessary surgical procedures and overinvestment in expensive and highly specialized medical equipment. On economic grounds alone, the case for increasing the number of physicians is a very strong one. Few investments would yield a higher money rate of return, and when nonpecuniary factors are taken into account the case is even strong (one of us in the process of completing a study of physicians' income which will support these claims.) It has also been suggested that we increase the number and the quality of paramedical personnel, that we improve the quality of management training for hospital administrators and that we invest more in physical plant and equipment for hospitals. All of these things will take time but will result in lower medical care prices.

Senator SAXBE. I understand that we have one gentleman who asked to appear, Dr. Amos Johnson. Is Dr. Johnson here?

Dr. JOHNSON. Yes, Mr. Chairman.

Senator SAXBE. I notice that you have information, and we want to put it in the record.

Dr. JOHNSON. I did put together last night a statement which just this moment arrived from the printing office. I have again analyzed what the situation is as regards the timing of this hearing; so I did, last evening and this morning, put down the essential thoughts which I wanted to relate here today. I will submit this prepared text for the record.

Senator SAXBE. Very well.

STATEMENT OF AMOS N. JOHNSON, M.D., GARLAND, N.C.

Dr. JOHNSON. I have been practicing as a family physician for 36 years. Fifty percent of my patients now, I think, are in the elderly age group. Fifty percent of my practice is Negro; 50 percent is white: 100 percent is in rural North Carolina. I am here as advocate for my patients.

Eighty-five percent of my patients from whom $4 per month is withheld from their meager monthly social security checks to pay for professional (physician) charges never receive any benefit from this deductible insurance. These 85 percent of my patients can be seen in my office from 6 to 12 times per year without exceeding the primary $50 deductible sum. Let me hasten to say, however, that for those in the relatively small group who have catastrophic illness, requiring hospitalization, this insurance is a "God-send."

Senator SAXBE. Prolonged.

Dr. JOHNSON. That is right, but the people for whom I work are very poor and they can ill afford the $44 per year insurance. When you must live on a check of $80 or $90 a month, you cannot afford $4 per month for an insurance payment.

One of the major problems of this group is drug cost. Drugs, for my patients, cost three, four, to five times what their professional costs are on an average. When I go into the drug store, which I do occasionally, and see the unfilled prescriptions or see the bottles filled which the patient has not been back to get, and the patient comes in to see me the next time and is no better or is worse, or maybe the patient does not get back at all; this is sad.

Senator SAXBE. They will take their prescriptions in and have them filled, but then they do not go back because they do not have the money.

Dr. JOHNSON. That is right. Frankly, I get from drug companies quite a lot of free medicine. I write directly to the companies and tell the detail men that I need this, that, and the other medicines and they are very good about sending it to me and I give it to the needy patients.

Transportation is quite a cost factor and there is no mechanism under medicare and medicaid to take care of that. In my instance, when I refer my patients 100 miles to an excellent teaching medical center, even at our cheap costs, this represents an investment of $25 each time that they go. These people cannot afford many trips to get examinations, treatment, and therapy. So transportation is a problem. The Veterans' Administration does supply transportation to and from the veterans facilities for needy veterans, so there is precedent for assistance.

MEDICAID A "MONSTROSITY"

Medicaid, presently, is an administrative and fiscal monstrosity.

Senator SAXBE. What limit do they have in North Carolina?

Dr. JOHNSON. We do not have medicaid, yet, sir. We will implement it when this becomes mandatory. We have now what we think is a better system than is implemented in quite a few of the other States under medicaid programs and certainly a better system than will be resultant from some of the cutbacks. If we did implement it, which we will, we would be forced by our legislature to implement it at the lowest possible level and, currently, we are doing a little better than this. So we do not, as yet, have it implemented.

I am on the National Advisory Committee to Medicaid, the Medical Assistance Advisory Council. I did help hold the Atlanta regional medicaid hearing in December for the Southeastern States and interviewed many recipients: therefore, I am reasonably familiar with the

program. It will require a complete "comprehensive diagnostic work-up," and heroic therapeutic measures to make this program acceptable.

Medical education; yes, we can, with plans and funds, increase the number of students 100 percent in each medical school. This is currently in the plans for the University of North Carolina. At the University of North Carolina we have what we think is a unique plan. We will provide basic science training of 2 years for the 200 students at the present location and then we will use medical centers which we have in our State with excellent hospitals for teaching the last or clinical 2 years of medical education.

Senator SAXBE. That will be what?

Dr. JOHNSON. Last 2 years of medicine plus the internship and residency training.

Senator SAXBE. Right.

Dr. JOHNSON. If we are ever to see doctors trained to make health and medical care available to the areas which need health care, we will have to radically alter medical education. The only way medical education will ever be altered is for you gentlemen of the Congress to do it because medical educators are now in the second and third generation of educators who have never, themselves, provided a day's service, certainly in a comprehensive manner, to a patient in their lives. They are honest and sincere and firmly believe that they are producing doctors in exactly the right manner and pattern, but let's see what happens to them. They all, of course, congregate around medical centers; they are totally hospital oriented. The last two or three decades of graduating physicians have been trained to see patients on an in-hospital basis entirely. We desperately need skilled help at a level of training less sophisticated than the doctor.

I have working for me in my practice a man who has been with me 29 years and he is a damn good doctor. He is trained to adequately care for about 30 or 40 percent of the menial work which I would normally have to do in the run of the day's office work. I have a group of four trained people who work in my office. If we could train enough of these people—and it is not a long expensve process—so that we could use them efficiently in community centers and in doctors' offices which are supplying comprehensive health care for people, we could effectively free up at least 25 percent of the doctor's work day time. This 25 percent work time of 200,000 doctors is the equivalent of a pool of 50,000 doctors. We are not using efficiently the time and skills of our present physician resources.

WRONG STUDENTS IN MEDICAL SCHOOLS

Another important matter; I think that in increasing numbers we may be selecting the wrong type of students for medical schools. I have reason to believe that many students who apply to medical school who may well be oriented and who desire to take care of people may be, by the present admission process, unwittingly, selectively excluded from medical school.

I am quite sure that we need to look long and hard toward educating more physicians from the minority groups. North Carolina is about 50 percent Negro. Students admitted from North Carolina to

all medical schools for the last 3, 4, or 5 years have been less than 5 percent Negro students. I proposed to our legislature that we identify a group of young black high school students who could perform to certain specifications and perhaps subsidize them and guarantee them that they will be admitted to medical school if they perform to these specifications and will be financed for medical training.

I think that we have to look not only to more students and doctors to solve our health care problem, but to altering the product of medical education. The majority of panels of experts which have been put together to advise in this area in Washington are medical education experts. If you stop and think, it is this same group of experts which has advised us to where we are. When Washington decides to get more advice, these same advisers come in and confer with each other. When they are through conferring the answer is that we can remedy the problem by providing more of the same. This not true.

Senator SAXBE. How big a community do you serve there at Garland?

Dr. JOHNSON. Eight hundred of us live in the village and some 4,000 additional people live in the area working farms and timber.

Senator SAXBE. Mills?

Dr. JOHNSON. Mills, yes sir, farms and mills.

Senator SAXBE. Now you operate a clinic and you are on 24-hour call?

Dr. JOHNSON. I have a setup, sir, with paramedical personnel so that I do not have to be on call 24 hours a day. This same situation can be created in many, many other places.

I might say this. Not every crossroads needs a doctor. There is a fourth dimension of necessity for medical care. This is time. Any person who lives within 30 minutes of adequate medical care is amply covered. The need in little communities for doctors quite often is more apparent than real and there will be many such communities without doctors.

As I come to my conclusion I want to comment on a class of unique aged people which Dr. Knowles commented on a little today which, to me, is of immense importance. We have old children, old young people. There are children who, due to ignorance, poverty, and deprivation, are irreversibly mentally retarded by the age of 6. By law, they have to go school until they are 16 years of age and the system just passes them along in their retarded ignorance. Here is the greatest potential to make an important investment that I know of. This would be a very, very real investment, and for reasonable amount of money these children could be salvaged. Now, I frankly do not think that our Headstart programs help much here. We have a Headstart program in my community with which I am closely associated and from this I make this observation. Any Headstart program can be no better than the head which heads it. Using indigenous people in these programs is merely creating a job, they are spending money for poor results. I have reason to know that there are private companies which can contract to do this job to contractual specifications, and do it nationwide at a lower cost than we are paying now for Headstart.

Senator SAXBE. I think one of the problems there, it has been my observation similar to yours, they try to do two things at once. They

try to provide income for the area and at the same time to provide Headstart and they did not do a good job on either one of them. It is a little unfortunate because the concept is excellent. However, I like your opinion on this. I have come to the opinion that they are starting too late.

Dr. JOHNSON. The time to start this program is at conception. I have contended that we can begin to habilitate a child during pregnancy. I know my people and I know them very well. When I see certain girls come in pregnant I know that that child does not have a possible chance to develop normally so I try starting right then with the mother to see that she gets an adequate diet and adequate health care and thereby will produce a more healthy baby. Actually, child development should start at pregnancy. The most important years are the first 2 or 3—perhaps 5.

Senator SAXBE. I recommended to you a feature that was in the New York Times magazine a week ago Sunday. It goes in depth into just what you are saying—that the association of the child up until 2 years old has a tremendously significant impact upon the rest of his life. The die is cast, as you say.

Now as to these older people, I come from a small village and I think I know what you are talking about on some of these problems. As you know, they become loners and many times inaccessible for medical treatment. How can you overcome that in a rural area?

Dr. JOHNSON. Somebody has to be their advocate. It is necessary almost to send someone out to get them. In my instance, I know everybody's background. I know how to get the most of my people in. I could use more help, however.

Senator SAXBE. In the city what happens so many times is that this loner winds up in a rented room embarrassed by his situation.

Dr. JOHNSON. Develops tuberculosis and schizophrenia.

Senator SAXBE. Diabetic. He stays there under conditions that are horrible in usually a rooming house, an old hotel, some kind of an arrangement like that which makes him almost inaccessible to medical treatment.

"SEEK THESE PEOPLE OUT"

Dr. JOHNSON. There is only one answer; somebody has to go out and seek these people out and bring them in. Let me tell you this: If my community were afforded totally free medical care, one-third of the people would be in my office two or three times a week; one-third would use medical care effectively and judiciously; and one-third would not use it at all except when it was crises oriented; that is, they either could not walk, or work, or they were in pain. The minute this last group was free of pain or could walk or work I would not see them again until the next episode, regardless of health considerations.

Senator SAXBE. Just a minute.

Mr. ORIOL. Do you serve on the Medical Assistance Advisory Committee? In your testimony you said that this committee is not used much.

Dr. JOHNSON. That is true.

Mr. ORIOL. This is a committee which was established under the 1967 Social Security Amendments, I believe. It is a matter of—

Dr. JOHNSON. By the Congress.

Mr. ORIOL. Yes. We on this committee are especially interested in that because that legislation grew primarily from hearings by a subcommittee on long-term care.

Why can't you meet more? For example, the deliberations over the standards for skilled nursing homes, under title XIX this would seem to be a very important issue.

Dr. JOHNSON. This committee actually has not convened in some several months now. Standards for skilled nursing homes was discussed very superficially at our last meeting.

The mandate creating this committee says that this committee shall be advisory to the Secretary of Health, Education, and Welfare. Not all of the regulations which have been promulgated from that office during the past have been discussed or called to the attention of this committee.

Mr. ORIOL. You described medicaid as a monstrosity and gave some of the reasons for thinking so. What is your alternative to medicaid?

Dr. JOHNSON. I think the concept of medicaid is good but I think that the whole program has to be pulled apart piece by piece, studied and put back together, not using the same blocks and the same molds. Medicaid can be an immense adjunct to medicare for the people over 65. Medicaid should provide, for those medicare recipients who are impoverished, the first $44 of hospitalization expenses, as well as the first $50 expense for professional services, as well as the 20 percent coinsurance for services. Drugs should be provided for needy old people over 65 under the medicare program without necessarily having to do it across the board. Money is to come from the general tax fund to augment the insurance program of title X–III, maybe we can use those funds more efficiently. Instead of giving them to XVIII across the board give these funds to a properly functioning XIX program and pick up the deficiencies of XVIII under that. These deficiencies need to be picked up somewhere.

Mr. MILLER. Mr. Chairman, before we get too far away from the comments on the Advisory Council, how long have you served on that council?

Dr. JOHNSON. Thirteen months so far, for its duration.

Mr. ORIOL. I have a question to ask. May I defer to the Advisory Committee to see whether there is any point that they would like to bring out?

Mrs. BREWSTER. I will submit my questions in writing.

Mr. ORIOL. Fine.

Senator SAXBE. Doctor, we want to thank you for coming. As I say, we are sorry that our time has not been better but your statement is here, it will be in the record. Your statement is very worthwhile. We really appreciate it.

Dr. JOHNSON. Thank you, sir.

(The prepared statement of Dr. Johnson follows:)

PREPARED STATEMENT OF AMOS JOHNSON, M.D., GARLAND, N.C.

ADVOCATE OF THE PATIENT

I testify here today before your Committee, Mr. Chairman, as a General Practitioner (family physician) who has been largely responsible for the provision of Continuous Comprehensive Health Care Services for a North Carolina

rural village of some 800 population, with a surrounding supportive population approximately 4,000 people. This practice has been my life work and has provided my livelihood and emotional satisfaction for over 35 years now.

I soon learned that in order to provide my community of patients with adequate and effective comprehensive *health* care services I must know and be able to provide them with much more than crisis-oriented fragmented *remedial medical care.* This involved studying and evaluating essentially each patient as he relates to those components of their lives concerned with family community, recreation, habits, occupations, economics, religion, social attitudes, etc. This I have done and now have this composite picture of most of my patients stored on my computer (mind) for instant recall from day to day as I provide health care for these people.

I appear here today to testify as a "medically oriented" "patients' advocate." I disclaim any skills or expertise in *scientific* medical research or the process of scientific medical education. I am not a medical statistician. I do, however, consider that I have considerable experience and knowledge related to the basic components of the process of management and provision of health and medical care services for individuals, families and communities of patients.

I shall now offer my personal observations and comments concerning several of the problem areas concerned with "health aspects of the economics of aging."

Medicare—(Title XVIII A and B of Public Law 89–97). A large majority of my patients derive no benefits what-so-ever for health or medical services from Medicare.

In excess of half of my patients can ill afford to pay the forty-eight dollars per year cost of buying Title XVIII B professional services coinsurance; nor can they afford the first fifty dollars deductible, nor the twenty percent coinsurance cost above the fifty dollar deductible feature of this program. For the same reasons these people can not afford the first forty-four dollars of hospitalization charges when hospitalization is necessary. It follows logically therefore that considerably over half of my Medicare patients can not afford to buy the drugs and prosthesis (eye glasses, dentures, etc.) when they are so vitally needed.

I am frustrated, as a conscientious physician, when my patients are financially unable to purchase those drugs which are absolutely essential to their well being and, perhaps, to their very life itself. As an aside, I must admit to a bit of frustration also when, occasionally, the patient's state of well being does improve without the medications which I have prescribed.

In my community the cost of out of hospital medication and prosthesis far exceeds the costs of professional services. My Medicare patients are in dire need of financial assistance for the purchase of essential drugs.

Transportation is a problem as relates to its cost and availability. This problem varies in direct proportion, in most instances, with the distance which patients must travel. For those patients whom I must refer 100 miles to the closest medical school affiliated medical center for especial examination and treatment, the availability and cost of transportation can become a major factor. There is precedent for Federal financial assistance for travel in instances of real need. The Veterans Administration gives this support for travel to and from Veterans medical facilities when there is evidenced need.

Perhaps if the pursuant or an amended social security system can not adequately provide financial support on an "across the board" concept then there might be need for financial assistance from the general tax fund. If this new funding were needed it might be set up as a separate resource and consequently it would not be necessary that these funds be expended on an "across the board" concept.

Put vividly, it is factual that the present Medicare program has many short comings and deficiencies.

Medicaid—(Title XIX Public Law 89–97). This program, under its present legislative and mandated structure is an administrative monstrosity. Perhaps this situation is best illustrated and understood as explained by an analogy. This program presently seems to me analagous to a fairy castle containing 50 rooms (50 States) and three closets (Puerto Rico, Guam and the Virgin Islands). This castle was built on pure 14 carat gold to the specifications of an architectural monstrosity and is manned for upkeep by a "Corporal's guard."

Up to the present time less than ninety people have been assigned to this Federal administrative staff for Title XIX. Is there any wonder that the "Corporal's

guard" could not prevent the gold being stolen from the walls, sills and underpinnings?

I serve as an original member of the Medical Assistance Advisory Committee which was mandated by the Congress to advise with the Secretary of HEW regarding the administration of this Medicaid program. Although this committee has been little used, it has afforded me the opportunity of a degree of reasonable insight into the operation of this program at a national level. I helped to hold a one day regional hearing on Medicaid in Atlanta, Georgia last year which provided further insight. I am firmly convinced that the present administration staff of this Title XIX program is to be complimented for "guarding the castle and keeping the grounds" as well as they have.

As for those providers of professional services who have violated moral, ethical and statutory laws, I offer no defense or excuse. Suspects should be thoroughly investigated, prosecuted before the law and, when proven guilty, given the maximum penalty allowed by law. Ethical medical organizations should drop those members who are proven guilty, and State licensing boards should revoke their licenses to practice their profession.

Summarily, I would say, Medicaid needs a "comprehensive diagnostic work up with intensive therapeutic measures to be instituted where indicated." I am pleased to see that Secretary Finch has appointed a task force to carry this out.

Availability and Cost of Health and Medical Services—Much of the problem of maldistribution of physicians with its resultant numerous nationwide areas of insufficient or total absence of physician health care coverage is a product of the success story of scientific medical research and increasingly sophisticated medical education. Ever-increasing scientific medical research has produced remarkable intricate and in-depth knowledge in a multitude of body organ system and specific disease oriented processes identified now as areas for specialization in depth by physicians for the delivery of largely remedial medical services. This process pursued to its ultimate end has produced the fantastic explosion of scientific knowledge in our time which has resulted in exodic but highly expensive organ transplant procedures. Factually these highly scientific "break throughs" have contributed much to our present Apollo Eleven interplanetary moon mission which most surely will enable our astronaut to walk on the moon.

However, this very desirable and productive era of research and highly scientific productivity has produced an intolerable paradox. A great majority of physicians trained in recent decades have become hospital and research centers oriented so that we see most physicians clustered excessively within and around these medical centers to the great detriment of an essential system for the provision of adequate health care services broadly distributed throughout our nation.

Those physicians who have completed their medical education during the past two, perhaps three generations have been conditioned to examine and treat patients only while the patient lies horizontal in a hospital bed. These physicians are sincere and largely honest in following this technique of provision of remedial organ and disease related medical care. This is the way research oriented medical educators have taught this generation of medical doctors to practice medicine.

This methodology of practice plus the phenomena of "eight hour per day—five day per week" work pattern, which has been fostered upon us largely by unionized labor, has forced upon the American people, as affluent as we are, a system of health care delivery which we can not afford.

This, largely "inn keeping," cost of sixty to one hundred dollars a day, we cannot afford for inhospital patients who are seen and treated only eight hours per day from Monday through Friday. It is conservatively estimated that 25 to 35 percent of these hospitalized patients could be equally well treated, if not better, and certainly more cheaply on an ambulatory or outpatient basis anyway.

The time is past due when we must re-evaluate medical education and its product. While I am a family physician (General Practitioner) and sincerely believe that this is the best methodology of providing continuous and comprehensive health and medical care, I do recognize the absolutely essential need for those physicians who are trained in-depth of knowledge in many areas of presently recognized specialization.

Almost daily I refer one or more patients to these specialists for medical assistance. However the well trained Family Physician can comfortably and efficiently care for 85 percent of the usual and ordinary illnesses, which beset mankind. This he largely does in his office, a clinic or outpatient department, and at a financial charge which most patients can afford. Paradoxically, medical

education today is a production which provide 85 percent of its graduates as a specialists and only 15 percent or less as family physicians. It is absolutely essential that this ratio be reversed if we in this country are to have ample medical services available for all, and at a price which we can afford.

You, gentleman of the Congress of the United States, are the only ones who can alter this paradoxical medical education catastrophe. So long as medical education is supported almost entirely through the wasteful techniques of the "skim off and seep through mechanism" of support for scientific research grants this system of medical education with its inefficient productivity will not only continue, but will grow worse.

Already we in medicine today are 10 years ahead in the knowledge of "what to do" as contrasted to present knowledge and techniques of "how to do it." Highly sophisticated scientific knowledge is totally non productive if we do not have a methodology of making this knowledge of services to our people.

This system whereby medical educators and specialists who are basically now providers of health care are called to Washington to be on "blue ribbon committees" to solve problems of the delivery of health care has no chance of being practically productive. I submit to you that these are the people who have advised us into the untenable position in which we now find ourselves. Daily they meet now here in Washington and ultimately produce recommendations that the answer to the problem is "more of the same."

We must *do a complete overhaul of our present systems of medical education* and the delivery of medical and health care.

The aging process of children—I know that this Committee is concerned chiefly with the economics of aging. I also know that aging is a matter of relativity. Some people are young at age 75; others are relatively old at age six years. A child who is caught up in the cycle of poverty, ignorance and deprivation may be irreparably mentally retarded by or before age 6. To this extent one most important process of the aging phenomena is finalized. This child has no chance to live a full and productive life. He or she will be a ward of government and welfare for the remainder of his natural life. Worse, they will marry similarly deprived mates, produce children, and thereby perpetuate this circularity of poverty, ignorance, and deprivation.

It is amazing to some of us, how our socially conscious Federal Government, through its Department of Health, Education, and Welfare, glibly speaks of and spends vast sums of money in an effort toward "rehabilitation" of these pathetic and unhappy people. I submit that you can not "rehabilitate" a people who were never primarily "habilitated."

It is high time that our Federal Government spends money, as an investment, to identify in our society these unfortunate children and effectively see that they are properly fed, clothed and intellectually stimulated in order that we efficiently break this cycle of poverty, ignorance and deprivation which is largely a production of the matter about which we are here today.

Present programs, O.E.O. and its program "Head Start" for instance, are better than no program; but very little better, however. There is reason to believe that if we effectively pulled together, at a national level, over some 40 fragmented and categorically oriented child health and welfare programs, their overhead and administrative costs alone might finance one meaningful and productive program.

I know of private sector private enterprises kindergarten programs which can and will contract to guaranteed specifications, at a national level to do this job. This productive private enterprise program would, I am almost certain, be less expensive to the Government than O.E.O.'s present "Head Start" program. I would like to challenge our Congress to see that a meaningful program of "habilitation" be established in this unique area of the economics of aging of these old young children. This, you must recognize, would be an *investment* which could pay off handsomely in both social and economic productivity.

Mr. Chairman and Members of your Committee—I thank you for the privilege of being allowed to testify before you today.

Senator SAXBE. We will stand adjourned unless the Advisory Committee has some other suggestions.

We stand adjourned.

(Whereupon, at 1:35 p.m., the subcommittee adjourned.)

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. A REPORT ON THE HEALTH OF THE NATION'S HEALTH CARE SYSTEM, ROBERT H. FINCH, SECRETARY OF HEALTH, EDUCATION, AND WELFARE; AND ROGER O. EGEBERG, ASSISTANT SECRETARY-DESIGNATE OF HEALTH AND SCIENTIFIC AFFAIRS

This Nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector. Expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond. The result is a crippling inflation in medical costs causing vast increases in government health expenditures for little return, raising private health insurance premiums and reducing the purchasing power of the health dollar of our citizens.

As examples of the situation inherited by this Administration Medical costs are rising at more than double the increase in the cost of living. Physicians' fees, which were increasing at a rate of about 3% a year up until 1965, have since the introduction of Medicare and Medicaid been rising at 6% a year. The expense of one day's stay in a hospital, not including a physician's care, has gone from $44 in 1965 to $70 today, and will probably be $80 next year. Within three years at the present rate of inflation, hospital expenses will hit $100 a day. The Medicaid program is costing $2½ billion a year in Federal funds alone, more than double the estimates made at the time of its passage.

Badly conceived and badly organized, the Medicaid program has attempted to provide medical services for the poor by pushing them into the Nation's already overburdened health care system without developing the capacity in the system to serve them and without building the capability in the States to manage the program. As a result, by 1975 at the present rate of increase, Federal costs for Medicaid could go as high as $12 billion per year with the States paying an additional $12 billion. And this on top of a Federal expenditure for health which today is larger than the entire budgets of each of the Departments of Agriculture, Commerce, Housing and Urban Development, Interior, Justice, Labor, Post Office, State, Transportation and Veterans Administration. The Federal health budget in fact now exceeds the total national budget of all but eight nations in the world.

Our overtaxed health resources are being wastefully utilized, and we are not adding to them fast enough to keep pace with rising demand. Our health priorities are critically out of balance. Our incentive systems all lead to overuse of high-cost acute-care facilities, while the need increasingly is for lower-cost alternatives. We emphasize spectacular achievements in the healing arts, but have given too little attention to the prevention and early care of illness, which must be the first line of attack on our health problems.

Faced with this extremely difficult situation, we nevertheless cannot abandon our National goal of effective and dignified health care for every American no matter what his station in life or where he lives. We cannot accept anything less in this the most affluent society in the world. As long as there are people in this country who are denied essential health services because of poverty, or race, or lack of access for any reason, we have fallen short of our promise as a Nation.

Our task now as a Nation is to acknowledge the extreme urgency of the situation, to take certain steps to arrest the inflation that is paralyzing us, and to put into motion initiatives that ultimately will reshape the system. This task is obviously not one for the government alone, although government has a major role

to play. Much of the burden must be taken up by the private sector since it has the primary responsibility for the delivery of health care. Unless government and our vast array of private institutions can learn to work together we cannot succeed. The fault in the past has been shared by both. Too often government has operated independently, and even blindly. Medicaid was launched without adequate preparation, with a stuff of only 80 people to manage $2½ billion in expenditures, and with no provision for expansion in the Nation's capacity to meet the increased demand for health services thus created. And too often the private sector has been reluctant to give up outmoded practices that are unsuited to the incredibly rapid changes of our society—to new demands, and increased demands.

This Administration is committed to correcting these past failures of government, and to challenging the private sector to begin the process of revolutionary change in medical care systems. To this end we are taking the following administrative and legislative actions:

we are eliminating the allowance to hospitals and nursing homes for unidentified costs;

we are enforcing regulations limiting payment to individual practitioners under Medicaid;

we are increasing reviews of drug utilization, drug pricing, drug efficacy and safety;

we are directing the Public Health Service to promote alternative medical care facilities:

we are requiring tighter, more frequent reviews of hospital care for patients;

we are requiring that physicians be identified by Social Security number in all Medicare and Medicaid transactions in order to assist in the audit and review of those transactions.

to help alleviate a serious manpower shortage, we are establishing an Office of New Careers with the top priority of developing programs for returning Vietnam Medical Corpsmen;

we are proposing legislation under Medicare and Medicaid to bar from participation practitioners who have consistently abused the program; to gain greater flexibility to engage in incentive reimbursement and demonstration projects; to withhold reimbursement for facility expenses incurred contrary to regional or local plan for health care facilities; and to insure that government does not pay more for services than the charges to the public at large;

we propose to shift emphasis of the Hill-Burton hospital construction program to the development of facilities for preventive care, outpatient care, and to the modernization of inner-city hospitals.

we will move in the direction of reducing the Medicaid burden on general revenues by shifting to various forms of prepayment.

we are establishing a Secretary's Task Force on Medicaid and Related Programs under the leadership of Under Secretary John Veneman and Mr. Walter J. McNerney, to deal immediately with the crisis in that program. This work group will:

(*a*) Develop and recommend utilization review procedures, incentive reimbursement methods, and standards for medical care;

(*b*) Develop procedures for better determining eligibility for medical and public assistance, to aid the States to simplify eligibility determinations, and to develop methods for more accurately predicting costs; and

(*c*) Develop a stronger administration on the Federal level, to aid States and localities to better control their programs, and to develop technologies of medical assistance management.

These steps will insure that the Federal government gets more for its health dollar. But the major portion of the health care dollar is not spent by government. It is spent by and on behalf of private consumers through voluntary insurance and personal expenditures in the private sector. Millions and millions of health care transactions occur every day in which the determining factors are utilization and pricing decisions made by private individuals, by physicians and other professional persons, by industry and labor and by voluntary institutions. Neither government decision nor government review is a determining factor in these transactions.

We must insure that the private consumers in these actions receive adequate services at a reasonable price. This requires a major commitment by the varied

segments in the private health care industry to drastic changes in the industry. To this end, we will ask National, State and local organizations to assume new responsibility for leadership in promoting such change. A good part of the job is theirs to do, and with great urgency.

In particular:

we will ask and challenge the health insurance industry, including non-profit insurers, to mobilize itself to expand coverages to additional groups, to provide broader and more effective coverage, to change their coverage to encourage preventive services to provide incentives to keep people out of hospitals and other high cost facilities, and to play an active role in monitoring the excessive use of scarce facilities, such as hospital beds;

we will ask and challenge the physicians, dentists, and other practitioners of the Nation through the national societies, and through the county associations, to establish procedures to review the utilization by their members of various services; to review in particular the use of nursing homes which now absorb one-third of the $5 billion expended on Medicaid by Federal and State governments; to encourage utilization by their members in all instances of less expensive types of care; and to discipline those who are involved in abuses;

we will ask and challenge the hospitals of the Nation through their boards of trustees, their administrators, and their organized medical staffs, to review and revise their procedures for admissions and discharges so that no patient stays longer in an acute facility or long term facility than is absolutely necessary; and we will ask them to work with other hospitals in the community to promote management efficiency, to share equipment and services, and to reduce the unnecessary duplication of facilities;

we will ask and challenge the deans and faculties of the medical schools and all who are involved in the education and training of professional manpower to find new ways to expand the number of persons they are training, to shorten the time needed for training and to orient their training more towards the immediate needs of the country, such as comprehensive medical care for the poor and near poor;

we will call upon the Governors and State Legislatures to re-examine and evaluate the role of State health departments in improving the delivery of health services and to review State requirements for licensing and certification which stand in the way of the proper use of scarce manpower;

we will demand of ourselves and the Federal government, in general, that we put our own house in order, including reviewing the role and performance of Federal hospitals, Federal health programs, and the future of the Commissioned Corps of the Public Health Service;

we will call upon citizens' groups and consumer organizations to continue their efforts to hold the medical care industry and government responsible for good management and for constructive policies in delivery and pricing of services;

we will ask and challenge American business to involve itself in the health care industry, including the creation of new and competitive forms of organization to deliver comprehensive health services on a large scale in what has been up to now largely a cottage industry.

We are creating a special industry group under the chairmanship of Mr. David J. Mahoney, President of Norton Simon, Inc., to develop and stimulate industry programs to provide health education and preventive health care for employees at every level and their families.

Over the coming months we will call together each of these groups to hear what they propose and to learn what they will expect of us in return. Many dedicated persons among them are already working towards these goals. We have much to learn from them. What we will ask of all is that their efforts be greatly broadened and intensified.

This country has made achievements in the quality of care beyond anything that could have been imagined at the turn of this century. It is that very success that has brought us to the present test of whether we have the capacity to extend that same quality of care to all in society at a price which they can afford. What is ultimately at stake is the pluralistic, independent, voluntary nature of our health care system. We will lose it to pressures for monolithic government-dominated medical care unless we can make that system work for everyone in this Nation.

ITEM 2. STATEMENT OF JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, BEFORE THE SENATE COMMITTEE ON FINANCE, TUESDAY, JULY 1, 1969

Mr. Chairman and Committee Members, I am pleased to be the first witness in these hearings which you are holding on the Medicaid and Medicare programs. I am quite aware that the focus of your investigation is on the methods to improve the programs and to eliminate any possibility of or opportunity for fraud and abuse. I am also aware that specific cases of fraud and abuse create worry and frustration in professional circles and among beneficiaries.

A year ago I chaired a committee of the California Legislature which dealt with many of the same issues which we are now facing. No one condones wrongdoing. Persons guilty of fraud must be punished, but I think it is essential that we place these things in their proper perspective. What we are really talking about is the capacity of government both at the state and Federal level to detect and resolve problems such as this quickly and effectively. More importantly, if we place more emphasis upon strengthening our managerial capabilities, abuses and fraud should be greatly reduced.

Our lack of data—especially in some of the title XIX programs—on such important matters as how much providers receive and how many patients are being served clearly shows some of the problems that exist. I think that we all would agree that these hearings must strengthen program operation and develop the kinds of controls which will make abuse infrequent or unprofitable.

Much of my discussion will be directed toward steps which we have already taken and which we propose to take to provide strong administrative and managerial control. The Department of Health, Education, and Welfare wants to make clear that its basic commitment is to the original objectives behind Medicare and Medicaid. We are committed to providing quality medical care to the aged and to other persons who could not otherwise afford it. This commitment carries with it a heavy responsibility for assuring that the administration of funds allocated for these purposes fully meets these objectives.

As you well know, both Medicare, Title XVIII, and Medicaid, Title XIX, programs are massive in their scope. Virtually all persons over 65, of which there are nearly 20 million, are eligible for services under the Medicare program and during this past fiscal year, this program paid over 6 million claims for in-patient hospital stays and over 25 million bills for physicians services. In addition, under Medicaid, 9½ million persons this last year also received medical services. Thus, we are talking about programs which began in 1966 and were designed to serve the needs of at least 30 to 40 million people.

Since 1966 we have been faced with a rapid rise in the costs of medical care and services. Perhaps the Title XVIII and XIX programs may not have been primarily responsible for price increases, but we would not deny that they have contributed to it.

The desire for so-called "mainstream medicine" united many forces, both professional and beneficiary groups, behind the legislation in 1965. For the first time, many persons were given access to medical services of their choice. As a consequence, the demand for all services increased, and since the supply of manpower and facilities has not grown at the same rate rapid price increases resulted. However, this has been in a period when most prices have been rising and the cost factors affecting medical services are certainly more complex than these programs alone would account for.

This leads us directly to the administrative capabilities in the Department, in the states, and among the intermediaries. It is this combination that must deal with millions of people and billions of dollars in payment for medical care services. Let me say frankly that the 5 months that I have been in the Department has confirmed my previous opinion that administrative deficiencies do exist on all levels in the Medicaid program. That program is not one program but really 44 varying according to each state plan. While the participating states all had some experience with vendor medical payments before 1966, in Public Assistance Medical Care and Medical Assistance to the Aged programs, the expenditures have more than tripled since Medicaid started.

States have in many instances demonstrated the lack of administrative capacity to manage programs of the scope and magnitude of Medicaid today. The number

of doctors and other providers who now participate has vastly increased—in most places to a majority of all practitioners and facilities.

I would like to review briefly with the Committee the results of our audit of the Medicaid program, which has been completed in 10 states, copies of which have been submitted to this Committee. We anticipate audit reports covering 6 additional states will be completed by the end of this month. The audit demonstrates the existence of widespread administrative problems requiring immediate action to protect program objectives and to retain public confidence.

Although conditions varied among states, the following were problem areas of most concern in terms of overall program administration of Title XIX:

1. The audit found many instances of duplicate payments, excessive rates and fees, and other types of erroneous charges that would not have occurred if adequate management controls had been established by the states, or their fiscal agents, over Medicaid claims submitted by hospitals, nursing homes, physicians, pharmacists, dentists, and others.

2. Systematic review of utilization of services were not being made. Instances were noted of excessive prescription drug refills and other over-utilization of services. Unless the required utilization reviews are effectively carried out, there will not be adequate assurance that such instances are not in reality widespread.

3. The audit noted a need for improvement in the important function of assuring that payments are made only for persons who have been determined eligible for medical assistance. Considerable public expenditures rest on the reliability of these determinations.

Mr. Kelly, Assistant Secretary, Comptroller, is here to give further elaboration on the audit findings if the Committee wishes.

Federal and state governments have been negligent in their failure to provide the kinds and numbers of staff needed to give the necessary leadership, guidance and supervision which is needed to assure the effectiveness of these public expenditures.

In 1966, HEW had a division of 32 people to supervise the entire Medicaid program. Today, we have 100. We have asked the Bureau of the Budget to amend the Budget for 1970 to provide for 150 additional positions for the Medical Services Administration. This would include 10 additional persons in each of the regional offices to work directly with the states. This represents a major step in moving forward to achieve better control and supervision of the state programs.

States have also been deficient in providing adequate staff in terms of numbers and skills. We are proceeding with a review of all state plans to determine their capability of supervising the Title XIX program.

With respect to the Medicare program, the Health Insurance Benefits Advisory Council, which was established by law to advise on the administration of the program and which is composed of individuals drawn from the health field and from the general public, recently reported to the Congress that "the overall record to date can be viewed with a great deal of satisfaction." We can all be proud of what this program has accomplished, for it has substantially fulfilled the mandate of Congress. However, we recognize, as did the HIBAC, that there is also room for improvement in our administration of Medicare—Title XVIII.

The Medicare program has not been burdened with requirements for different state plans, the division of Federal-State responsibility, and the extreme insufficiency of staff which characterize the Title XIX Medicaid program.

However, a number of areas of weakness have been identified. Some of these would require legislative solutions. For example:

1. Under present Medicare law, there is no authority for the program to deny reimbursement to a licensed practitioner, who has demonstrated a clear pattern of fraud, repeated overcharging of the program or the use of supplies which are inferior or harmful. We are recommending authority under Title XVIII to discontinue future reimbursement and to put all parties on notice to this effect, where on the basis of clear evidence, a finding is made that this is justified by reason of such abuses. We must continually remember that only a very small minority of the practitioners or suppliers of the Nation would be affected by such a change, but nevertheless it seems essential. It is the first in the list of HIBAC recommendations recently sent to the Congress. Similar provisions under Title V and XIX would strengthen present state authority to deal with this problem.

2. We believe it would be desirable to limit cost reimbursement under Titles V, XVIII and XIX to a facility's charges to the general public for the same services. There are some situations where the application of the cost formula pursuant to law may now result in an institution receiving more than charges collected from the general public. You will recall that this proposal is included in S. 1195, sponsored by Senator Anderson and others.

3. We believe serious consideration should be given to withholding from or reducing Federal reimbursement under all three programs to health care facilities with respect to depreciation of capital expenditures and interest on loans for plant and equipment where such expenditures have been found not to conform to an overall local or regional plan for health care facilities. This would support the efforts that are being made by state and local planning agencies to assure that expansion and modernization of health care facilities are made on a basis which encourages their most efficient distribution. For example, we want to prevent helping to pay for highly specialized equipment in adjacent facilities if one set of equipment would suffice. A provision along these lines was adopted by the Senate as part of the Social Security Amendments of 1967, but was dropped in conference.

4. We believe that more flexibility is needed in the authority to engage in incentive reimbursement experiments and demonstration projects. Broader legislative authority than that provided under the Social Security Amendments of 1967 would permit a wider variety of projects aimed at increasing the efficiency of health care delivery. It would also give greater assurance that we could negotiate for participation in professionally acceptable projects aimed at fostering more effective cost control methods. The Health Insurance Benefits Advisory Council also recommended an expansion of the present authority for incentive reimbursement experimentation.

These recommendations are certainly not all-inclusive but they illustrate the kinds of issues and remedies we must consider along with a number of other recommendations recently made available to you by the Health Insurance Benefits Advisory Council.

In both Medicaid and Medicare, we feel that much more can be done with utilization controls than has been accomplished to date. Peer group review must become widespread not just in hospitals but also for other medical services. But peer group review alone is obviously not enough to control abuses and escalating costs. We have issued regulations for Medicaid which provide that, starting July 1, 1970, no state may raise fees without demonstrating to the Secretary that its utilization review is effective and that it has effective measures to control fraud by practitioners and facilities. We need new machinery for this purpose—"self-control" by the providers of service is being given a chance, but by itself is inadequate. Too often "peer review" is simply "peer justification". The public and the patients both deserve better.

The last questions which so deeply concern us in these programs are part of a larger, longer-term issue of medical economics. There must be incentives to stop further fragmentation of medical services. We must encourage increased use of prepayment plans and greatly expanded experimentation in new methods of delivery of medical services.

The emphasis on incentives must be geared to keeping people well and preventing illness. We should devise provisions to penalize those participants in the program who are responsible for keeping patients in hospitals and nursing homes unnecessarily. Stronger emphasis must be given to shortening hospital stays and treating people at an earlier time on a shorter-term out-patient basis.

Finally, let me report to you on four new initiatives that have recently been taken by Secretary Finch.

1. The Secretary has directed the Commissioner of Social Security, on the basis of experience with Medicare, to provide assistance to the Social and Rehabilitation Service in the monitoring of intermediary services and the provision of technical assistance to the states in effective use of intermediaries under Medicaid. Twenty-seven states, out of 44, use fiscal intermediaries for at least some part of their program. Thus, Social Security Administration expertise in this area is a resource which can make a contribution. Furthermore, more specific

efforts are being made to assure closer coordination in states where both use the same intermediary.

2. Secretary Finch has directed changes in regulations to eliminate the allowance to providers—2 percent to non-profit and 1½ percent to profit institutions—for unidentified costs. A flat percentage allowance that increases as all other costs rise may, in effect, reward an institution for increasing its cost. This administrative change will apply to the Medicaid program, as well as to the Medicare program, since both programs pay hospitals on the basis of reasonable cost. We are working with the American Hospital Association and other representatives of providers to re-examine our entire reimburesment process to be sure that, with this change, and others we expect to make, reimbursement will be fair to all concerned.

3. The Secretary has published a new regulation to control escalating costs of payments made to physicians, dentists, and other medical practitioners who serve Medicaid patients. This regulation holds a state to the level of fees allowed under the payment structure it used to January 1, 1969, unless those payments represented a preailing level at less than the 75th percentile of customary charges. States may increase the level with the approval of the Secretary but not to exceed the 75th percentile. In seeking ways to reduce the cost of program expenditures for physicians services under Medicaid, we considered limiting payments to the amounts established under Blue Shield fee schedules in the various states. Upon analysis by a special Task Force we found that most Blue Shield plans cover primarily surgery and in-hospital medical services. On the contrary, most Medicaid plans cover physicians home and office visits, dental services, eye care, etc. So even if a Blue Shield schedule were utilized, it would still be necessary to develop another system of payment for a significant part of the total services covered by Medicaid.

Many Blue Shield plans make payments to physicians on the basis of their customary and prevailing charges. Most of the plans now offered to large group contractors include a provision for reimbursement on the basis of usual and customary charges. Where this is done, the payments tend to be higher than those authorized under Medicaid. In view of the increasing trend among the plans toward paying on the basis of customary and prevailing charges, tying Medicaid payments to Blue Shield plans could well result in increased Medicaid costs.

An important consideration of any Medicaid proposal to control rising costs is the participation of a substantial proportion of practicing physicians. We believe that our decision to limit physician reimbursement under Medicaid to a level that will cover charges made at the 75th percentile in a locality for a given service will generally serve to make medical services available to Medicaid participants and at the same time assure an appropriate limitation on program expenditures.

4. Secretary Finch has also announced the formation of a Medicaid task force, chaired by Walter J. McNerney, to investigate rising costs, fraud, inferior management, and other problems in the system. The task force members will include authorities in the fields of medical care, public assistance, and management, as well as representatives of existing advisory groups and top level HEW officials. This task force will not be a passive study group. It will play a dynamic outreach role in assessing these problems and developing management capabilities for dealing with them. By giving top priority to the need for meeting the management crisis in Medicaid, it is important not to overlook the basic program goals of providing quality medical care quickly and efficiently to those who need it.

Mr. Chairman, let me again thank you for the opportunity that this hearing provides for allowing the Department to express its views, initiatives and plans in relation to these very worthwhile programs. With the cooperation of Congress, I am confident we can correct the deficiencies that exist.

Dr. Land will discuss the medicaid program, and Commissioner Ball will then go into greater depth with you with respect to the medicare program. Other staff members are here to be of further assistance.

Thank you.

MEDICAID REPORTS

The following is a tabulation of the States that have been audited under the medicaid program, title XIX of the Social Security Act. As indicated in the schedule, 10 audit reports have been finished and released and six are still in process. The estimated release dates are shown below.

State	Report released	Estimated release date
Massachusetts	June 25, 1969	
New Hampshire		July 18, 1969
Rhode Island		July 31, 1969
New York		July 17, 1969
Pennsylvania		July 13, 1969
Illinois	June 4, 1969	
Michigan	May 26, 1969	
Wisconsin	May 28, 1969	
Minnesota		July 13, 1969
Missouri		July 9, 1969
Oklahoma	Mar. 26, 1969	
Texas	Mar. 28, 1969	
New Mexico	Apr. 24, 1969	
California	June 25, 1969	
Oregon	Mar. 21, 1969	
Washington	Apr. 2, 1969	

ITEM 3. LETTER FROM BERT SEIDMAN, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATION, WASHINGTON, D.C.

AMERICAN FEDERATION OF LABOR AND CONGRESS
OF INDUSTRIAL ORGANIZATIONS,
WASHINGTON, D.C., *July 18, 1969.*

DEAR SENATOR MUSKIE: During the hearing of the Subcommittee you very appropriately stated that by perfecting Medicare for the elderly we might pave the way for assuring better health for Americans of all ages. As you know, our Advisory Committee stated in our report that it was our view that the best way of bringing quality medical care to all Americans would be through a comprehensive system of national health insurance.

I am sure you are aware that this has long been a position of the AFL-CIO. I am enclosing a resolution on national health insurance adopted at the most recent Convention of the AFL-CIO in December 1967. This resolution reaffirms organized labor's long-standing support for universal comprehensive national health insurance.

The Subcommittee may also find useful the enclosed article reprinted from the January 1969 AFL-CIO *American Federationist.* In this article I have set forth some of our thinking regarding the way in which a national health insurance system might be established. You will note that in addition to other important aspects of such a system, the article gives a rough estimate of what the cost of national health insurance might be. Its major conclusion regarding this point is "that a National Health Insurance program could now, or in the near future, be financed without increasing taxes and with most workers paying less for health care than they do today." I would greatly appreciate it if the AFL-CIO Convention resolution, as well as the article from the *American Federationist,* could be included in the record of the hearings.

I wish to thank you for having given me the opportunity to serve on the Advisory Committee for hearings that you held on a subject which is of concern to all Americans, young and old alike.

Sincerely yours,

BERT SEIDMAN,
Director, Department of Social Security.

[Enclosures]

EXHIBIT A. POLICY RESOLUTION ON NATIONAL HEALTH INSURANCE, ADOPTED DECEMBER 1967

The preservation of health, the prevention of disease and deformity, the curing of illness—the development of a state of positive good health—are cherished goals toward which our society should strive. The magnificant new discoveries of talented research workers, the advanced state of the medical sciences and the rapid development of the application of computer technology to medicine now make the achievement of these long sought goals a realistic possibility.

For over two decades the labor movement, through its fight for a comprehensive national health program, has tried to remove the barriers between health needs and health opportunities.

During the 1904s we came close to achieving our goal. But because of powerful and reactionary forces mobilized against us, we were unsuccessful in gaining the national health insurance program which we wanted and which our country needed.

Since then we have sought to achieve our objective partly through collective bargaining and partly through more limited health benefits legislation. On both fronts we have been successful. Today, more than 80 percent of the American people have some health insurance protection. Those not having such coverage were mostly concentrated among the aged and the poor. Passage of Medicare and Medicaid for these two groups should give some financial protection against the cost of illness for almost all Americans. However, private health insurance is only paying for about one-third of all consumer expenditures for health care. Medicare pays for about 50 percent of the health expenditures of the aged. The implementation by the States of the Federal-State Medicaid program has been extremely uneven in scope of benefits and in coverage. These Title XIX programs range from very good to very inadequate. Moreover, many people eligible for medical assistance under Medicaid actually do not elect to participate because the program has a means test which is an offense to their dignity.

As the richest country in the world, we should not need to offer "half a loaf" when we have a unique opportunity to make this a nation of healthy people, but the hard facts are that we have not measured up to our potential. We are not leading the rest of the world in the measurable health of our people. In 1950 we ranked 6th out of the leading countries in the world in infant mortality rates. In 1960 we ranked 11th and by 1965 we have fallen to 15th place. Significantly, all countries whose infant mortality rates are superior to ours have a system of providing or of financing health care for the vast majority of their citizens.

Seventy million Americans suffer from one or more chronic diseases. Millions with heart disease, arthritis and mental illness suffer untold agonies and lead frustrating and unproductive lives—and thousands die—not because we do not know how to help them, but because they cannot obtain the quantity and quality of medical care that our nation is capable of and morally obligated to provide.

In substantial part this deficiency derives from an outmoded and unsatisfactory system of organization and distribution of medical services which places a premium on exploiting the health needs of people as a basis for commercial gain.

No one should be denied the right to necessary and available medical services simply because of lack of funds. Neither should a democratic society force millions of its citizens to take a pauper's oath before they receive the pittance of medical charity. America can afford to relate services to medical needs rather than to make money the primary passport to good health. Therefore, be it

RESOLVED, The AFL–CIO reaffirms its longstanding support for national compulsory health insurance. And be it further

RESOLVED, That organized labor should take the initiative to unite with other progressively minded groups in the nation in devising and promoting a medically advanced and economically sound program of national health insurance based on the following principles:

1. Universal coverage
2. Comprehensive benefits
3. Adequate financing.
4. Assurance of high quality health services with adequate cost controls.

EXHIBIT B. THE COMING BATTLE FOR NATIONAL HEALTH INSURANCE

(By Bert Seidman*)

Renewed interest in a universal and comprehensive health insurance program has been gathering momentum in the last few years as the rapid rise in medical costs have made it increasingly difficult for people to pay their health bills.

There is increasing evidence also that special programs for the poor, including medicaid and the neighborhood health centers of the Office of Economic Opportunity, are not meeting the need. And although federal and state governments are literally "pouring" billions of dollars into many different health programs, there is no appreciable impact on the efficiency with which health services are delivered.

Since 1938, both the AFL and the CIO repeatedly endorsed a national health insurance program for all the American people. The 1955 merger convention, in its resolution on health programs, called upon Congress to enact:

"A national health insurance system which would make complete prepaid health protection available to all Americans, with contribution geared to income; assure high quality medical services, facilities and personnel in expanding quantity and quality; and at the same time provide free choice of doctors and patients, with control of medical decisions in the hands of the medical profession."

In 1957, the AFL-CIO reaffirmed the 1955 convention action as the continuing position of the federation. At its February 1967 meeting, the AFL–CIO Executive Council again called on Congress to enact a program of national health insurance embodying the principles of universal coverage; comprehensive benefits; adequate financing and assurance of high quality services. This action was underscored by a comprehensive resolution adopted at the AFL-CIO convention in December 1967.

Support for National Health Insurance has waxed and waned in this country, but at least three times since World War I it was strong enough so that its establishment was under active consideration.

A universal compulsory system of medical care insurance was first advocated in the United States before World War I. This early movement covered the years 1910 to 1920. Significantly, this initiative had the support of the American Medical Association. Professional opposition soon developed, however, and at the annual meeting of the AMA in New Orleans in 1920, the House of Delegates established a basic policy which has not been revised to the present day. This is what the AMA said nearly 50 years ago:

"The American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory insurance against illness, or other plan of compulsory insurance which provides for medical service to be rendered contributors or their dependents, provided, controlled or regulated by any state or federal government."

In 1025 and 1926, a number of conferences were held which were called to formulate plans for a study of the structure of medical services in the United States. As a result of those conferences, the Committee on Costs of Medical Care (CCMC) was established, financed by six foundations. The final report of the Committee was published in 1932. Battle lines were quickly drawn. The majority of the members of the Committee were of the opinion that "medical service both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel" and that "the costs of medical care to be placed on a group payment basis" through the use of insurance, taxation or both. The minority report, which was supported by the AMA, objected to the proposal for group practice and the adoption of insurance plans unless sponsored and controlled by organized medicine.

Following the report of the CCMC, a serious movement began for enactment of a National Health Insurance program. Originally, it was to have been a part of the Social Security Act which was passed in 1935. Apparently for tactical reasons, it was left out. Later, Senator Wagner introduced his first National Health Insurance bill (S. 1620) in 1939 with the Roosevelt Administra-

*Bert Seidman is Dierctor of the AFL–CIO Department of Social Security. This article is based on a recent address before the 20th Anniversary Conference for graduates of the St. Louis University Program in Hospital Administration, Clayton, Mo.

tion's blessing. The first Wagner-Murray-Dingell bill was introduced in 1943 and subsequently reintroduced in 1945, 1947 and 1949. Despite considerable interest and support, the bill never passed either house of Congress.

We all know what happened then. Despairing of the likelihood that universal National Health Insurance could be enacted in the foreseeable future, organized labor and other supporters made a tactical retreat. It was then that the long, successful fight for medicare began which now provides health insurance for 20 million elderly Americans. I hope that early in its first session the Congress will extend medicare to the disabled and eventually to other social security beneficiaries. In this way, health insurance under federal auspices may gradually cover more and more of the population. But there is an easier way of doing it and that is to recognize that America needs now a National Health Insurance system with universal coverage.

What would be the main features of a National Health Insurance program for the 1970s? First, let me clear up one possible misconception right way. By National Health Insurance, we do not propose a government-operated health system as, for example, in Great Britain. Rather, it would be a financial mechanism to pay for the costs of medical care for all people much like the present medicare program for the elderly. A National Health Insurance program would not "interfere" with the clinical practice of medicine. Benefits under the program would be broad and should cover hospitalization, physician services in the office, home and hospital, extended care as well as custodial care in nursing homes, home health services, outpatient and inpatient psychiatric services, eye examinations and prescriptions. Preventive health services such as physical examinations would be covered for members of compresensive group practice prepayment plans or in community multi-phasic diagnostic centers for those beneficiaries who prefer to receive benefits from a physician on a fee-for-service basis.

We would propose universal coverage, including not only the working population and their families but also the unemployed, students in school and those on public assistance. Rather than a separate program for the poor such as medicaid, all citizens would be covered on an equal basis, thereby implementing the concept of health as a basic human right.

Coverage of those on public assistance and the unemployed naturally implies federal participation from general revenues. We, therefore, feel the program should be financed on a tripartite basis under social security, probably with the employer paying one-third, the employe paying one-third and the federal government participating by paying one-third from general revenues.

Physicians would be given a choice of practicing fulltime under the system or combining care of patients paid for by the system with care of those who prefer to pay for their care privately or of continuing to practice fulltime outside the system. But since most people would get their care under the system, care of patients under National Health Insurance would constitute the bulk of most physicians' practice. Whether caring for prepaid patients or for others, physicians would be free, as they are now, to practice alone or as members of a group. Physicians would also be free to choose to be paid by fee-for-service or by capitation, that is, periodic payments for each individual or family covering total health care. Capitation payments would be payable for physician services or for entire health delivery systems such as Kaiser or other group health plans which undertake a total responsibility for delivering comprehensive care.

Patients should have not just free choice of physicians but also free choice of health delivery systems. The government should not "freeze in" either the fee-for-service system or a capitation system. Rather, the National Health Insurance program should allow maximum flexibility in methods of paying for services so that innovations and experiments designed to develop new ways of delivering health care would be encouraged.

Since the trade union movement believes in competition, we think the interests of the American people would best be served by stimulating competition between health delivery systems. We also think that fee-for-service enterpreneurial medicine cannot, by its very nature, ever be efficient and would in time lose out to an organized system.

No one should get the idea that the AFL–CIO would favor a completely laissez-faire system under National Health Insurance. Frankly, we would not.

Some of the trials and tribulations we have experienced under medicare and some of the mistakes other countries have made under their national health insurance programs could be and should be avoided under a National Health Insurance program. We would not tolerate sky's-the-limit doctor fees and we would insist on both controls and incentives for moderating hospital charges. We would also want to institute some type of negotiation of physician fee schedules and hospital charges instead of present arrangements which largely permit providers to determine their own compensation. Moreover, we would do everything possible to provide appropriate incentives to improve quality, enhance efficiency and reduce the cost of medical care.

These are the bare bones of a National Health Insurance program for the American people. There remain a number of questions. One surely is how much would such a program cost? Can we afford it? Are there enough hospital beds? Enough physicians? Enough health manpower? These are indeed legitimate questions.

First, there is no doubt that if the unregulated fee-for-service, entrepreneurial system of delivering health care is to remain sacrosanct, then we may as well resign ourselves to inefficient, costly. fragmented and ineffective health care of inferior quality. But National Health Insurance, by providing financing for across-the-board health care, will help to move us away from predominant reliance on fee-for-service.

Today U.S. health expenditures are now over $50 billion, 6.3 percent of the Gross National Product. This is more, not just in dollars but as a proportion of the total economy, than for any other country in the world. Great Britain, with its National Health Service which provides a scope of health services as broad as proposed in this article, spends less than 5 percent. Most other western countries have national health programs covering substantially all of their citizens. Yet they all spend less than we do as a percentage of their gross national product. On the basis of what we are now spending, the United States has ample resources to underwrite a National Health Insurance system covering the benefits outlined with the proviso that something will be done to begin to rationalize the health delivery system in this country.

Next, let us examine the question of hospital beds. We have 3.9 hospital beds per 1,000 population. However, about one-third of these should be modernized to conform to minimum federal standards. The Division of Hospital and Medical Facilities of the Department of Health, Education, and Welfare estimates an additional 75,000 beds are needed under our unorganized system of delivering hospital services.

But it is conceivable that, with a more rational medical care system, we might now have too many beds! The fact that the group practice prepayment plans have but one-half the rate of hospital bed utilization as under conventional fee-for-service has been well documented. For both federal employes and for employes of the State of California, the number of hospital days per thousand enrolled under the group practice prepayment plans, as compared to those enrolled under Blue Cross and under commercial indemnity insurance for federal employes, was as follows for the contract year ending December 31, 1965: Blue Cross, 990; Commercial Insurance, 1,006; Group Practice Plans, 475.

The group practice prepayment plans used to use as a rule of thumb that two beds were required for every 1,000 subscribers. Now, as a result of experience they are planning on the basis of 1.7 to 1.8 beds per 1,000. This is less than half our present ratio. The backlog need for modernization of hospitals under the present "non-system" is estimated to be $20 billion. Under an organized system of health care, most of these obsolete hospitals could be simply torn down.

Now, just one more jolt. Under a rational system of health care, we might even now have enough physicians!

Prepaid group practice plans also make physicians' services more efficient so that fewer of them are needed in relation to the patient population. Kaiser Portland has one physician for every 1,500 subscribers. Group Health Cooperative of Puget Sound has one physician for every 1,200 subscribers. The East Nassau clinic of the Health Insurance Plan of Greater New York has one physician for every 1,100 subscribers. Kaiser of Northern and Southern California likewise have one physician per 1,100 subscribers.

These ratios are for plans which have a fulltime medical staff. Let us be conservative. Let us assume that 1 physician per 1,000 population is needed. With about 200 million population, we would need 200,000 physicians. We have

slightly over 300,000 doctors but, of course, many of them are in government, in full-time teaching and research in our medical schools and some are retired.

It is estimated that there are 233,000 "patient seeing" physicians in the United States—more than we would need if health services were rationalized in this country!

With regard to nurses, dentists, psychiatrists and many categories of allied health personnel, we do need more health manpower but, except for psychiatrists, the training period is not as long as for physicians.

In order to implement a National Health Insurance program in the United States, we would propose a double attack. We, of course, realize that group practice prepayment plans will not become the predominant form of medical practice for many years to come—perhaps never. To solve our facility and manpower problems, we should support federal programs to meet these needs under our present "non-system" while at the same time federal funds should be provided to encourage largescale development of new group practice, prepayment plans in order to reduce our future requirements. At some time in the future, our increased supply of facility and manpower resources will converge with a gradually decreasing need for such resources as the health delivery system becomes more rational.

Now, let's talk about money. Can we afford National Health Insurance? For the fiscal year ending June 30, 1967, total expenditures for personal health services in the United States total $41.5 billion or 5.4 percent of the gross national product. This excludes expenditures for health facility construction, medical research and other items not associated with personal health care. While a National Health Insurance program would certainly result in an increase in personal health services, assuming we can make some headway in rationalizing our delivery system I believe we could finance such a program providing more comprehensive and higher quality health services to the American people for no more and perhaps less than we are now spending for personal health services.

Moveover, a National Health Insurance plan as broad as the one outlined would not have cost $41.5 billion in fiscal 1967 because there are some items of personal health expenditures included in the total figures that would not be covered, such as over-the-counter non-prescription drugs.

The more comprehensive group practice prepayment plans cover about 75 to 80 percent of the personal health expenditures of the subscribers and their benefits are roughly comparable to those outlined. Granted that such a comparison is rough, it would seem that an 80 percent coverage factor for a comprehensive National Health Insurance program should be reasonable. Eighty percent of $41.5 billion is approximately $33 billion.

With tripartite financing, this comes to an annual contribution of about $11 billion each by employees, employers and from general revenues. Now, in fiscal 1967, total public expenditures—federal, state and local—for personal health services came to $12.6 billion, of which $7.8 billion were federal. If the appropriate adjustments are made to take account of the fact that public expenditures included medicare payments partly financed by employer-employe contributions, federal expenditures out of general revenue combined with state and local expenditures for personal health services approximated $11 billion. So the one-third government contribution for National Health Insurance would be less than what government is now paying for inadequate health care.

Labor is particularly interested in what the financial impact of National Health Insurance would be on workers. Health plans negotiated by unions under collective bargaining seldom meet more than 50 percent of the health expenditures of workers and their families. In addition, workers pay on the average one-seventh of the cost of their private health insurance. This means that workers today are paying for nearly two-thirds of their total health care costs. Under National Health Insurance, they would pay one-third in contributions plus 20 percent out-of-pocket or a total of 53 percent. But this would be for comprehensive across-the-board health care instead of the fragmented partial services they can afford today.

From these facts, we conclude that a National Health Insurance program could now, or in the near future, be financed without increasing taxes and with most workers paying less for health care than they do today.

The time is now ripe to again make a determined effort to enact National Health Insurance. This is why the last AFL–CIO convention unanimously reaffirmed organized labor's longstanding support for National Health Insurance.

And we resolved that organized labor should take the initiative to unite with other progressively minded groups in the nation in devising and promoting a medically advanced and economically sound program of National Health Insurance.

Frankly, labor does not anticipate the support of organized medicine. But the AMA was opposed to medicare and it is now law. We hope others will support us.

Trade unionists are not the only ones who want National Health Insurance. When the question is put to them, a majority of the American people want "medicare for all," which is exactly what National Health Insurance would provide. The Harris poll asked in January 1967: "Do you favor or oppose a federal plan such as medicare for older people which would cover all members of your family?" Fifty-one percent answered "yes," 39 percent "no" and 10 percent were not sure. This majority in favor of the National Health Insurance approach is all the more remarkable when one considers that the issue has not been in the public eye for more than a decade.

With the health services National Health Insurance would make possible, America could have the best medical care in the world. This is a goal worth striving for. It is time to bring the wonders of modern medicine to all the American people. It is time for National Health Insurance.

LABOR'S GOAL

The passage of the 1965 amendments to the Social Security Act, which included medicare (Title XVIII) and medicaid (Title XIX), was an outstanding achievement of the 89th Congress.

Title XVIII provides protection against the cost of illness for a significant proportion of the American people—those over age 65—as a matter of right. Title XIX commits the federal and state governments to comprehensive health care programs for low-income people.

Despite these advances, they do not meet labor's long sought goal of providing and financing comprehensive health services for all of the American people. We take this occasion to reaffirm this fundamental principle. Therefore, the AFL–CIO Executive Council calls upon Congress to enact a program of National Health Insurance embodying the following principles:

1. Universal coverage.
2. Comprehensive benefits.
3. Adequate financing.
4. Assurance of high quality health services.

—Statement by the AFL–CIO Executive Council on National Health Insurance, Bal Harbour, Florida, February 20, 1967.

Appendix 2

LETTERS AND STATEMENTS FROM ORGANIZATIONS AND INDIVIDUALS

ITEM 1. LETTER FROM ARTHUR F. ALLAN, VICE PRESIDENT, AREA 1, AMERICAN ASSOCIATION OF RETIRED PERSONS

AMERICAN ASSOCIATION OF RETIRED PERSONS,
August 21, 1969.

DEAR SENATOR MUSKIE: Your letter dated July 31, 1969, and the Advisory Committee report received and carefully read. It is a pleasure to submit to you several phases of the Economic aspect of those persons over sixty-five who reside in Maine.

I have spent some eight years working as a volunteer officer for the Association. The American Association of Retired Persons was started in 1958 and since then has grown to a membership of 1,800,000, and of this number 16,500 are Maine citizens. We have no connection with the fifty-four Senior Citizens Centers in Maine. We are an independent corporation and receive no financial help from the Federal Government, the State of Maine, or any Municipality in Maine. Our dues are $2.00 a year and cover member and spouse.

Our services include hospital insurance, and drug service, that are of special interest to you. These services have saved thousands of dollars for its members. Today we have seventy registered Pharmacists in Washington, D.C., Long Beach, California, and St. Petersburg, Florida. Our specialty is filling physicians' prescriptions. I wish that I might show you my personal files where I have thank-you notes from hundreds of our Maine members. In some cases the combined income of a couple was so small that after paying for their medicines, there was not enough left to eat. In other cases where each had to take three or four prescription drugs, I have seen them save over $250. a year, which, even at inflated prices, will buy a lot of groceries.

Many retired couples have been forced to sell their homes on account of the constant increase in Real Estate taxes. These were the homes they built by savings from their low pay checks. Here their children were born and here they were raised. Many of the children moved to states where there were better jobs, married, and had their own expenses to pay, so they could give their parents little or no assistance. The house once sold, the couple or in many cases, just one of the old folks, came to Portland and got a room, found they did not have enough from their Social Security, so they had to turn to Charity. It would have been better and less expensive if the State or Municipality had reduced their taxes and allowed them to stay in the home they built.

I tried to put a bill through in 1968 to freeze the taxes at the 1967 level. It was passed unanimously by the Committee, and was well on the way to being passed by the Senate when they had a freeze in Augusta and not enough money to pay the State employees so my bill and eighty others were tabled. This year the bill was rewritten, changing it entirely, allowing the property owner to borrow money from the town to pay his taxes and the heirs eventually repaying it, plus 6% interest. Gov. Ken Curtis said he had never seen a bill that was so poor, and yet it passed.

Inflation is foremost in the minds of everyone. So far as I have been able to find out Maine has made no effort to ease the burden of the elderly, except charity. Now is the time they need help. We need more Out-of-Hospital Homes that meet the Federal Requirements and yet at a rate that we can pay. We need homes of some type that I would call "Terminal Homes." Just where people will be sent when their money runs out is a question.

For those who move to the cities it is a cheap room and a sketchy menu. Widows fear to leave their rooms, especially at night. They come unprepared to get in touch with the Agencies that we have that could help them. Senior Citizens have done a great deal but many Centers open only once or twice a week.

Let us face it. What the elderly need most is money to help them out.

Sincerely,

ARTHUR F. ALLAN,
Vice President, Area 1, A.A.R.P.

ITEM 2. LETTER FROM EDUARD C. BRANDT, C.L.U., CONNECTICUT GENERAL LIFE INSURANCE COMPANY

CONNECTICUT GENERAL LIFE INSURANCE CO.,
Bloomfield, Conn., July 22, 1969.

DEAR SENATOR MUSKIE: As a Senior Citizen I am dedicated to helping to determine a feasibile plan to aid those suffering with chronic disease who—

1. Are not aided by Federal or State program—Welfare—Medicare or otherwise.
2. Are in desperate need of financial assistance.
3. Are not given their proper share of the economic resources of the U.S. Government, and are not equitably represented in the Health, Education and Welfare programs.

My interest has been expressed in letters to your associates, Senators Ribicoff and Daddario, and now to your special subcommittee for health and economics of the elderly for study and with the request that they be printed into the subcommittee record.

Sincerely yours,

EDUARD C. BRANDT, C.L.U.

[Enclosure A]

JUNE 11, 1969.

Re: HEW and aid to the very sick.

Hon. SENATOR ABRAHAM A. RIBICOFF,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR RIBICOFF: Thank you for your prompt acknowledgment of June 3 and June 5 to my letters appealing for a new concept of aid to very sick American citizen.

As I know, the problem is not what the existing HEW Act does, it is what it does NOT do to aid the catastrophic sick.

There is an existing vacuum of aid in this law. This needs to be uncovered. This failure to help those suffering with catastrophic chronic disease is one of the nation's number one problems. It has been with us longer than the Vietnam War or World War II or World War I; it has been neglected thruout this century. When will our Congressmen take heart and help these financially pressed and distressed families of the middle class.

Do you need facts? Does not a single proveable case crying for aid to his Government—when all else fails—deserve care? If 2 and 2 equal 4—then the science of mathematics is true and proven, so in like manner—if my appeal is valid for one—it is valid for the millions of chronic diseased Americans. HEW as it stands is inadequate—incomplete—partial—and discriminatory.

Please give of your busy time a top priority to this appeal so action can be taken in this session of Congress.

It is urgent—it is the voice of thousands crying in the wilderness for help. Will you answer? These hundreds of thousands for whom I am writing to you cannot—they are unable—they would if they could—and this is not the case of thousands of healthy men and woman on Welfare, or State Aid in Connecticut who could work, even if it meant cleaning up the rubbish off Hartford streets—repairing broken buildings—acting as volunteer policemen—and a hundred other neglected things—they are physically well; those whom I speak for are terribly incapacitated. They would work if they could—Justice place aid to the chronic sick in priority over paying money to support people to hang around and do nothing. The fostering of illegitimate and pregnancy thru financial care of unmarried mothers, and other un-American tendencies.

Therefore, I summarize the problem and solution for your consideration and action as follows:

PROBLEM

1. Financial.
2. Nursing Care.
3. Housing specially designed; opportunity for the spouse to have uninterrupted free time to work.

SOLUTION

Recommended new benefits specifically legislated to aid senior citizens under a new health education and Welfare Act.

1. (*a*) *Finance.*—That the cost of medical and nursing care required for a spouse or self wherever performed, at home or in any residence, by any person acting as a nurse's aide, where the need and qualifications of nurse's service is attested by a doctor, be deducted in full from earnings to arrive at a net figure monthly or annually as a maximum of earnings allowable for Social Security monthly benefits prior to age 72—(at present disallowed.)

(*b*) That business expenses of other than salaried employees incurred in the performance of their work be deductible in arriving at net earnings for eligibility to receive Social Security payments prior to age 72—(at present disallowed.)

2. *Nursing care.*—That nursing care for the elderly be defined as care including "custodial care," "nurse's aide," etc. for a sick person, performed by any person other than spouse, authorized and attested to by the sick person's physician in any location of residence, be reimbursed under provisions of Medicare. That this sickness continuing six months or longer be defined as "chronic sickness" (at present disallowed.)

3. *Housing specially designed.*—A new housing act specifically designed to meet the need of families caring for a member suffering from a catastrophic chronic disease. For example, installation at entrance to include ramps to accommodate wheel chairs—bathroom and other doors of ample wheel chair width. A new concept of government-sponsored housing—high-rise fireproof apartments for chronically diseased senior residents and complete in living appointments such as are now in existence at 3030 Park Avenue, Bridgeport, Connecticut, for senior citizens in good health at time of admittance, with additional facilities for "nursing care" floors to permit daytime care through employment of nurses' aides—not Registered Nurses—in order that a spouse could deposit the invalid with nurses' care and be free to go to work. These new buildings in all major cities from coast to coast to be financed under government appropriations and the rent geared into number of rooms and individual income. (At present nonexisting)

4. *The opportunity for the spouse to go to work.*—This is an urgent matter—a must—in order to at least partially contribute towards the terrible expense as long as sickness continues—usually for a lifetime. (At present this is a cruel handicap and a resultant hidden expense to the government.)

SUMMARY

This action will (1) release unneeded Registered Nurses; (2) remove condition of nurse's employment from Visiting Nurses; Association to Doctor's authorization of any nurse's aide for custodial care; (3) return many patients from hospitals and convalescent homes to family homes, freeing needed rooms; (4) save money in the program aid resulting from the above and (5) bring money immediately to the many thousands of middle class Americans not presently receiving it; (6) lessen the severe financial pressure to earn greater income to meet medical bills resulting in disqualification from Social Security Benefits; (7) eliminate discrimination against government aid to persons suffering from chronic disease and totally disabled and unable to speak for themselves; (8) reduce the present hospital route (3 days) then to convalescent home (100 days) for custodial care at government expenses by some chronically diseased persons, and (9) of greatest importance, the availability of creative housing units designed to meet their special needs.

Senator, why the urgency? It is a problem of today to save lives. It is not charity that is asked for—but a rearrangement of the government's program for Health, Welfare and Social Security payments, and a meaningful housing program specifically designed with specifications to care for American citizens experiencing prolonged catastrophic chronic sickness under nursing care on a financially cooperative basis.

Please accept the leadership in our State and Country to resolve this terrible problem in a new manner which up to now has gone unsided with respect to the invalid having prolonged disabling disease who has a home and family to live with. They and their families will be eternally grateful to you. It could help themselves and not extend aid to the chronically sick who can't help themselves but who are trying to.

Another compelling reason for a new Health Act is the fact that long-term sickness is catastrophic while short-term aid under the present Act in most cases could be paid for over a period of time. This is well known by the medical profession.

This entirely new and progressive program can be accomplished during your administration. I pledge to do my part to help you in any way possible. The start must come from Congressional leaders like yourself. Neither I nor any other dedicated person can motivate a new era for the chronically sick without support, but with your active help, who can limit the good that can be done this year.

Sincerely yours,

EDUARD C. BRANDT, C.L.U.

[Enclosure B]

JUNE 14, 1969.

Re Citizens suffering with chronic disease and a New Health, Education and Welfare Law.

Congressman EMILIO Q. DADDARIO,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN DADDARIO: I had intended to talk with you personally on this subject but to brief you in part on what I have as an objective on this. I am enclosing copies of letters written to President Nixon, Senator Ribicoff and Governor Dempsey, as well as copies of a letter written to me by Mrs. Bradfield and one written Congressmen William Ryan by Mr. Blumenthal—both of the letter being associated with the Parkinson's Disease Foundation.

Governor Dempsey has been very co-operative in assigning state assistance to me in researching this matter.

In brief, there is an unlimited opportunity to make some very exciting progress in new legislation for an improved HEW Act as follows:

1. An entirely new concept of a nursing corps.
2. An entirely new creation of housing restricted for families supporting in their homes a member who has certain chronic diseases.
3. An equitable adjustment of Social Security and sick payments, including nursing and custodial care, and redefinition of same.

For these valid reasons and believing that you, Congressman Daddario, can do this for the thousands in Connecticut, as well as for the millions in the United States. I would like to have the privilege of conversing with you further, and urge the immediate preparation of a Bill covering the required legislation for this session of Congress.

Sincerely yours,

EDUARD C. BRANDT, C. L. U.

ITEM 3. STATEMENT BY OTHIE G. BURK, VICE PRESIDENT, NATIONAL ASSOCIATION OF RETIRED CIVIL EMPLOYEES

Mr. Chairman and Members of the Subcommittee: This statement is presented so you may be more fully aware of the peculiar position most Civil Service employees find after their retirement. This Association represents more than 135,000 members and speaks in behalf of more than 800,000 retired Federal employees and more than 200,000 of their survivors.

The peculiar position is caused by the fact that more than 60 percent of Civil Service retirees have not worked at other employment after their retirement. On page 74 of the Civil Service booklet on Retirement Planning, published December 1968, they report the results of a survey completed in June of 1968. They show that only 37 percent of retirees had worked at other employment since retirement, and at the time of the survey only 25 percent were then working, 16 percent at part-time jobs, and only 9 percent full time. Under such conditions, many of our retirees find they cannot qualify for Medicare hospitalization, as I know from personal experience.

Some of our retired people can no longer afford the cost of medical insurance. I talked recently with a widow who told me, "I got the cost-of-living increase which amounted to barely $3.00 per month. The next mail I received notice of an increase in premiums for two health insurance policies I have carried for a long time. The total increase was about $3.16 per month, so I just told them to cancel the policies. Now isn't that awful?"

That is a bad position to be in, but our mail indicates we have others equally as bad. We have numerous letters saying they have three or four prescriptions laying on the table and no money to pay for the medicine and hardly enough for food. Such conditions do not make sleep come any easier.

One of the more serious problems our retired persons face is that of trying to guess what type of medical insurance they will need. Many policies including Medicare require three days confinement in a hospital before the person becomes eligible for convalescent or nursing home care. Too often this becomes a real problem as illustrated by the actual case below:

The man of the house with more than 35 years of Civil Service work and at that time 85 years of age was totally unable to care for himself. The wife, herself age 82 became unable to care for him in their home. The man was blind, had high blood pressure, arthritis so bad he could not walk, and finally became incontinent. The doctor in charge of the case sent the man to a Nursing and Convalescent home. The wife found their policies did not cover the case unless the man had been in the hospital. When he had been in that home for a couple of months, he developed a bad case of kidney trouble, called Nephritis. The doctor still refused to place the man in the hospital and treated him where he was for more than two weeks before he became better. When the doctor was told the expenses were beyond the ability of the wife to pay unless the man could be hospitalized and she could get some help on the bills, he told her she could always mortgage her home.

I have in my files a letter from another lady who tells me she is fortunate that her husband's retirement income will nearly cover the cost of his health care each month. She claims to be fortunate because she still has a little income of her own that enables her to have food on the table.

Gentlemen, these are samples of the problems our retired Federal workers find in the later years of their lives. They are no less real because they do not number in the millions. Health care is one of the major problems for the Aged, and is one of the major causes of their financial difficulties.

The problems are there; the solutions may not be easy, but surely this great Government can manage to provide better health care for their former employees. I would suggest consideration of the following:

1. All persons, including Federal retirees, to be eligible for hospitalization under Medicare at age 65.
2. Prescription drugs to be available under Medicare.
3. The Government to pay a greater share of Health Insurance for its employees, both active and retired.
4. Support preventive health care clinics to better utilize Doctors and Medical facilities available.

Thank you for giving me this opportunity to present this statement in behalf of our retired Federal workers.

ITEM 4. STATEMENT BY WALTER P. REUTHER, PRESIDENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA–UAW, ON HEALTH CARE NEEDS OF THE NATION, JULY 29, 1969

It is a source of satisfaction that President Richard Nixon and his Administration have joined those who have been aware that this nation faces a "massive crisis" in health services unless action is taken to correct the alarming breakdown of the so-called health care system.

Deeply concerned with this breakdown and convinced that the American people have come to regard access to good health care as a right and not a privilege, the Committee for National Health Insurance, organized in November 1968, has been studying the nation's health care problems and working on developing constructive solutions.

We have reviewed carefully the proposals made by the Nixon Administration within the past few weeks to deal with the crisis. Many of these proposals are constructive in their own way. Even if they were all fully implemented, however, they would fail to come to grips with the fundamentals of the overall problem. They will not produce the "revolutionary" changes which admittedly are required if we are to increase the life expectancy of the American people to the levels of less affluent societies, and save the lives of thousands of infants and adults who die needlessly each year in this country. They would not deal with the basic economic problems involved in the financing of health care services. They constitute a series of band-aids placed on a health care non-system which requires major surgery.

The health care crisis in America is documented by appalling facts.

At least twelve other nations in the world have infant mortality rates lower than the United States.

We are twenty-first in life expectancy for males and twelfth for females.

A 40 year old worker in this country has less chance of living to be 50 than his counterpart in most of the industrialized countries of the world.

Among the poor, infant mortality rates often are five times greater than among the non-poor. There are five times as many disabling heart conditions, six times as many mental and nervous conditions, more orthopedic impairments, arthritis and rheumatism, visual impairments and other deficiencies.

Not only the poor but also the majority of Americans in the middle income groups sense the danger signs of a complete breakdown of our health care programs.

Medical care costs are on a moon shot trajectory; in the last three years they have continued to increase at a rate more than twice as rapid as the increases in the cost of living.

The breakdown of our health care "system" is not something for future generations to worry about. It is happening right now. It requires immediate massive corrective measures.

In Philadelphia announcement has been made this week of the recommended closing of the emergency rooms of six hospitals, faced with bankruptcy because of a proposed state welfare cut. In our cities all across the country creeping obsolescence afflicts hospitals. Shortages of personnel are forcing health care facilities to restrict essential programs.

Faced with rising costs in a marketplace economy, consumers, increasingly find it necessary to put off needed medical and hospital services.

In New York, Chicago, Boston, Portsmouth and elsewhere organizied consumers—denied equality of health care—demand vastly improved services and a strong voice in their development. Across the nation the frustrations of consumers—and providers alike—mount steadily, and down each road, in each community, angry confrontations seem inevitable.

Health care in America is in crisis because we have not acted realistically and adequately to deal with the "non-system" that characterizes this field.

In examining the new proposals of the Nixon Administration, we are deeply concerned about the approaches being made, because there is either lack of understanding of or lack of desire to treat the basic problem.

We agree that program improvements can come from putting effective controls on the costs of medical care under present government programs.

We agree with the Administration that the establishment of government utilization review procedures, with teeth, under Medicare and Medicaid can properly save tens of millions of dollars annually.

We support the work of the new Task Force on Medicaid and Related Programs.

One can only applaud the announced intention to bar from participation in the government programs, providers of services who have consistently abused their privileges. All Americans should be appalled by the well documented evidence that many physicians are taking grossly unfair advantages of private, and the new public health care programs. It is not enough to say that which is the truth—that the great majority of physicians are not taking unfair advantage of Medicare and Medicaid. We do not know how extensive are the abuses. The system which makes them possible needs to be changed so that they cannot continue to occur.

No week goes by without new examples of exploitation of the structural deficiencies of current programs:

From the July 11, 1969, issue of *The Detroit News:* One Michigan physician received $169,000 in one year in Medicaid payments alone. By his own statement this represented about one-third of his work. By a rough calculation this physician apparently devoted an average of 160 seconds to each of his Medicaid patients as he delivered the high quality of medical care which is the objective of this program.

The July 1, 1969 report prepared by the staff of the U.S. Senate Committee on Finance indicates there is substantial evidence of many physicians engaging in "gang visit" to nursing homes whereby 30, 40 or even 50 patients are seen in a single day and Medicare is billed for as much as $300 or $400 for one "sweep" through a single nursing home.

The *Detroit Free Press* reported on May 30th an investigation by U.S. Postal authorities of an alleged conspiracy among three Detroit osteopaths to swindle Michigan Blue Shield out of nearly one million dollars through the submission of phony insurance claims over a three year period.

Revelations by the Senate Finance Committee staff of widespread physician investment in nursing homes and proprietary hospitals, resulting in conflict of interest situation situations where physicians have an economic incentive to order as many services as possible, and unnecessarily extend the duration of stay for patients placed in facilities in which the doctor has a financial interest.

The *AMA News* of June 23, 1969 states that Senator John J. Williams (R., Del.) cited nine cases where the Social Security Administration had found abuses of Medicare by physicians including such practices as making fraudulent claims for hospital visits not made; a physician who cut his claims to one-seventh the original amount after being queried on the number of patients seen and the similarity of diagnoses and treatment; a physician-operator of a hospital accused of deliberately providing unnecessary and medically contraindicated surgical and hospital care, filing for double payment for physicians' services, and falsely setting costs and charges.

The *Detroit News* account of July 22, 1969 of a hospital in Tampa which refused the use of its life-saving dialysis unit (which assumes the kidney's function of filtering impurities from the blood) to a young female victim of kidney failure because her parents, who live on Social Security and veteran's pension payments, were not able to guarantee the cost of dialysis treatment which could reach $15,000 annually.

The Administration has called upon citizens' groups and consumer organizations to continue their efforts to help the health care industry and government to develop better management and more constructive policies in the delivery and pricing of services. The Committee of 100 for National Health Insurance, representing distinguished leaders from the health professions, labor, business and consumers, as an organization, and as individuals, will do everything in their power to comply with the Administration's request. But no one should feel secure that these actions will deal effectively with the health care crisis. Much more is needed.

We do not agree that the "revolutionary" changes which the Administration calls for can be effected through tightening up federal administrative procedures in Medicare and Medicaid, pleading with physicians and hospital directors to become far more cost conscious than they are at present and exhorting the private health insurance industry to do a better job than they are now doing. Solutions to the problems will be found through courageous facing of the issues of: financing, coverage and benefits, delivery system and quality controls.

Financing.—The federal government is now the largest single purchaser by far of personal health services. The patterns it has set in these purchases are largely responsible for the escalation of health care costs. The payment of so-called "reasonable and customary" physicians' fees, which was adopted from the commercial insurance industry, reimbursement of hospitals on a cost formula taken from Blue Cross, subsidy of private industry profits in the two-thirds of the approved nursing home beds in this country which are privately owned—these are major causes of escalation of costs.

Massive sums of monies are being spent on a bewildering set of public and voluntary programs. These are uncoordinated and at best provide only fragmented and inadequate treatment of episodic illness. Medicaid, maternal and child health and crippled children's programs, Medicare Part A and Part B, a helter-skelter variety of private health insurance programs underwritten by more than 1200 health insurance carriers add up not only to confusion, but to

payment of no more than one-third of personal health care expenditures in this country.

And the consumer is required to subsidize the heavy duplications in administrative costs, sales costs, reserve costs, etc., that are built into a competing, non-integrated series of arrangements.

Twenty-four to thirty-four million Americans under age 65 have *no* private health insurance benefits. The lower the family income the greater the likelihood that hospital insurance (the most costly of all health care protection) will be lacking. Two-thirds of the people with under $3000 in income have no hospital insurance.

As was demonstrated in the report of the Advisory Committee for Senator Muskie's Special Committee on the Aging only two weeks ago, even those of the elderly who have private health insurance supplementing Medicare find this insurance of relatively little assistance in helping meet the gaps in their coverage. And the gaps are large. In 1968 one-fourth of all the money expended in this country for personal health care was spent by or in behalf of the elderly, although they made up only one-tenth of the total population.

What this country needs is a universal, nationally financed, national health insurance program, related to the Social Security system, which will make health care available and accessible to all Americans. Such a program, based upon efficient organization of the delivery of care, is the objective of the Committee for National Health Insurance, which in the past nine months has been addressing itself to America's growing health care crisis.

There is neither reason nor economic sense to continue to avoid facing the issues, which are that health care costs should be spread across the entire population at risk, that the most economical financing is through the tested Social Security system, supplemented by general revenues, and that it is wrong to have separate programs for the elderly, for the poor, for children, for wage earners, for veterans, etc., etc.

Coverage and benefits.—In sum total present public programs continue to address themselves to episodic illness and fail to provide the comprehensive health services which our health professionals recommend.

In each instance when concern has been expressed about the rising costs of the public programs, Medicaid particularly, the response has been to curtail further the already inadequate benefits. In its new statement of last July 10th the Administration proposes tighter cost controls and more orderly administrative arrangements. This is desirable but avoids the basic problem. Medicaid, for example, is achieving only a small part of its potential and its promise. In 1966 an HEW official stated, "When adopted by all states the new medical assistance program can provide comprehensive, high quality medical care for as many as 35 million medically needy people". Three and one-half years later, as of July 1, 1969, only 10.8 million persons are estimated by the states which have these programs to be eligible for services. The primary need is to get coverage to people who require it. As of today there are still ten states without any Mediciad programs at all.

The UAW was in the forefront of the fight to achieve Medicare, knowing full well it was only a small step in the direction in which we need to go. Last year Medicare covered less than half of the personal health expenditures of the elderly. Two weeks ago an Administration spokesman testified that 40% of the elderly population is poor or near-poor. Medicare is not meeting the largest part of their crucial health care costs.

Further evidence of the deficiencies in Medicare is that 45% of the Medicaid expenditures go to the elderly. In other words, they supplement the government insurance program that was supposed to take care of the health expenditures of these people.

The Administration's statement calls for increased development of facilities for preventive care. No reference is made to providing payments for preventive services. For example, it is generally recognized that the elderly, at high risk, would have had far fewer serious flu illnesses, with resultant deaths last winter and the winter before when the Hong Kong flu and the Asian flu raged throughout our country had there been mass immunization programs. Such preventive services are provided neither through Medicare nor through practially any of the Medicaid programs.

Decent health care will not be achieved until universal financing is related to provision of comprehensive services. Immediate steps in this direction need

to be taken through elimination of the Part B coverage under Medicare and its incorporation into Part A, provision for capitation payments for comprehensive health services provided through group practice programs, expansion of home health services, elimination of co-insurance and deductibles and early implementation of prescription drug coverage.

An organized delivery system.—The Administration's July 10th statement commented that the delivery of health services in this country at present is "largely a cottage industry". We concur with this characterization of the solo practice, "fee for service" method of providing medical care. The Administration, however, appears to forget that it took an industrial revolution to convert "cottage" industry to more rational forms of industrial enterprise. Similar drastic change is required in the health care field.

The solution lies not in the Administration's proposal to ask American business to create new and competitive forms for delivery of comprehensive health services. Rather the solution lies in using the leverage of public monies and the knowledge and competence of professional health personnel more rapidly to develop newer forms of organization for the delivery of services.

Many of these patterns already exist. Through cooperation of the health team, rather than the competition of the marketplace, we have learned that it is possible to provide economical high quality health services. The medical generalist, the specialist and related health professionals are providing such services. Programs like Kaiser Health Plans, HIP of New York, CHA in Detroit, Ford Hospital, the Mayo Clinic and many university affiliated teaching facilities provide guideposts for the needed new developments.

We require both reorganization of delivery services and the linkage of these services to provide the continuity of care which exists but rarely in this country for the poor as well as the well off.

There is great potential pay-off in a reorganized delivery system in terms of improved quality of care, substantial cost savings and the use of more appropriate less costly facilities when indicated.

Reorganized delivery of services will make for more efficient use of scarce manpower resources. There will, however, continue to be a pressing need to train more doctors, nurses and other health professionals.

The Administration's proposal to find ways of providing health training for returned medical corpsmen from Vietnam has merit. In addition, however, it has been clearly demonstrated that greatly augumented federal resources will be required to assure that increased numbers of health personnel are trained to meet the new requirements of modern health care.

And many of those with the greatest potential for service are barred from entry. According to a recent study of four representative medical schools, published in the Journal of the American Medical Association, approximately 12% of the students came from the lowest social classes. They, however, constitute some 54% of the U.S. population.

This past April the project director of the National Medical Association Foundation was quoted as saying, "The chances of a Negro becoming a doctor are one-tenth those of a white man. . . .".

If the Administration is to deal responsibly with the critical shortages of health manpower, it is essential that it face squarely the present patterns of recruitment to the health professions, particularly physicians, and come up with imaginative programs to deal with de facto discrimination.

Assuring quality health services.—It is a source of deep disappointment that nowhere in the White House report on health care needs is a reference made to safeguarding and improving the quality of the care made available through public and private programs. It is possible from reading the report to envisage that we shall know "the cost of everything and the value of nothing". We do not know of any other sector of government programs where huge payments are made to purchase materials or services without quality controls. Neither government nor industry can afford not to have such controls. The government quite properly stipulates with precise detail the kind of equipment required for the automobiles it purchases, and for the tanks and the planes—but not for health services so vitally required by the people. There is indignation expressed when physicians receive hundreds of thousands of dollars annually in public funds for treating patients, but there is no outcry about the lack of quality care provided by physicians who may see patients an average of two minutes and forty seconds each.

There is documented evidence that morbidity and mortality from major surgery could be dramatically reduced by requiring that Board qualified surgeons be the only ones permitted to undertake such surgery, except in emergencies. Yet our payment system makes no provision for this.

There is substantial evidence that many medical services, particularly to the poor, are provided by health professionals, particularly physicians, who have not kept up with newer developments in the field. New York City has done an outstanding job in correcting this situation. Such standards could and should be incorporated in national requirements.

The so-called "peer review system" is proving of minimal value for it has no teeth, and is not backed up by the force of government sanctions.

It is possible to have far better controls on the quality of care when they are related to the financing and payment system and when they have the force of government standards and public support.

The "revolutionary" changes which the Administration states are required in the health care system of this country will be achieved only through dealing with the fundamental problems facing us. These involve universal participation and national financing of health insurance, comprehensive benefits and coverage, reorganization of the delivery system, and effective quality controls. It is toward these objectives that the Committee for National Health Insurance is working.

Prior to the great events of this past week, Arnold Toynbee wrote that "The significance of a landing on the moon lies in forcing us to face—and, we may hope, to deal effectively with—the ludicrous but also perilous discrepancy between our attainments in technology and in morals."

The landing of men on the moon is a challenge that we get on with the great issues here on earth. Health care in America is one of the gravest of these issues.

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ITEM 5. LETTER FROM SIDNEY KORETZ, ARLINGTON, VA., TO THE CHAIRMAN, AUGUST 14, 1969

DEAR SENATOR MUSKIE: The working paper by your advisory committee on "Health Aspects of the Economics of Aging" has something in common with the Report on Health Care Needs by H.E.W. Secretary Robert M. Finch and Dr. Roger O. Egeberg released at the White House on July 11, which among other things anounced the establishment of a Secretary's Task Force on Medicaid and Related Programs. Although implied in several places, economy and cost reduction are never mentioned explicitly. Why not?

There seems to have been an inflation of confusion since the economic analysis already achieved by former Secretary John W. Gardner. (Both your advisory committee's report and the one released at the White House misuse the word "inflation." It is applied to specific price rises when properly it should refer to a general price rise.)

On June 28, 1967, before the National Conference on Medical Costs, called at the direction of the President, H.E.W. Secretary Gardner said we need a "radical shift of emphasis" from the "financing mechanism" to the examination of "the efficiency, the productivity and the logic of the system by which (health) care is delivered."

The "financing mechanism" was represented at this conference by Social Security Commissioner Robert M. Ball. In his address titled "Problems of Cost—As Experienced in Medicare," he showed his interest in "how to correctly reflect the cost." This is an accounting problem for the past and an actuarial problem for the future, not a "how-to-do-it" problem to shape the future to make the most from limited resources. The White House Report wants "to develop methods for more accurately predicting costs," as if cost reduction is contrary to nature and both the sick and the healthy must take rising costs lying down. Your advisory committee's report, let it be said to its credit, does chafe at the bit and towards the end of the report advocates "containing costs" and shakes a fist at the excessive respect paid for "prevailing" and "customary" prices because they are "imprecise." (page 25) The fact is they are not economically reasonable although called "reasonable cost" in the law.

At the conference, "efficiency, productivity and logic" was represented by Dr. Roger O. Egeberg, then Dean of the School of Medicine, University of Southern California, but since then named as the new Assistant Secretary for Health and

Scientific Affairs in the H.E.W. He hasn't started working there yet although his name is used to sign a report with ideas in conflict with what he said at the conference.

His address was called "Organization for the Delivery of Care." He called upon deliverers of medical care to learn business principles. This means "searching out cheaper ways of delivering medical care and at the same time worrying about standards." He said: "The reduction in the cost of medical care or improvement in the level, amount, and distribution of medical care without further increase in costs must be brought about by thoughtful organization and reorganization at many levels." He put economists at the head of his list of non-medical personel required in health delivery.

Just before Medicare was passed in the Senate, Sen. Russell B. Long, now Chairman of the Finance Committee, said that it could "be better judged by an economist than an actuary, better by a social worker than an accountant . . ." (*Congressional Record*, July 9, 1965, page 15582). This judgment is not found in either of the two reports abovementioned. What are they waiting for? I suppose, for Dr. Egeberg to get on the job.

As you study your advisory committee's working paper, you should also look at Volume I of the *Report of the Commission on the Cost of Medical Care*, 1964. I brought this to your subcommittee's attention in July, 1967. (See page 290 of the subcommittee's Hearings on "Costs and Delivery of Health Services to Older Americans.") Too many fail to heed the warning in this study that "cost, price and expenditure may be, but generally are not, equal." (". . . each has a different *economic meaning*. For use in the context of medical care economies, these terms require definition and qualification . . ." page 30.) Chapter 3 of this report, "The Medical Care Price Index," has a valuable critique of the Medical Care Component of the B.L.S. Consumer Price Index, which your advisory committee's report, in common with a prevailing but wrong practice, accepts uncritically as the sole measure of the "rising cost" of medical care, contrary to explicit instructions from the index's producer, the Bureau of Labor Statistics.

Official government reports, including that of your advisory committee, fail to distinguish between "costs" and "expenditure." They talk as if the rich have higher costs than the poor because they spend more. When President Johnson *boasted* that health expenditures of the government had more than doubled in his administration, was he boasting of higher costs?

Your advisory committee's report deplores how "medical cost inflation intensifies the problem," and produces "higher costs." Even if there is some truth to this, it's only looking at one side of the coin. Everything is going wrong, we are told. because hospitals are charging more. Then comes along an article in the October, 1968, *Social Security Bulletin*, "Financial Position of Hospitals in the Early Medicare Period," by Paul J. Feldstein and Saul Waldman, to inform us that "the financial position of most hospitals improved," since the start of Medicare. It that bad? One magazine had an article about how "sick" our hospitals were, with blood-curdling accounts of some cases, with no information about how representative they were. The view has also been expressed that it is harmful to a doctor's patients for him to get rich. A Michigan doctor "who collected $169,000 in Medicaid fees in one year has returned the full amount pending an audit because of crank letters and what he termed harassment of his family" (*N. Y. Times*, August 2).

Taking up his lance against costs "running wild," Sen. John J. Williams said, in the Senate on May 14, that "the law requires intermediaries and carriers to exercise effective controls on utilization of services" (*Congressional Record*, May 14, p. S5202). Senator Williams was not stating correctly what is actually in the law. In a later speech, Sen. Williams changed his tune, resting his case on certain sections of the U.S. Penal Code, "which set civil penalties for fraud such as those perpetrated under medicaid and medicare . . . " (*Congressional Record*, June 25, pp. 7172–3). These sections of the law make no explicit reference to hospitals or doctors. Maybe fraud is adequately covered by the laws, the fact remains that the economics of health and medical care gets poor treatment. Those framing the Medicare and Medicaid laws did not get good economic advice.

At the June, 1967, National Conference on Medical Costs, called by the then H.E.W. Secretary John W. Gardner, at the President's direction, there is another paper worth mentioning now. Victor R. Fuchs, Ph.D., Associate Director of Research, National Bureau of Economic Research, spoke on "The Basic Forces Influencing Costs of Medical Care." "The basic analytical approach is a con-

sideration of those factors affecting the demand for medical care, and those affecting the supply. Demand and supply, the two magic words. Some of us, when visiting hospitals, have discovered that by putting on a white coat and talking rudely to nurses, it is easy to pass for a physician. To be mistaken for an economist is often simpler. All one need do is nod gravely and say 'demand and supply.' "

Your advisory committee's report (in Part V) states that "three years of experience under Medicare have provided invaluable lessons in the operation of a major public health insurance program. The time has come to heed those lessons." (page 41). This is most strange. A perusal of the two Annual Reports to Congress on Medicare by the Secretary of Health, Education, and Welfare (who turns out to be the Honorable Wilbur J. Cohen, in both cases, with no mention that the Honorable John W. Gardner was ever there) and of the Annual Report on Medicare by the Health Insurance Benefits Advisory Council (over the signature of the present Chairman, Charles L. Schultze, who actually was Budget Director, during the period covered by the report, July 1, 1966–December 31, 1967), provides no clues as to what these "invaluable lessons" are. In this connection, see my letter to your predecessor, Senator George A. Smathers, July 14, 1967 (pp. 288–90, the subcommittee's Hearings on "Costs and Delivery of Health Services to Older Americans"). I wrote: "An elaborate statistical program is provided but no economic study in the sense called for by the Gorham group which prepared the H.E.W. report to the President on Medical Care Prices. (See *Social Security Bulletin*, January, 1967, 'Health Insurance for the Aged: The Statistical Program' by Howard West. 'Analytical Studies' including 'Studies of Utilizations and Costs of Health Services,' 'Studies of Effectiveness of Administration,' and 'Studies Relating to Specific Provisions' are here envisaged as awaiting future findings of the 'statistical system.' Defense Secretary Robert S. McNamara's warning that we must do our basic thinking 'before we start to bend metal' has not yet reached the Social Security Administration. Here they are in the habit of awaiting the results of 'actuarial experience,' (another name for muddling through). According to an article in the March 23, 1967 *Washington Post* ('Budgeting System Spreading Slowly' by William Chapman) the Programming-Planning-Budgeting System, or PPBS, announced with fanfare almost two years ago by President Johnson as a 'very revolutionary system,' still meets with bureaucratic resistance. 'Even in H.E.W., where the most significant progress has been recorded, Gorham encountered considerable inertia when he pushed custom-ridden officials into the cost-benefit field.' I can supply evidence of such 'inertia' in the Social Security Administration. Some of this may be found in my letter to the Honorable Wilbur D. Mills, mentioned above (that is, in the hearings record, House Ways and Means on H.R. 5710, 'President's Proposals for Revisions in the Social Security System, pages 2445–9). In this, I refer (page 2448) to testimony before the Subcommittee on Health of the Elderly on April 27, 1964, which I brought to the attention of my supervisors in the Social Security Administration in connection with an official assignment."

I had an assignment in the Social Security Administration to relate a University of Michigan Study of Hospital and Medical Economics to possible application to Medicare, and how Governor George Romney defended it against my criticism. The director of the Study I criticized was Mr. Walter J. McHerney, who has just been named Chairman of the H.E.W. Secretary's Task Force on Medicaid and Related Programs. Mr. Arthur E. Hess, Deputy Commissioner of Social Security, will be the Staff Director. He was the Director of the Division of Disability Operations where and when I had my assignment there. The House Ways and Means Committee put into its record of hearings on H.R. 3920, "Medical Care For the Aged," in 1964, an exchange of letters between me and Governor Romney, which I brought to Mr. Hess' attention, together with other material on Medicare economics. Mr. Hess wondered why I thought he should be interested in this material. This lack of interest in economic analysis, also shown by members of the Health Insurance Task Force in the division, was reflected in a similar lack in the Report of the Advisory Council on Social Security, 1965. My warning in March 1965 against the economically unreasonable "reasonable cost" concept, which this report helped foist upon Congress, with everybody now deploring it, but leaving it there, appears in a letter found in the Hearings of your subcommittee of 1967 on "Costs and Delivery of Health Services to Older Americans" (pp. 290–1).

On August 7, you voted for the Schweiker proposal to make Pentagon contracts for weapons subject to the independent scrutiny of the General Accounting Office, the auditing arm of Congress. It passed 47 to 46. This kind of audit should be extended to the health area.

On February 17, 1967, Senator Abraham Ribicoff upbraided Congress for "abdication of responsibility" because it relied exclusively on the H.E.W. Department in formulating the Medicare program. He was "shocked to find how little Congress really knew about the inner workings of the bureaucracy . . . shocked how subservient the legislative branch was to the executive branch . . . still shocked, as a U.S. Senator, at the unwillingness of Congress to regain its initiative in the legislative process." (*Congressional Record*, Feb. 17, 1967, p. S2169). Then he went on to say:" As a former Secretary of Health, Education, and Welfare, I have great respect for that fine Department. But I do not want all the information or knowledge on the subject of medicare to come out of the Department of Health, Education & Welfare. I want the staff on the Finance Committee to be able to make its independent examination, exercise independent judgment" (*Congressional Record*, Feb. 17, 1967, p. S2170).

The Finance Committee made a beginning in using the General Accounting Office's services just before Medicare went into effect. Hearings, in executive session later made public, were held on May 25, 1966 on "Reimbursement Guidelines for Medicare." The bases for this were a study by the Finance Committee Staff, "Proposed Medicare Reimbursement Formula: Congressional Intent, Policy and Costs," and a Review by the Comptroller General, which appears as Appendix A of the Hearings Record. Great misgivings were expressed over the reimbursement principles adopted by the Social Security Administration, but it was too near the deadline when Medicare was to go into effect to do anything about it then.

The false impression is given in the First Annual Report by H.E.W. on Medicare that the reimbursement guidelines had the prior review of the Finance Committee. Here is how they put it: "No aspect of the program was more carefully considered by the Administration and by the Health Insurance Advisory Council, which endorsed the principles at each stage of development and promulgation. And in addition, the Senate Committee on Finance reviewed the proposed principles in executive session in May, 1966" (*First Annual Report on Medicare*, June 14, 1968. p. 40).

It also sounds as if, Charles L. Schultze, present Chairman of Health Insurance Benefits Advisory Council, signs an endorsement of principles against which he fought when he was Director of the Budget Bureau. Formerly he said "program evaluation" makes "cost reduction" possible. Now he allegedly endorses the principle that cost reduction is contrary to nature. This could stand some clarification from the General Accounting Office.

I would appreciate having this letter placed in your hearings record because they will help the clarification of issues through public discussion.

Yours sincerely,

SIDNEY KORETZ.

ITEM 6. LETTER FROM GEORGE G. READER, M.D., PRESIDENT-ELECT, AMERICAN GERIATRICS SOCIETY, INC., NEW YORK, N.Y.

AMERICAN GERIATRICS SOCIETY, INC.,
New York, N.Y., July 21, 1969.

DEAR SENATOR MUSKIE: I cannot speak for the whole of the American Geriatrics Society; we still have an imperfect mechanism for expressing consensus. As President-elect, however, I see the health care needs of the elderly as a major problem for the United States despite the accomplishments of Medicare. The population by 1990 will be older and younger than it is today—with a relatively smaller economically-productive, middle-aged group supporting the rest.

The enlarging elderly population of the future will make for an increasing utilization of health care services without having the means from their own resources to meet the expense. Medicare now does not cover two major elements: drugs and prolonged custodial care. These will have to be supported in the future either by increasing the income of the olderly or subsidizing these special expenses. The Medicare mechanism with its insurance principle appears to be the best approach. Certainly Medicaid is a dismal failure, as was predictable. Some form of umbrella reinsurance by government such as is recommended by the Committee on

National Health Insurance may be the answer. In any case public surveillance of consumer costs, for the elderly particularly, seems to me to be inevitable. Conscience will not allow exploitation of this already-disadvantaged group. Furthermore, studies have shown that the older segment of the population can be relied upon to vote regularly.

In regard to the role of the National Center for Health Services Research and Development there is much information needed about delivery of services, appropriate levels of care including development of new subprofessional health personnel, and the economics of health care. I do not know what is now being supported but would believe that this type of research is best done under university sponsorship in the field rather than in the Center itself. One specific type of development that is badly needed is an educational program for the elderly that helps them make the optimal use of their physical resources and of medical services. This would have large effect on both costs and quality.

Sincerely,

GEORGE G. READER, M.D.
President-elect.

ITEM 7. LETTER FROM RICHARD H. HOOPER, EXECUTIVE DIRECTOR, ANDROSCOGGIN HOME HEALTH SERVICES, INC., LEWISTON, MAINE

ANDROSCOGGIN HOME HEALTH SERVICES, INC.,
Lewiston, Maine, August 22, 1969.

DEAR SENATOR MUSKIE: Thank you for your letter of July 31 requesting my comments relative to problems confronting the aging. I welcome this opportunity to make a few remarks, and regret not having been able to respond sooner.

It would be a difficult task, indeed, to bring new information to the attention of the committee. The plight of the elderly is widely known and well documented. The American dream of a rewarding retirement is a reality for precious few of our senior citizens.

The agency of which I am director, the Androscoggin Home Health Services, is engaged in providing home health care in a three-county region of West Central Maine which includes 150,000 people. Because our program is geared primarily to serving those who are chronically ill and in need of part-time care, the great majority of our energy is focused on the 65 and over age group. My few comments below are limited mainly to the services I represent and its clientele.

There is no questioning the fact that Medicare and Medicaid have had an enormous impact on the health care of the aging. In our region alone, 500 elderly persons will receive upwards of 20,000 home health visits in 1969, all of which will be covered at least partially by Medicare and Medicaid. Without the Medicare legislation, we would not be in existence, and most of these patients would be forced to receive health care elsewhere, or go without.

For some time however, we have been vitally concerned about Part B of Title XVIII and, specifically, the deductible and coinsurance features pertaining thereto. For a considerable number of our clientele, the inability to meet even this meager financial responsibility is beyond question. More importantly, the economic feasibility of requiring patients to pay coinsurance seems questionable in that it requires a great deal of additional bookkeeping in our office, not to mention the additional computer services which must be employed in Baltimore. It further seems that reduced benefits available to patients who have not had prior hospitalization, and therefor have not achieved eligibility for Part A coverage, is one more evidence that we in America reward those patients who receive in-patient hospital care, but tend to penalize those who are not admitted to hospitals. It is high time that we look seriously at our insurance systems, public and private, and that new emphasis be given to providing adequate coverage in cases where hospitalization is not an absolute necessity. In so doing I believe that we will achieve a significant reduction of unnecessary hospitalization and with consequent financial relief for the health consumer.

A major goal of home health care is, of course, to permit many patients to shorten periods of institutionalization. In our experience a large number of patients have been discharged to our program, from extended care facilities as well as hospitals, when their medical requirements have been reduced to the need for part-time professional nursing care. One Lewiston surgeon claims, for example, that his colostomy patients are now able to leave the hospital one week

earlier because of the availability of this service. While examples such as this may be gratifying to us and to the patient, there is much more that could be done to enable many more elderly persons to be safely maintained in their homes. One specific measure would be broadening the home health provisions to include home maintenance service (homemaker). Presently the law provides for the services of a home health aide, but this is limited in that this service is only reimbursable when the aide is required to assist the professional nurse in giving personal care to the patient. Many of the infirm, often living alone or with an equally feeble spouse, could comfortably maintain themselves at home with the additional assistance of a homemaker, and delay or avoid the sad day of departure to a nursing home. The burden of providing homemaker service for ten, or even twenty hours per week could well prove less costly than nursing home care, in psychological as well as economic terms.

The cost of prescription drugs is a problem of spiraling proportions with the elderly particularly affected. It is not unusual for our patients to have expenditures of from $40 to $50 per month. For those who are existing within the limits of a Social Security check, such a burden often means going without other life essentials. Particularly distressing is the fact that we often find patients doing without vital medications. While assistance for many is available from local welfare departments, and this varies according to where one happens to live, many of the aging are too proud to ask for help, Sadly, some would rather die. The fact remains that welfare of this type is totally unacceptable to many aging persons who have never required public assistance in their lives.

While Medicaid in Maine will soon be extended to help the elderly indigent to absorb some drug costs, this measure will not adequately cope with this massive problem, and further investigation into it is clearly needed.

I cannot conclude without airing yet another concern—the federal debt. I do not believe that federal government alone can or should provide all the money that is needed to give all Americans decent health care. Only through a partnership of government, the private insurance industry and, indeed, business and industry can we hope to achieve our goal short of federal taxation that will put all of us in the poverty class.

I appreciate this opportunity to share several thoughts with you. I am confident that the work of the subcommittee will be influential in helping millions of aging Americans toward our goal of making the "golden years" truly brighter.

Sincerely yours,

RICHARD H. HOOPER,
Executive Director.

ITEM 8. STATEMENT BY WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION

Mr. Chairman and members of the committee: It is a privilege for me to have the opportunity to present my views to you on the health care problems of the elderly. These hearings come at a particularly appropriate time—a time when the nation's newspapers are filled with allegations of fraud and abuses in the Medicare and Medicaid programs and a time when it is easy to forget the very real accomplishments of these programs. We must, of course, tighten the administration of both Medicare and Medicaid but we must also be ever mindful of the great needs of the elderly that remain to be met. The problems range from low income to inadequate clothing, shelter and medical care.

The great hopes and aspirations engendered by the passage of Medicare and Medicaid have been diminished by the current "cost spiral." These cost increases, while causing a great deal of consternation amongst the middle class, fall especially hard upon those persons with fixed incomes—the age, the disabled, the marginally employed and the unemployed.

The Blue Cross Association, speaking on behalf of its 75 Member Plans (who collectively provide: hospital benefits for 18.5 million older Americans through their administration of Titles XVIII and XIX; and, complementary health insurance coverage for an estimated 5.5 million older Americans) wishes to commend this committee for undertaking its present inquiry into the health needs of the elderly. Blue Cross has a strong and continuing interest in this subject through its involvement as the primary intermediary under Medicare and its substantial private enrollment of senior citizens.

Nowhere in our economy is the cost situation as dramatic as in the health field. Just over two years ago, I appeared before this committee and testified that:

"Health care costs are rising at a rate which is measurably greater than the increase in wages and earnings. If this disparity were to continue at the present rate, the ability of several groups in our population to afford care would be jeopardized." *

Since that time, hospital costs have risen a total of 29% and are projected to go up another 12% this year. Physicians' fees, while rising at a lower rate than hospital costs, deserve equal attention because the financing mechanism for Part B of Medicare (the voluntary program which few can do without) distributes part of the burden of physicians' fee increases directly to the Medicare beneficiary in the form of higher Part B premiums. Our aging citizens are finding that the payments for Medicare benefits are taking an increasing percentage of their rather limited fixed incomes while these benefits cover a decreasing percentage of their total health costs. These factors only point up the need for a better rationalization of our nation's health system aimed at:

(*a*) the implementation of control mechanisms and incentives for efficiency to moderate the rise in medical care costs; and

(*b*) the development of new legislation to improve the operation of Medicare and Medicaid.

The problems that we face in providing care to the elderly are not unique to the elderly but rather they represent a microcosm of the general ills which beset our present health care system. Our health industry, presently a 55-billion-dollar industry, lacks a number of the checks and balances that exist in a free market environment.

If Medicare and Medicaid have taught us anything, it is that pouring more and more money into a fragmented health care system is more likely to cause inflation rather than new and better services. So it is necessary for all those involved in the health field to formulate incentives and controls which effectively allocate resources into the most productive channels. Many important controls exist today in the form of self-imposed professional controls as well as other fiscal and legal controls. Some of these controls are widespread (*i.e.*, utilization review groups), but are not being utilized to their maximum potential. Others must become more widespread to be effective, while still others are yet to be fashioned.

I might add that one of the major objectives of the new HEW Task Force on Medicaid and Related Programs, a group of which I am serving as Chairman, is to explore several immediate possibilities in this area. We plan to look down the road, say five to ten years hence, towards the development of a structured approach to the promotion of incentives for efficiency in Medicaid and related programs.

What are our options at the present time concerning cost moderation? How can we build on these opportunities to incorporate into the system the checks and balances that are lacking? These are the kinds of questions that must be answered whatever financing system is involved.

One problem which has recently come to light due in large measure to evaluation of Medicare-Medicaid patient data is non-appropriate use of health care services and facilities; *i.e.*, the use of an expensive care modality when an less expensive care modility would be sufficient. There is no question that such non-appropriate usage adds to the cost of health services and to the expenses of federal health insurance programs. The increased cost comes in the form of overuse of services and facilities.

A major problem related to non-appropriate use is the lack of ambulatory, preventive and extended care facilities outside of but related to the general hospital. This points to the need for incentive structures whereby such facilities would be constructed and health benefits could then, realistically, be expanded to cover such services. Expansion of benefits is, however, not enough because we are faced with the greater challenge of organizing facilities so that care is coordinated more effectively.

Increasingly in recent years, we have seen new options for organizing care. Group practice, the campus medical center concept, neighborhood health centers

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*McNerney, Walter J., *Costs and Delivery of Health Services to Older Americans*, U.S. Senate, Special Committee on Aging, Subcommittee on Health of the Elderly, June 22, 1967.

and other forms of coordinated facilities and services could provide improved access for elderly persons while at the same time giving greater cost credibility. Such organizational approaches, or care formats, provide one very important means to achieving medical care cost moderation but the selection of a particular care format is dependent upon many things—for example, community organization, geography, population density, etc. There is no *one* answer to the problems of organization of services, however, I feel quite strongly that the philosophic premise behind "adequate health care for all the people" lies in the integration and coordination of facilities and service.

The need for coordination of facilities and services becomes paramount when we start to talk of an expansion of benefits under Medicare and Medicaid. A new benefit becomes less than meaningful if our care system is not equipped to provide good quality services in that benefit area. Given that premise, I think it is clear that we must move towards benefit expansion to relieve the elderly of the cost burdens of quality health care.

An initial step that could be taken is the elimination of the deductibles and co-payment provisions in Medicare. Such devices, originally intended to serve as incentives for appropriate use of services, have little application in the payment of health care expenses. In addition, they are particularly inappropriate among the elderly, where their potential effectiveness in deterring overutilization must be weighted seriously against their potential promotion of underutilization. Deductibles and co-payments are devices which should be reserved for the small repetitive expenses where the costs of administration could otherwise become excessive. Other areas for administrative improvement include a reevaluation of the reimbursement policies in such areas as cost and incentives for efficiency.

Benefit growth is a complex strategy due to both the needs of the elderly on the one hand and the administrative difficulties involved in expansion of benefits to, for example, prescription drugs on the other. Hard decisions will have to be made about price controls, dispensing fees, generic vs. brand name drugs, etc.

However, I feel that we should go ahead and broaden benefits drawing upon the public and private sectors, while seeking professional, fiscal and legal solutions to the controls issue. In the coming years, we should endeavor to expand the benefits to cover: eye care; dental care; prescription drug coverage on an ambulatory basis; and the whole area of long-term care benefits for the elderly.

In summary, I want to emphasize that good health should not be considered to be an end in itself but rather a means by which our elderly citizens can achieve the full life that they so richly deserve. Keeping their medical needs in mind, we must also seek new programs of income maintenance which will afford our elderly citizens the work and recreational opportunities so necessary for the preservation of self-dignity in the retirement years.

With regard to health care for the elderly, Medicare and Medicaid have performed a good service in that the elderly are in a much better position than they were before July 1, 1966. However, improvements must be made in these programs if we are to avoid losing the gains that have been made. These improvements will require the concerted efforts of both governmental and private sectors if they are to be a success. We, at Blue Cross, will continue our present efforts to simplify benefit structures and to provide complementary benefit coverage where gaps now exist. Thank you.

ITEM 9. LETTER FROM RICHARD W. MICHAUD, DIRECTOR, COMMUNITY SERVICES, DEPARTMENT OF HEALTH AND WELFARE, AUGUSTA, MAINE

STATE OF MAINE,
DEPARTMENT OF HEALTH AND WELFARE,
Augusta, Maine, August 22, 1969.

DEAR SENATOR MUSKIE: It is a pleasure to hear from you and to be asked to submit a statement on the "Health Aspects of the Economics of Aging."

Instances are brought to our attention daily of individuals who worked hard all their lives, saved diligently for the retirement years who because of illness are forced to give up everything they own to pay for medical expenses. As if the illness is not worrisome enough, the loss of self-respect and dignity compounds

it when the necessity for "going on the Town" or the "State" becomes the inevitable result.

The following interview between a welfare worker and a low income older person is all too typical of the plight of many of our older people in Maine which have to go without food and clothing in order to be able to purchase medication and pay their property taxes.

The clock had stopped at 8 o'clock.

A picture of Jesus praying in a garden hung on one wall of the combination bedroom-living room. On the other side of the bed there was a picture of Jesus talking with some children. The next wall held a scene of the Maine Coast. The room contained two chairs, a couch and an old-fashioned iron bed.

From the mantle hung a faded purple ribbon bearing the words "past president."

The slight, white-haired occupant of the three-room apartment fiddled with her hearing aid. It shrieked in protest as she tried to get it working.

"How long have I been on Welfare?" she repeated the question. "Well, before my husband died in 1958 he wasn't working and I wasn't able to leave him to go out and work. We got food from the Town.

"I tried to get someone to come visit him . . . They promised they'd come . . . They never came near . . . Not one of them came near me . . ." she said.

"I should just answer your questions," she said, "but I want to give you an idea of what some of these old ladies go through."

Two hours passed quickly within the walls of her gray shingled home. The woman talked about her husband, hard times, illness, and death. Her total monthly income, she said, was $104.

"I'm getting $49 a month old age assistance," she said. "I wouldn't call that welfare, would you? When I die they'll take it out of the property. They'll have to bury me. I understand, but the burial money will come out of this property."

Her social security funds, she said had risen from $44 to $55 a month.

"I'm all alone, you see. There's nobody with me . . . I don't get things right . . .

"Well, I went to church Sunday and I didn't have a dress that was short enough. . . . All my dresses were too long . . . I never go anywhere so I didn't shorten them. . . ."

She moved to the city from a farmhouse. "If my husband hadn't died when he did, I would have lost my home. I paid the taxes with the insurance money and the rest went for his funeral. The house and farm were worth more than I got for it . . ."

To supplement her income, she tried renting an apartment. "But everyone I rent to lately is no good. They leave without paying . . . The last time I got stuck with a young man and woman who said they were married . . . I should have put them out when I found out the girl wasn't his wife . . . I didn't dare take another chance of someone because I was too sick . . . I don't feel good . . . been taking bad spells lately . . . My head's awful tired."

She spends her daytime hours "trying to keep the filth down. It's awfully dusty in here. I don't get out unless I go to the store and then it's all I can do to get there. I have to use a cane," she said.

"If I could hear, I'd be a help. I could go to the Senior Citizens Club. I try to live a good life—but people can't be bothered by anything like this—no matter how good you've been . . ." Her eyes suddenly reddened and she wiped them quickly with a white handkerchief. "My heart's not good—but I don't worry about death." More quick wiping.

She talked about her limited finances and one primary need: new hearing aid batteries: "If I could depend on the batteries . . . I've paid out $300 on this thing behind my ear. They got my money and that's all they want. Deaf people have it very hard. I don't know what I'm going to do. I can't make it next winter. . . ."

Then there is the cost of medicine—digitalis—and ever present taxes. "I feel licked and I don't see any way out for a woman in my condition. They should not ask me to pay taxes the way I am—the state, town or city should give us a break, not ask for taxes. That money would help me out so much. . . . I've paid $35 or $40 for medicine lately."

Most of her income is spent for medicine or related supplies. A minimum amount, perhaps $6 a week, goes for food. She doesn't eat much—doesn't feel like eating. Cooking is a bother. There is little expense for clothes, most of which come from rummage sales.

She hasn't got long to live, she said.

"I went over to the undertaker's to see how much a funeral would cost . . . he showed me the caskets. There was a gray one . . ."

She ran her hand over the gray casket and asked if it wasn't the cheapest one. "It was $520. The vault was $98. They had gone up. I didn't get there quickly enough."

The undertaker took notes, she said. "He told me the state would allow me $450 toward burial . . . I'd pay the rest. We got it all straightened out . . ."

She's afraid to get into the bathtub. "I've got arthritis bad. My knees are no good. I can get into the bathtub but after I'm in . . . well . . . Oh, I'm clean enough, but the other night I washed my hair and asked God to give me strength to be clean."

The afternoon sun was shining through the windows as she talked. Outside, brown leaves were on the ground and children were shouting. Some teenagers walked along the street, guitars under their arms. Through the windows you could see some neighbors standing in doorways, looking . . .

She walked down the hallway of her apartment to the kitchen. "I don't do much cooking anymore . . . Don't feel much like eating . . .

The back door led to a grassless yard enclosed by a wire fence. "Got to get those gutters fixed . . . Water's leaking on the house. . . .

". . . When I die I'm giving my eyes to the Eye Bank . . . I can see all right. . . ."

I wish you and your subcommittee on the "Health Aspects of the Economics of Aging" the best in your efforts to alleviate a very important problem in the lives of our Older Americans.

Very sincerely,

RICHARD W. MICHAUD,
Director, Community Services.

ITEM 10. STATEMENT BY THE AMERICAN PODIATRY ASSOCIATION, WASHINGTON, D.C.

The Congress of the United States, having declared that the Nation's elderly citizens are entitled to the best health care available without regard to economic status, has enacted, since July, 1965, significant legislation in pursuit of this objective. Yet it is clear that the nation has only begun to redeem this pledge.

The American Podiatry Association has deep concern for and a professional commitment to the health and welfare of the Nation's elderly. The Association furthermore supports the concept of comprehensive planning to responsibly meet the health needs of an aging population. Such planning must include, however, the important aspect of foot health, a major cause of disability among the elderly.

The human foot has too frequently been the least considered part of the anatomy. Though the foot is seldom the cause of mortality, it is often the site and the cause of morbidity, disability, and limitation of activity. With the advent of chronic disease as the nation's number one health problem and the growing stress being placed upon geriatrics and long term care, much emphasis has been placed on maintaining an ambulatory population. It is essential, therefore, that increased attention and services be focused on the foot health problems of the aging. To complement the testimony of previous witnesses, namely, Commissioner John B. Martin, Mr. Bert Seidman, and Dr. Frank Furstenberg, the Nation's current commitment to comprehensive foot health care is sorely inadequate.

Evidence to support the need for foot health care, especially among the elderly, has been clearly documented. Two projects, in particular, have served to demonstrate the prevalence of the problem.

First, the Minnesota Podiatry Association, in cooperation with the Minnesota State Department of Health and the U.S. Public Health Service, conducted, in 1966, a survey of 1,011 Minnesota nursing home patients. The survey team screened 991 persons who required either hygienic (627) or professional (364) foot health care; and among those who were in need of professional attention, only 163, or 44%, were under the care of a podiatrist or other physician. Only 45 % of those requiring hygienic care were receiving the attention they required.

Equally distressing are the results from another U.S. Public Health Service project in Philadelphia, Pennsylvania. Involving the City Health Department

and St. Luke's and Children's Medical Center, the "Keep Them Walking" program was designed to demonstrate the importance of foot health services as integral parts of any geriatric health program. Among the 1,366 non-institutionalized older persons screened by this program, each individual averaged more than three (3) foot complaints and presented at least two known chronic diseases for which he was currently under care. Less than 3% cited no complaints whatsoever and 74% stated that their feet hurt at the time of evaluation.

The facts gleaned from these and other projects revealed widespread, unmet podogeriatric needs throughout the country. These facts, too, convinced the 90th Congress of the necessity for including podiatrists' services under Medicare. In addition, more than two-thirds of the states with approved and operating Medicaid plans have made provision for the services of podiatrists in their medical assistance programs.

Though the demand for podiatric services has outdistanced the supply of trained foot specialists, the Congress has also taken responsible action to close this gap. The *Health Manpower Act*, by the grants it has made available for podiatric education, has made possible an 80 percent increase in student enrollments at colleges of podiatric medicine during the last five years.

It must be observed, however, that the quality foot care available to the elderly does not yet approach the demonstrated need. If the health goals this nation has established for its older citizens are to be realized, the Congress must continue and strengthen those imaginative programs which provide for the elderly ". . . the best possible physical and mental health which science can make available without regard to economic status." It is furthermore required, due to the impending national crises in health care, that new and innovative approaches for planning, delivering, and financing health services be thoroughly evaluated; that the public and private sectors of the health community, including the Nation's consumers, join together in advancing programs which will assure for all citizens qualitative, efficient, and available health services.

To succeed in the achievement of this mission will require a comprehensive effort, including an expanded national commitment to foot health. Medicare and Medicaid have represented giant steps forward towards achieving national health goals; but it is erroneous to assume that their enactment has enabled every older person to obtain the health care he needs and demands. This is certainly true in reference to foot health; and the American Podiatry Association, in continued cooperation with its Federal partner, will strive to offset these defiliencies to meet the challenge of assuring for the elderly optimal foot health care. Consistent with this pledge, the American Podiatry Association offers the following observations and recommendations which, it is hoped, will serve to hasten the day when all older Americans can share in this Nation's abundance.

First, as an immediate priority, prior to the adoption of needed, more comprehensive national health proposals, the many inadequacies in existing programs, particularly Medicare and Medicaid, must be overcome.

Among these shortcomings, which have been detailed by previous witnesses, the gap between what the elderly can personally afford to pay and what Medicare will reimburse for health care must be reemphasized. The fact that Medicare pays for less than one-half of the health care costs of the elderly represents an indefensible barrier, especially since the average income of the older person is only half that of the non-elderly. The fact that Medicare does not cover the cost of prescription drugs, most dental care, eyeglasses, and many aspects of foot health care represent a few glowing program oversights, ones which place needless financial burdens on countless older persons. This coupled with onerous deductible and coinsurance features further increases the burden on an already oppressed segment of the population.

Medicaid, too, has its many shortcomings, not the least of which is the unequal application of benefits throughout the country. Though foot care services are covered in two-thirds of the states with approved medical assistance programs (Title XIX), the remaining jurisdictions do not include the podiatrist's services within the scope of benefits afforded the categorically and medically indigent, many of whom are the elderly poor. To resolve this immediate problem and to assure for the aged poor more equal access to qualitative foot health care, the Congress should stipulate in Title XIX of the Social Security Act—as was accomplished in Title XVIII—that the podiatrist is included within the definition of physician services.

The above references, though limited examples, identify partial but significant gaps in delivering high quality of health care—including foot care—to

the recipients of Medicare and Medicaid. Yet these inadequacies and others previously detailed to the subcommittee, if resolved, will not eliminate for the elderly all the barriers to comprehensive and quality health care. A preponderance of defects can only be removed by changes in the organization and the delivery of health care and the establishment of more effective and efficient cost controls as outlined by the subcommittee's advisory panel. In recognition of this fact, and as a second important observation, the American Podiatry Association supports the concept of group practice activities, the establishment of comprehensive neighborhood health centers, and the need for new methods to finance health care as necessary ingredients for the improved delivery of health services.

Third, as the nation progresses in its fulfillment of health goals for the elderly, an expanded commitment to preventive health must also be achieved. Clearly an oversight in presently supported public health programs, particularly Medicare and Medicaid, the subject of prevention deserves herein special consideration. When the primary indicator for measuring the comprehensiveness of any health program is the extent of attention paid to preventive care, present public supported health care programs are, at best, seriously lacking. The American Podiatry Association unequivocally supports, as efforts are undertaken to improve health services for the elderly, the inclusion of compreshensive preventive health measures as necessary and integral benefits deserving public support.

The ever increasing demand for improved health care cannot be adequaetly met without the manpower needed to supply essential services, a fourth area of relative concern. Podiatry, in its efforts to keep pace with a burgeoning aging population and new demands for foot health services, must significantly increase the number of foot specialists during the next decade. Not only must existing colleges of podiatric medicine be expanded, new colleges must be established to supply the additional manpower so urgently needed. As earlier stated, the *Health Manpower Act* has provided invaluable resources in this respect, but even greater assistance will be required for the future.

Podiatry must also utilize existing health manpower resources to better respond to the foot health needs of the aging. Working closely with the Public Health Service, the Administration on Aging, and the American Nursing Home Association, the American Podiatry Association and colleges of podiatric medicine are sponsoring short-term education programs in foot health for the nursing personnel of long term care facilities. Designed to upgrade nursing competence in understanding and appropriately ministering to podogeriatric problems, the project seeks better, more productive ways to employ current manpower resources in matters of aging foot health concern. In furtherance of this objective, the profession must employ even more innovative methods, including the utilization of medical corpsmen, to meet the growing demands for optimal foot health services.

The 1960's have served to express deep national concern for the health needs of older people. Noble and responsible programs have been initiated to counter their special health problems, to advance the day when all older Americans will have access to and the availability of the best possible health care. It is essential that the Nation build on its already impressive record of accomplishments by immediately responding to the deficiencies in existing programs and systems of health care. To this challenging and essential mission, the American Podiatry Association offers its full support and cooperation.

ITEM 11. LETTER FROM KENNETH WILLIAMSON, DEPUTY DIRECTOR, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

AMERICAN HOSPITAL ASSOCIATION,
August 14, 1969.

DEAR SENATOR MUSKIE: Thank you for asking me to comment on a series of questions in connection with your subcommittee's hearings on the health aspects of the economics of aging. Since the Task Force Report prepared for the Senate Special Committee on Aging and the report of your Advisory Committee have admirably set forth the nature and scope of the problems facing the elderly in obtaining and meeting the cost of the medical care they need, I shall reply directly to your questions.

1. I am supplying for your hearing record statements which set forth the position of the American Hospital Association with regard to the 2% allowance in

the formula for reimbursement of hospitals for services provided to Medicare patients.

The statement headed "Fact Sheet—Medicare 2% Allowance" was prepared just after the April 15, 1969 announcement that the Administration planned to eliminate the 2% factor. It contains background information about the negotiations that led to establishment of the reimbursement formula agreed to at the beginning of the Medicare program which contains the 2% factor. The AHA and the hospitals of the country believe the federal government was clearly committed to further discussions and an evaluation of the fairness of this formula before any changes were made in it.

The other statement "Medicare Reimbursement" which is dated July 30, 1969, was prepared after the government acting unilaterally eliminated the 2% factor. This action necessitated a total re-examination and renegotiation of the method for determining Medicare patients' appropriate share of allowable costs. Such a renegotiation is now under way and AHA representatives have been meeting with officials of the Social Security Administration seeking remedies for the inadequacies and inequities created by the original reimbursement formula that have been compounded by the removal of the 2% factor.

The hospital field has approved a statement of principles on the financing of and payment for health care services which the Association believes should be accepted by all purchasers of health care. The statement sets forth the financial requirements of health care institutions and how these requirements can be met. It recognizes that in addition to the cost of patient care, these requirements include replacement of physical plant, expansion of services, education, research, retirement of debt, and other hospital obligations that have been only sporadically supported heretofore by purchasers of care. The statement makes clear that the health care system's obligation to the community is to meet community needs, expending funds wisely and only in accordance with appropriate community planning. I am enclosing a copy of this *Statement on the Financial Requirements of Health Care Institutions and Services* as approved by the Association's members for your committee's information, but not to be printed in the record.*

The terms of physician reimbursement under Medicare and Medicaid are not a matter of direct concern to hospitals, but in reply to your query about the effect of new HEW regulations relating to physician reimbursement, two possible results come at once to mind. Some physicians may decide to treat fewer Medicare patients and spend more of their time serving patients who can pay higher fees. On the other hand some doctors might decide to see more Medicare and Medicaid patients at a faster rate with a consequent lowering of the quality of care to these patients. Some doctors might simply find it expedient to move out of ghetto and other low income areas and confine their practice entirely to the more affluent.

When the Medicare legislation was before Congress hospitals strongly argued against separate coverage for the hospital based medical specialists, fearing this would disrupt and disturb the relationship between hospitals and such medical specialists. The Senate supported the position of the hospitals (the Douglass amendment) but it was defeated in the conference committee. We believe the effects we predicted then and the fears which we strongly expressed have come true.

2. Are there shortages of hospital beds for patients 65 or over anywhere in the U.S.?

Representatives of the AHA testified earlier this year before both House and Senate committees in support of legislation to extend the Hill-Burton program and initiate a new program of guaranteed loans with interest subsidies for construction and modernization of hospitals and other types of health facilities. In this testimony we pointed out that our nation still has a backlog of unmet health facilities needs, despite the assistance provided under the Hill-Burton program and the impetus it has given to non-governmental efforts. The latest compilation of estimates submitted by the states show we have a 10% shortage of hospital beds and that more than ⅓ of existing hospitals in the U.S. are in need of modernization or replacement. Additionally, there is a very pronounced trend of hospitals being forced to close down some beds, or a wing, or an intensive care unit due to lack of nurses and other trained personnel.

*Retained in committee files.

The shortage of beds is spread unevenly over the nation and I feel sure it poses in some geographical areas a special problem for patients 65 and older, but I have not seen any collected data or study on this.

3. The June 16 "Hospital Indicator" reported that admissions of patients 65 or older increased during the first quarter of 1968 at a faster rate than admissions of patients under 65. To what is this attributable and will future increases cause shortages or strains on existing facilities?

First I would point out that patient days are a more meaningful measurement of hospital utilization than hospital admissions, and that the June 16 Hospital Indicator shows the average length of stay of 65 or older patients during the first quarter of 1968 was 13.4 days while for patients under 65 it was 7 days. The AHA's National Hospital Panel Survey did not begin collecting data on the use of hospitals by patients 65 and older prior to the advent of Medicare and information for contrasting hospital utilization by those 65 and older before and after Medicare is limited. Data collected by AHA from the start of the Medicare program (July 1966) through December 1968 indicate the number of patient days used by these 65 and older is increasing while the number of patient days used by patients under 65 has remained almost constant. Medicare patients currently comprise about 34% of all patients in short-term hospital beds whereas it has been estimated the elderly occupied only along ¼ of such beds prior to July 1, 1966. Commissioner Ball of the Social Security Administration was quoted in a recent *U.S. News & World Report* interview as stating the older people in this country are getting now about 20% more hospital care than they received before Medicare.

Indications are the elderly will continue to occupy higher percentages of hospital beds. I might add that the Canadian experience with national health insurance shows this tendency to consume more health care as a result of government programs is not limited to those over 65. For example, days of care per unit of population in Canadian hospitals rose 36% from 1946 to 1966, but only 12% during the same time period in the United States.

Without doubt the Medicare program has brought increased utilization of hospitals by those 65 and older and it has likely given rise to some shortages or strains on existing hospital facilities.

4. The AHA hears constantly from individual hospitals nationwide regarding the inadequacies of reimbursements to them for services provided Medicare patients, but we have not compiled statistics on hospital charges for such services. Reimbursements to hospitals under Medicare are made through intermediaries and your committee should be able to obtain such information from Medicare intermediaries from the Social Security Administration.

5. What recommendations can be offered for keeping the hospital costs of Medicare patients as low as posible?

Although studies have shown that the cost of routine care (mostly nursing costs) is higher for elderly patients, and that it takes longer and costs more to admit and to perform X-Ray and certain other ancillary services for elderly patients, I feel this question has to be approached from the standpoint of a broad, overall attack on the problem of rising hospital costs.

Hospitals are very much concerned about controlling hospital costs. New economies through increased efficiency and more effective forms of organization are being continually sought and tested in the hospital field. Such economies as can be achieved through prudent and innovative management, tighter utilization reviews (including shortening the recertification period for Medicare patients) and careful determinations of the cost of providing care and services will benefit both Medicare and non-Medicare patients.

An article summarizing ten case studies of innovations in hospital management aimed at helping to curtail the hospital cost spiral appeared in the June 16 issue of *Hospitals*, the Journal of the American Hospital Association. The studies were sponsored jointly by the AHA and the Department of Health, Education and Welfare and provide a basic list of cost control techniques and approaches. I believe the article will be of interest to your committee and I am enclosing a copy. I do not request it be made a part of the record of your hearings.*

I hope the foregoing will be helpful to your subcommittee, and if I can provide any additional information or assistance, I shall be pleased to do so.

Sincerely

KENNETH WILLIAMSON,
Deputy Director.

*Retained in committee files.

[Enclosures]

EXHIBIT A. FACT SHEET MEDICARE 2% ALLOWANCE

BACKGROUND

1. The American Hospital Association, which had been designated by 90% of the short-term general hospitals, negotiated for over six months with the Social Security Administration on the method of reimbursement for the Medicare program.

2. The final agreement was reached, 70 days before the commencement of the Medicare program, only after hospitals were forced to assume a very aggressive posture in the negotiations.

3. The principal area of dispute had been over the method of apportioning cost to Medicare program beneficiaries.

(*a*) Both the AHA and the Blue Cross Association had advocated average per diem (allowable costs divided by total patient days) as the basis for determining Medicare patient costs.

(*b*) SSA argued that the elderly were not like other patients because of a much longer length of stay for the elderly which resulted in a much lower usage of ancillary facilities, e.g., lab tests and x-rays. They advocated the ratio of costs to charges as applied to costs as the method of determining Medicare program costs. (This method requires extremely sophisticated accounting analysis in that both cost finding and accumulation of patient charges is required.)

(*c*) The specific provision of P.L. 89–97 around which this apportionment controversy revolved was Section 1861(v)(1) which states:

"Such regulations shall (A) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (B) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

4. Evidence:

(*a*) SSA was able to demonstrate that average charges per day decreased as length of stay increased.

(*b*) Hospitals were able to cite several local studies which indicated that the cost of routine care (mainly nursing costs) is much higher for the elderly. Since the ratio of costs to charges (RCC) method of apportionment allocates routine costs equally to all patients, the application of this apportionment method would of necessity result in inequities in defining Medicare patient costs.

5. The effect of these two factors—lower use of ancillary facilities versus higher costs of routine care—was compromised through the acceptance of the RCC apportionment method coupled with a 2% allowance for nonprofit hospitals (1½% for for-profit hospitals) partially as a recognition of the higher nursing costs for the elderly. The legality of this compromise was evaluated by:

(*a*) The Controller General of the United States, who reported to the Senate Finance Committee in May of 1966 that:

"We cannot, of course, precisely determine the appropriateness of the allowance in terms of its recognition of costs of the nature described (those relate to the higher costs of routine care). However, in our opinion, there is sufficient merit to the concepts involved when viewed in the context of the statutory provision authorizing the use of estimates to preclude our concluding that the allowance in question is illegal, at least to the extent which it reasonably reflects the amount of costs it is intended to cover."

(*b*) The General Counsel of the Department of Health, Education, and Welfare, also testifying before the Senate Finance Committee in May of 1966, reported:

"The first element on which I should comment is the imprecision of available methods, or at least of methods practicable of widespread application by providers, for allocating costs as between their aged patients and the rest of their patient populations. The principles will ordinarily mean that the cost of room, board and routine nursing service will be divided equally on a patient day basis,

but that laboratory and other ancillary facilities will be divided in proportion to the utilization of the specific services (as measured by the hospital's charges for them). The American Hospital Association has vigorously urged that payment for the care of the aged be based on the average per diem cost for all patients, in accordance with the traditional method of reimbursement of hospitals under a number of grant-in-aid programs and Blue Cross Plans. Since available evidence indicates that the care of the aged costs considerably less per day than the average for all patients, we concluded that this method was unacceptable because it would run counter to the clear indication in both the statute and the committee reports that the insurance system is not to bear any cost of caring for younger patients. But just as it would be unfair to the government to average costs for all services on a patient day basis, so it would be unfair to the providers to average the cost of routine nursing services (and some other services) if, as the hospitals contend, these costs are significantly greater for the aged than for other patients. The extent to which averaging should be carried is clearly a matter of judgment, but it would not seem reasonable to apply averages where they work in favor of the government while denying their use where they might work in favor of providers."

6. After agreement had been reached, both sides exchanged letters expressing the need to conduct subsequent evaluations of the formula. Then Secretary John W.Gardner, Ph.D. wrote to Philip D. Bonnet, M.D., then president of the American Hospital Association:

"May I also at this time repeat the assurances I gave your Association during the meeting that I am deeply concerned that we have a prompt evaluation of the fairness of the results of the application of these principles to the first year cost settlements. We are taking the steps to collect the data necessary for this evaluation and will work with you as well as the Health Insurance Benefits Advisory Council in the evaluation."

Dr. Bonnet replied to Secretary Gardner the following:

"We share your belief in the importance of a prompt evaluation of the fairness of the results of the application of these principles. We shall undertake during the first year of the operation of P.L.89-97 an evaluation of experience under these principles. In this way we can work with you on the assessment of the actual experience in order to assure that the most constructive long-run methods and principles for the reimbursement of costs under the government programs and further, to assure both the provision of high quality care and the strengthening of our health care institutions and services."

7. It is an oversimplification of the problem to assume that apportionment was the only issue between SSA and the AHA. In a letter of April 20, 1966, the American Hospital Association argued

"Unfortunately, we must conclude that based upon an interim and incomplete draft of 'Principles for Specific Reimbursable Costs' presented to us, there will be in effect a double tax on non-Medicare patients. They will not only be paying Social Security and other taxes to support the Medicare benefits, but they will also be forced through increased hospital charges to pay the deficits resulting from the inadequate reimbursement of hospital costs under the proposed reimbursement principles. They will also bear substantially the entire burden for: (1) acquisition or replacement of equipment in an ever-rising cost market; (2) expansion of existing services; (3) creation of new and improved services, and (4) retirement of debt, that will be so desperately needed to insure the entire population of quality of care. It does not seem to us to be unreasonable that such items be fully included in the reimbursable and allowable costs."

In light of the recent action by the Republican Administration, it is interesting to note that the House Republicans on the Ways and Means Committee in preparing a minority report to the Social Security Amendments of 1965 made the following statement:

"The consequences of the adoption of the 'reasonable cost' formula should be apparent. If the hospitals are prevented from charging the customary rates to the patients over age 65, hospital costs for patients under age 65 will have to be increased in order to make up the difference. In order to reduce its losses, when the patients under age 65 can no longer bear such increases, the hospital will be forced to curtail the quality of its service.

Interim AHA Reimbursement Activities

1. Since the major area of the disagreement had been the evidence on nursing cost of the elderly, the AHA undertook a national study immediately after July 1,

1966. The methodology for this study was reviewed by industrial engineers, representatives of the Public Health Service, and the Social Security Administration. The findings confirmed the hospitals' allegations that nursing hours per patient day for the elderly were substantially greater:

"An analysis of nursing hours per patient day by age group reveal little difference up to age 55. Below that age the hours of care per patient was 3.96. Patient groups above that age revealed: 4.23 hours per patient day for the age 55 to 64 group, 4.55 hours per patient day for the age 65 through 75 group, and 5.39 hours per patient for the age 75 and over group. The differences between these three age groups themselves and also between these age groups and younger patients were all highly statistically significant."

The results of the AHA study were confirmed by regional studies conducted by the Commission for Administrative Services in Hospitals (Southern California), the Hospital Association of New York State, Massachusetts Hospital Association, and a study conducted by the Veterans Administration on a national basis indicated that the magnitude of increased nursing time for patients over age 65 ranged from 15% to 26%. A study by the Associated Hospital Service of New York indicated that the additional cost for the elderly was not limited to nursing costs, but indicated that other elements of routine service costs also require more cost for the 65 and over.

2. In keeping with the agreement on evaluation of the reimbursement formula, AHA and SSA agreed to conduct a joint study of the capital financing of hospitals. We prepared a national sample of hospitals and collected five years of audited data from these institutions for the period immediately preceding Medicare. The purpose of this survey was to obtain a trend line from which we could evaluate the Medicare experience. These data have been fully processed and are on computer tape awaiting the arrival of data on the Medicare experience.

An evaluation of the Medicare experience has been impossible because we still, almost three years later, do not have audited data on the final settlements for the first six months of the Medicare program.

3. This delay in reaching final settlements on Medicare reimbursement is also indicative of the very high administrative costs of the program. It has been estimated that almost one-third of the nonhospital administrative costs of the Medicare program result from audit fees. Within the hospital, a survey conducted by the American Hospital Association of comparable HAS hospitals indicates that hospitals have had a 20% increase in administrative and general manhours to comply with the reporting requirements of Medicare.

4. As a result of our negotiations on the original Medicare formula, the AHA became acutely aware of the limitations in its position statement on contractual reimbursement. An extremely imaginative and progressive statement on reimbursement has been prepared and we are now seeking a hearing with government on the implementation of this approach which recognizes the responsibilities of health care institutions to the community and purchasers of care, as well as the full financial requirements of providing institutional health care. This was a major undertaking.

Current Controversy

On April 15, 1969, without any prior consultation with representatives of the hospital field, Undersecretary of HEW John Veneman announced that the Administration was going to eliminate the 2% factor in lieu of specific costs for both the Medicare and Medicaid programs, to be effective July 1, 1969. The apparent rationale for the elimination of this factor was solely for economy reasons. There was no consideration of the effect of such a reduction in reimbursement on the provision of institutional health care and it was announced without any evaluation by either hospitals or the Health Insurance Benefits Advisory Council.

AHA and the hospitals of this country believed that the federal government was clearly committed to discussions with the Association in response to any changes that might be considered in reimbursement for it was only through the cooperation of the nation's hospitals that the Medicare program was successfully inaugurated. It was also quite apparent that the 2% factor was important to hospitals in accepting their contractual obligation to the program. Even though the total dollars represented by the factor are small in terms of government finance, it is most important that the administration realize that the

2% factor represents a very substantial amount of resources essential to hospital operations. It should not be approached as if it were insignificant.

The American Hospital Association feels that no modifications in the reimbursement formula should be undertaken until we have had the opportunity to make a full evaluation of the current formula and the effects of any changes on the delivery of institutional health care to the people. It also believes that the new AHA Statement on the Financial Requirements of Health Care Instiutions and Services deserves formal consideration by the federal government before it undertakes any changes in the program.

EXHIBIT B. MEDICARE REIMBURSEMENT

JULY 30, 1969.

In passing P.L. 89–97, Congress specified that the "amount paid to any provider of services with respect to services for which payment may be made . . . be the reasonable cost of such services . . ." In endeavoring to define reasonable cost, the Social Security Administration and the American Hospital Association, designated negotiator for over 90% of the nation's hospitals, spent nearly six months in attempting a definition based on a reasonable cost formula. Although defining reasonable cost would appear to be a relatively simple matter, it is necessary to resolve three issues: (1) what are the allowable reasonable costs to be included in the payment system, (2) how is the reasonableness of total allowable costs to be determined, and (3) what share of these total costs should be borne by the Medicare progam for its beneficiaries.

It was agreed by both parties that the answers given to these questions in April of 1966 would be reviewed as soon as evidence on the fairness, adequacy, and the administrative effectiveness of the program was available. Because of the complexity of the current reimbursement formula, complete financial information is still not available on the first year of the Medicare program. Despite the belief by hospitals that the current formula was inadequate, the American Hospital Association assumed that no re-examination would be undertaken until such data were available. However, in April of this year, the Department of HEW unilaterally and without such a re-examination changed the Medicare reimbursement formula through the elimination of the 2% allowance in lieu of specific costs. This unilateral action in a program involving a partnership between the public and private sectors has necessitated an immediate re-examination of the entire formula.

A. ALLOWABLE COSTS

SSA's *Principles of Reimbursement for Provider Costs* include "all necessary and proper expenses of an institution in the production of services" as allowable costs. The measurement of allowable costs has been defined as actual accounting expenses. With only minor exceptions, it has been generally agreed that the basic definition of allowable costs has been satisfactory in terms of the accountant's normal definition of patient care expenses and that this definition was intended by Congress in passing P.L. 89–97.

Although the accountant's definition of allowable costs has been accepted for purposes of payment during the interim, the American Hospital Association believes that this definition is inadequate when compared with the *total* financial requirements of an institution. Hospitals, like any other economic organization, must be financed in terms of their *total* operating and capital requirements which are only partially recognized by the accountant's definition of cost. For example, the cost of the care of the indigent, not covered by state Medicaid programs, involves the consumption of health care institutions' resources and these costs are currently not included as allowable Medicare costs; the funding of capital items, such as plant and equipment, are also inadequately recognized under the accountant's definition of expense. However, it is recognized that the inclusion of these and other elements which are outlined in the *Statement on Financial Requirements of Health Care Institutions and Services* will require amendment to P.L. 89–97.

B. EVALUATING THE REASONABLENESS OF ALLOWABLE COSTS

In discussing the evaluation of reasonable costs, the report of the Committee on Ways and Means on the 1965 Social Security Amendments said: "the provision in the bill for payment of the reasonable cost of services intended to meet

the actual costs, however they may vary from one institution to another, except when particular institutions' costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors." During the first three years of the Medicare program, the administrative complexity of the reimbursement formula has precluded the accumulation of necessary performance data to implement this section of the law. An assessment of the ability of the reimbursement mechanism to provide information necessary for evaluation of the reasonableness of cost must be included in any re-examination of the Medicare reimbursement principles.

C. DEFINING MEDICARE'S SHARE OF ALLOWABLE COSTS

P.L. 89-97 establishes the following equity principle of sharing: "The costs with respect to individuals covered by the insurance program . . . will not be borne by individuals not so covered, and the costs with respect to individuals no so covered will not be borne by such insurance programs." The implementation of this principle was the source of the primary difficulty in the original Medicare reimbursement negotiations and remains as the principal source of dispute today. Determining the program's appropriate share of the total allowable costs is a difficult problem of equity which involves all patients. The failure of the federal programs to participate fully has necessarily increased the share assumed by other patients.

Prior to the passage of Medicare, the appropriate share of costs for most contractual purchasers was determined on the basis of average per diem (total allowable costs divided by total patient days). This was the American Hospital Association's position during the original negotiations. Average per diem payment is administratively simple and the averaging process usually quite equitable. However, the Social Security Administration contended that, because the elderly typically stay in hospital beds longer and do not use ancillary services—laboratory and X-ray—as frequently as other patients, the averaging process would be inequitable. SSA therefore recommended the use of the ratio of charges made for actual services received to total charges as the basis for determining the Medicare program's appropriate share of allowable cost. This method fails to recognize that certain standby or fixed costs (such as administration, housekeeping, plant maintenance, and capital costs) should be borne in equal amounts by all patients; moreover, it fails to recognize that the average cost of routine care for the elderly is higher than for other patients, as later demonstrated by national studies conducted by the American Hospital Association in consultation with the Department of HEW.

Nevertheless, the Social Security Administration was successful in imposing the charge ratio method as the basis for determining Medicare program beneficiaries' share of total allowable costs. In recognition of the inequities of this method in apportioning standby, fixed, and routine costs to program beneficiaries a 2% allowance was included. The elimination of this allowance has necessitated a total re-examination and renegotiation of the method for determining Medicare patients' appropriate share of allowable costs.

Proposed Modifications

A. IMMEDIATE ACTION

In accordance with Secretary Finch's statement of June 27, 1969 (Exhibit C.), the American Hospital Association is meeting with representatives of the Social Security Administration and is actively pursuing the following action to be taken by the administration as an immediate means of remedying the inequities created by the original reimbursement formula and further compounded by the unilateral elimination of the 2% allowance. The method of determining the Medicare program's share of costs must be greatly simplified to reduce the administrative cost and complexity of the program and to improve the timeliness of the information reporting system. The Medicare program's share of inpatient fixed and standby costs must be more realistically and equitably determined through the expansion of the number of cost elements which are apportioned on an average per diem basis. This method of apportionment must also reflect the significantly higher nursing cost for Medicare patients. The charges ratio method of determining Medicare patients' cost of ancillary services must be simplified.

B. LEGISLATIVE ACTION

Amendments to P.L. 89–97 should be adopted to permit the implementation of the American Hospital Association's *Statement on the Financial Requirements of Health Care Institutions and Services.* This statement seeks to end the price discrimination currently prevalent among patients by obtaining full participation of the federal health programs in the *total* operating and capital requirements of providing institutional health care to the entire community. In addition, this statement recognizes the health care system's obligation to the community to expend funds wisely and to expand only in accord with community needs as expressed through the community's appropriate planning mechanism.

EXHIBIT C. STATEMENT BY SECRETARY ROBERT H. FINCH, RELEASED JUNE 27, 1969; AMENDMENT TO THE SOCIAL SECURITY REGULATIONS

Robert H. Finch, secretary HEW, today announced publication of an amendment to the Social Security regulations to discontinue a percentage allowance (two per cent for nonprofit institutions and one and one-half percent for proprietary institutions) paid to hospitals, extended care facilities, and other providers in computing the costs incurred in furnishing services to Medicare, Medicaid, and child health program beneficiaries. The elimination of the percentage allowance follows a decision taken in formulating the administration's budget for fiscal 1970.

The proposed regulation will go into effect on July 1, 1969, the beginning of the new fiscal year.

"The Social Security Act provides that participating institutions will be reimbursed for the reasonable cost of covered services furnished Medicare beneficiaries," Secretary Finch said. "The method used for determining reasonable cost is determined by regulation.

"In developing the original regulations a flat percentage allowance was included to cover various elements of cost that might not have been specifically apportioned to Medicare beneficiaries in the early stages of cost finding under the Medicare program," Finch noted.

"After three years of experience we believe the cost which this allowance was intended to cover should not be determined in the future by the application of a flat percentage which increased directly in relation to increases in total cost, but should be specifically identified and thus recovered.

"Let me emphasize, however," said Finch, "that we are going to make certain that all reasonable cost of providing services to Medicare beneficiaries will be reimbursed. At my direction the Social Security Administration has already undertaken a series of meetings with representatives of the American Hospital Association to re-examine reimbursement mechanisms. Similar sessions will be held with other organizations representing institutions affected by the change. Of course, we will also consult with the Health Insurance Benefits Advisory Council which includes representatives of consumer and public interest as well as health professionals.

"Final cost settlements are now made with each provider on a representative basis after its fiscal year closes. If out of the reassessment we are engaged in we develop modifications in the reimbursement formula, such changes can be taken into account at final settlement so as to apply to cost incurred by providers beginning July 1."

91st Congress
1st Session

COMMITTEE PRINT

HEALTH ASPECTS OF THE ECONOMICS OF AGING

A WORKING PAPER IN CONJUNCTION WITH THE OVERALL STUDY OF "ECONOMICS OF AGING: TOWARD A FULL SHARE IN ABUNDANCE"

PREPARED BY AN ADVISORY COMMITTEE

FOR THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

JULY 1969

(Revised)

Printed for the use of the Special Committee on Aging

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CONTENTS

FOREWORD

—*Older Americans are victims of a retirement income crisis which is deepening rather than improving.*

—*Millions of the elderly in the United States are living today in poverty, and most did not become poor until they became old.*

—*Dismaying as the present situation is, all indicators point to a widening of the gap between income of retirees and income of those still in the labor force. The purchasing power of the retirees will continue to shrink unless we move promptly.*

—*What is needed are major new policy decisions and actions to assure economic security for those now old and for those now in middle-age or younger.*

Such were the major conclusions earlier this year of a Senate Special Committee on Aging Task Force in a Working Paper called "Economics of Aging: Toward a Full Share in Abundance."

That document offered a powerful summary of the forces that have caused the present crisis, and it also gave suggestions for additional inquiry. The Task Force called in particular for close attention to health needs of the elderly and the effects of rising medical costs upon their economic security.

Accepting the Task Force recommendation, the Subcommittee on Health of the Elderly of the Senate Committee on Aging will conduct a hearing on "Health Aspects of the Economics of Aging" on July 17–18, 1969. To prepare adequately, an Advisory Committee was invited to issue a report summarizing basic issues and problems in this area.

The Advisory Committee has done its work and presents its conclusions in the pages that follow. Those findings and conclusions may differ from those finally adopted by the subcommittee and the full Committee on Aging, but there can be no doubt that the Advisory Committee has performed a timely and helpful service by providing an incisive summation of medical cost pressures that afflict aged Americans today despite the invaluable help of Medicare and other public medical care programs.

Those pressures are especially destructive and unsettling for the elderly because of the heavy inroads they make on fixed retirement income, and because they fall so unevenly. A middle-income elderly couple, for example, may find itself in financial jeopardy because either the husband or wife needs nursing home care. They may be disqualified from Medicaid or welfare because they have a savings nest-egg or because of a private pension. Or perhaps a man who has been healthy all his life may, in his mid-70's, become disabled by an illness in which he requires constant attention and medication, but little or no hospitalization. Since, essentially, Medicare coverage begins with hospitalization, it is of little help to him.

The fact is that Medicare pays for only 45 percent of all health care expenditures for the elderly today. Other programs provide

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some help, but the threat of costly, catastrophic, disabling illness remains all too real among our aged population. That threat, intensified by today's rapid rise in medical costs, cannot be disregarded in any evaluation of the economics of aging in the United States today. If we in this Nation ever hope to establish an adequate retirement income maintenance program, we will have to resolve medical cost problems that otherwise will remain an intolerable drain upon the limited resources of the elderly and forestall every alternative in providing adequately for the economic security of the aged.

The Advisory Committee, working under formidable time pressures, has our gratitude for their generosity in sharing their knowledge and convictions with us. We are especially pleased to acknowledge the leadership of Mrs. Agnes W. Brewster in this effort. Mrs. Brewster, a medical economist with a long history of service in governmental agencies behind her, served on the original Task Force and has now made a major contribution to the report which follows.

HARRISON A. WILLIAMS, Jr.,
Chairman, Senate Special Committee on Aging.

EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

HEALTH ASPECTS OF THE ECONOMICS OF AGING

ADVISORY COMMITTEE REPORT

INTRODUCTION

Americans of age 65 and over—though drawing substantial, essential economic assistance from Medicare, and to a much lesser extent, from Medicaid—nevertheless continue to be the major victims of unresolved problems related to the costs, quality, and availability of medical care in the United States today.

Inflationary cost pressures of recent years in the health field intensify the uneven burden of expense, disability, and pain among our elders, creating acute financial problems for many and—for most of the others—the ever-present fear that similar problems will strike their households.

There is reason to believe that millions of old people in our Nation today postpone treatment until the crisis stage simply because (1) they expect old age to bring physical infirmity and misery, and (2) gaps in Medicare and Medicaid coverage make it difficult for them to receive high-quality health services and supplies except during and immediately after hospitalization.

Thus, the over-reliance on hospital care, the most expensive level of care available, is perpetuated and accentuated.

This brief working paper is not meant to be a definitive study of the dollars-and-cents realities faced by elderly Americans who need medical care. Rather, it is meant to comply with a recommendation of a Task Force which in March declared as part of its report on "Economics of Aging: Toward a Full Share in Abundance" that special attention should be given to rising medical costs, costs which compound the general problem of low income among the aged.

The Task Force report, made to the U.S. Senate Special Committee on Aging, was a profoundly disturbing document.

It declared that, for present and future generations of older Americans, their retirement income situation is deteriorating.

It declared that only major changes in social policy can deal adequately with the overall problem and its many components.

Implicit in every major finding of that Task Force was the realization that any needless or avoidable drain upon the limited incomes on which the great majority of the elderly must rely would endanger any public retirement income maintenance plan that might be developed.

Health care expenditures represent a major element in the ability of the elderly to maintain themselves financially. Many of the elderly, even with Medicare, are driven from a status of economic independence into dependency and must turn to Medicaid. Improvement of the plight of the elderly calls for major improvement in income maintenance programs combined with augmented health benefits.

What is discussed in this report are, therefore, matters that must, as a *prerequisite* for any realistic plans for economic security in retire-

ment now and in the decades to come, be dealt with as quickly and as thoroughly as possible.

Fortunately, the United States has already taken large strides toward such realistic plans.

Medicare, though certainly imperfect and hastily implemented, offers a good structure for improvements in our $50 billion health industry.

Medicaid is passing through troubled times caused in part by haste in its genesis, but it is focussing attention on the need for quality control, the need to eliminate waste and abuse, other clear goals in national policy, and greater understanding of the formidable economic barriers to high-quality medical care for all.

Faced by a deepening retirement income crisis, this Nation can ill afford to add to the burdens of the elderly by neglecting unresolved problems related to their health care.

In the following pages, some indicators of the extent and nature of those problems are presented.

MAJOR FINDINGS AND CONCLUSIONS OF THE ADVISORY COMMITTEE

- **Medicare has provided invaluable protection and peace of mind to millions of older Americans.**

  But—because it now covers only 45 percent* of all health costs of the elderly—the door is still open to catastrophic or steady, gnawing financial difficulties so serious as to be a source of great concern for all but the wealthy among the elder citizens of this Nation.

- **This problem, though not limited to those elderly living in or near poverty, affects low-income individuals and couples most directly.**

  Deductibles and coinsurance required under Medicare, together with problems related to availability of services and refusal of a majority of physicians to "take assignment" under Part B of Medicare, intensify the cash problems encountered by the low-income elderly.

- **Although Medicare and Medicaid have replaced a large segment of private spending for health care, 30 percent* of the cost of personal health care for the aged remains as a private responsibility for the aged and their children.**

  In addition to the 45 percent covered by Medicare, 25 percent of the fiscal 1968 expenditures of the aged were met by Medicaid and other public programs. Nevertheless, the amount paid *privately* by the aged remains higher per capita ($176) than for the nonaged ($153).*

  Private expenditure falls unevenly upon the aged population, causing desperate problems for many. Deductibles and coinsurance intensify such problems and in effect deny many elderly persons the care or services they need.

- **The refusal of nearly one out of two physicians (excluding those who are hospital-based)* to "take assignment" is accompanied by a rise in fees and a consequent inability on the part of many elderly to avail themselves of their Part B Medicare benefit, even when they have paid the premiums for Part B.**

- **Medicaid offers uncertain and uneven protection; and "meshing" with Medicare is far from adequate.**

  Cutbacks by the States in Medicaid benefits and beneficiaries will compound the problem.

- **About half of the aged population has supplemented its Medicare coverage with some form of private protection, but premiums for adequate benefits are beyond the reach of many.**

  The complementary coverage is more often than not limited so that benefits are paid only when the Medicare patient is

*See note on page 4.

in the hospital; and those enrolled under Medicare Part B are already paying $96 per couple annually in premiums.

- **Inflationary tendencies in the health field have an intense impact upon care provided for the elderly.**

  While Medicare can and has generated powerful inflationary forces in the health-care market, more positively, it can also be a force against runaway costs.

- **There is some danger that the current investigations of fraud and near-fraud in Medicaid and Medicare may lead to a defeatist or negative attitude toward each program.**

  There is also a danger that such emphasis may well thwart efforts to deal with more fundamental deficiencies in each program.

  Reform is needed, but it should be thoroughgoing and it should be positive. This Nation has declared that high-quality medical care is the right of every American. We should be innovative and positive in making changes. We should be as insistent upon upgrading quality as we are insistent that wrongdoing be recognized and punished.

- **As consumers of health care and services now costing approximately 3 times* as much as for other age groups, the elderly have special needs.**

  They include long-term care in hospitals or nursing homes, and out-of-hospital drugs. Medicare coverage is deficient or nonexistent in these areas of special need.

- **Deficiencies in the delivery system for health care services play a direct role in creating dollars-and-cents problems for the elderly.**

  They, along with other age groups, suffer not only in terms of inconvenience, but also in terms of direct dollar outlays, because of irrational or outmoded delivery systems for medical care and services. A special cause for concern for the elderly is the lack of decent alternatives to expensive hospital care.

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*NOTE: At the time the Advisory Committee was preparing this report, data were not available on the health care expenditures of the aged during fiscal year 1968. For the detailed analysis in its report, the Committee has therefore used data for the preceding year—the first year of Medicare.

The major findings summarized above have now been updated to reflect information released by the Social Security Administration in a Research and Statistics Note, dated July 16, 1969.

The conclusions remain unchanged.

FOR ADVISORY COMMITTEE RECOMMENDATIONS, SEE PART V

CHARACTERISTICS OF THE AGED POPULATION

Certain facts are needed as a frame of reference for consideration of the economic position of the aged, now and in the future.[1] Who are the people now 65 and older? How is the aged group changing? What are the population characteristics that help to explain low incomes in old age?

Every tenth American is 65 or older. Currently, there are about 20 million aged individuals. Fewer than 9 million are men and more than 11 million are women.

The rate of growth in the population 65 and older has slackened in recent years. In contrast to a 3.0 percent annual rate of increase for the decade 1950–60, the rate has averaged just under 2 percent during the Sixties.

Projections for the decade ahead indicate a growth rate for the aged population about the same as the rate for the total population. The ratio of the population aged 65 and over, consequently, is expected to remain nearly a constant proportion (about 18 percent) of the population in the "working ages" of 20–64 through 1985.

The population 65 and older is not a homogeneous group at any given date; the composition of the group is constantly shifting.

On the average day, roughly 3,900 people will celebrate their 65th birthday but about 3,080 already past 65 will die, a net increase of 820 a day. In the course of a year, this means a net increase of 300,000. In the course of 5 years, 35 percent of the population 65 and older are new additions to this age group.

The aged population is getting older. Half of all people now 65 and older are about 73 years old or over. Of every 100 older persons today, 63 (almost two-thirds) are under 75; 31 (almost one-third) are between 75 and 85; and 6 are 85 or over.

In the years ahead, the growth in the aged population will be particularly great at the highest ages. The population 85 and older may nearly double over the years 1960 to 1985, in comparison to a 50 percent projected increase for the total population 65 and older.

More of the aged in the future will be women, and most of these women will be widows, many living alone. Women 65 and older already outnumber men by a ratio of 134 to 100 and this disproportion is expected to rise to 150 to 100 by 1985.

Also, as our population grows older, more people outlive their children. Probably as many as one-fifth of all older people today never had children or had children who preceded them in death.

[1] The facts used here have been drawn primarily from *A Profile of the Older American*, by Herman B. Brotman, Administration on Aging, U.S. Department of Health, Education, and Welfare. The Task Force is indebted to Mr. Brotman for his assistance in providing data more recent than those in his published analysis and for his helpful advice.

THE ROLE OF MEDICARE IN FINANCING HEALTH CARE EXPENDITURES FOR THE AGED DURING ITS FIRST YEAR (FY 1967)

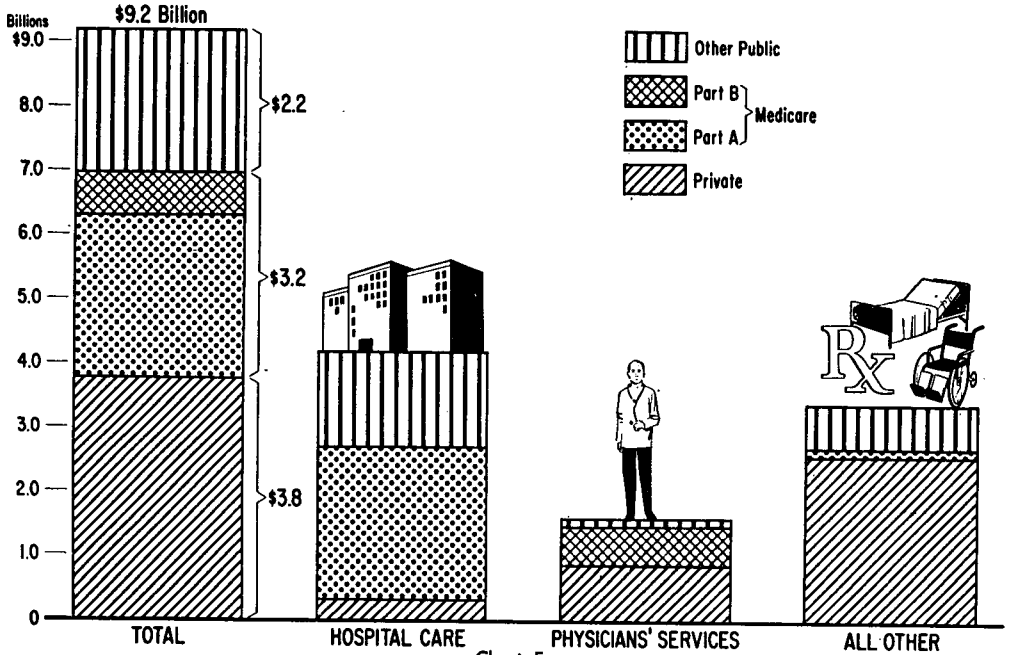

Chart E

Source: Social Security Bulletin, August 1968

CHART E. THE ROLE OF MEDICARE IN FINANCING HEALTH CARE EXPENDITURES FOR THE AGED DURING ITS FIRST YEAR

SOURCE: "Personal Health Care Expenditures of the Aged and Nonaged," by Dorothy P. Rice, Arne Anderson, and Barbara S. Cooper, *Social Security Bulletin*, August 1968, table 3, page 22.

TECHNICAL NOTE: Personal health care expenditures include all expenditures for health and medical care services received by individuals. Excluded are expenditures for medical-facilities construction, medical research, public health activities not of direct benefit to individuals (that is, disease prevention and control), and some expenses of philanthropic organizations. These data also exclude the net cost of insurance (the difference between health insurance premiums and benefits paid) as well as administrative expenses of several public programs.

Of the $9.2 billion in expenditures for the aged in fiscal year 1967, a total of $3.2 billion—or 34.6 percent—was expended under the public program of Medicare. In the distribution by source of funds, all expenditures under Medicare are classified as "public" even though the aged individual pays a monthly premium for Part B Medical Insurance. This serves to understate the amount financed by private funds and to overstate the public share.

The $626 million expended for physicians' services under Medicare in fiscal year 1967—its first year of operation—do not fully reflect the charges incurred under the program because there is a considerable lag between the time a patient visits a physican and the time the carrier receives payment from the trust fund for such a visit. (There are indications that incurred charges accruing under Part B Medical Insurance in fiscal year 1967 amounted to an estimated $1.1 billion instead of the $644 million actually expended; this would raise the proportion of total expenditures that were attributable to Medicare to roughly 37 percent.)

Public expenditures other than those under the Medicare program were largely through public assistance programs, commonly called Medicaid.

The category "all other" includes expenditures for dentists' and other professional services, drugs and drug sundries, eyeglasses and appliances, nursing-home care, and other health services.

THE FINDINGS: Medicare benefits paid in the first year of operation totaled $3.2 billion, 35 percent of the estimated personal health care expenditures of $9.2 billion for all people 65 and older. Of expenditures for hospital care, 57 percent was through the Medicare program.

AVERAGE HEALTH CARE EXPENDITURES PER PERSON

Aged & Younger, Fiscal Year 1967

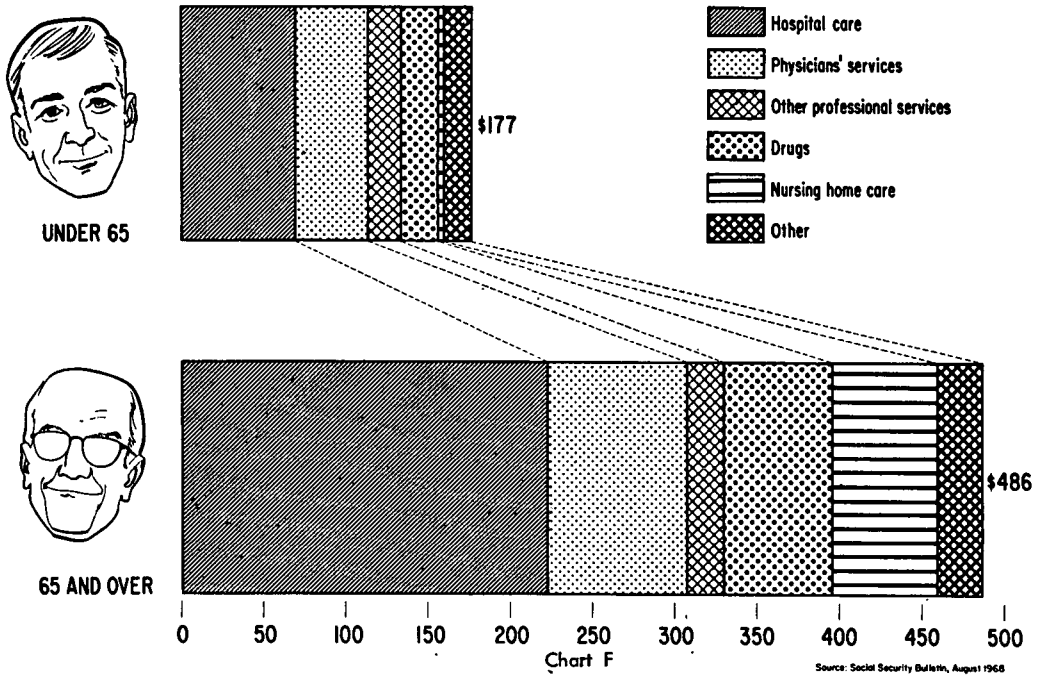

Chart F

Source: Social Security Bulletin, August 1968

CHART F. AVERAGE HEALTH CARE EXPENDITURES PER PERSON: AGED AND YOUNGER

SOURCE: "Personal Health Care Expenditures of the aged and Nonaged," by Dorothy P. Rice, Arne Anderson, and Barbara S. Cooper, *Social Security Bulletin,* August 1968, table 2, page 21.

TECHNICAL NOTE: Personal health care expenditures include all expenditures for health and medical care services received by individuals. Excluded are expenditures for medical-facilities construction, medical research, public health activities not of direct benefit to individuals (that is, disease prevention and control), and some expenses of philanthropic organizations. The data also exclude the net cost of insurance (the difference between health insurance premiums and benefits paid) as well as administrative expenses of several public programs.

The category "other professional services" includes expenditures for dentists' services and other professional services. The category "other health services" includes expenditures for eyeglasses and appliances and other health services.

THE FINDINGS: Personal health care expenditures in fiscal year 1967 averaged $486 per person 65 and older, about 2¾ times the average for younger persons ($177). The two age groups differ considerably in the average spent for the various types of medical care. For hospital care and for drugs, per capita expenditures of the aged are about three times those of younger people. The widest disparity is for nursing-home care; $64 was spent for the average aged person, compared with only about $2 per person under age 65.

HEALTH CARE EXPENDITURES PER AGED PERSON BY SOURCE OF FUNDS

FY 1966 and 1967 (Before and after Medicare)

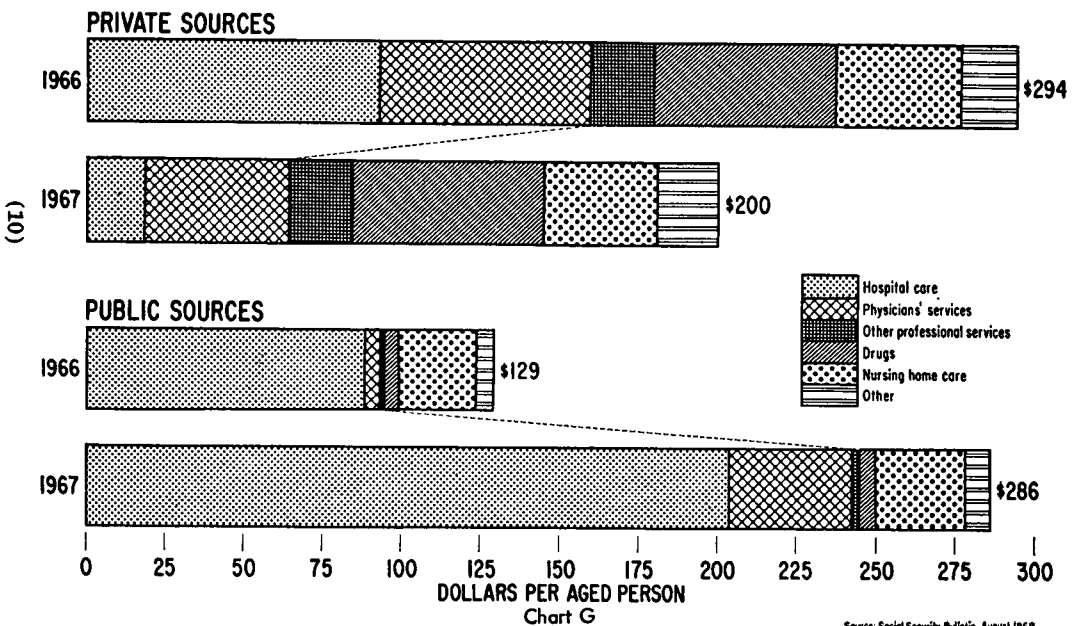

Chart G

Source: Social Security Bulletin, August 1968

CHART G. HEALTH CARE EXPENDITURES PER AGED PERSON, BY SOURCE OF FUNDS

SOURCE: "Personal Health Care Expenditures of the Aged and Nonaged," by Dorothy P. Rice, Arne Anderson, and Barbara S. Cooper, *Social Security Bulletin*, August 1968, table 2, page 21.

TECHNICAL NOTE: Personal health care expenditures include all expenditures for health and medical care services received by individuals. Excluded are expenditures for medical-facilities construction, medical research, public health activities not of direct benefit to individuals (that is, disease prevention and control), and some expenses of philanthropic organizations. The data also exclude the net cost of insurance (the difference between health insurance premiums and benefits paid) as well as administrative expenses of several public programs.

In classifying health care expenditures by source of funds, the Social Security Administration attributes to public sources all expenditures made through *public programs*. Thus, all expenditures under Medicare are classified as "public," even though the aged individual pays a monthly premium for Part B Medical Insurance.

The category "other professional services" includes expenditures for dentists' services and other professional services. The category "other health services" includes expenditures for eyeglasses and appliances and other health services.

THE FINDINGS: The average health care expenditure per aged person in fiscal year 1967 was $486, nearly 15 percent more than in fiscal year 1966. Primarily as the result of Medicare, the portion financed from public funds rose markedly in the first year of operation—from $130 per aged person in fiscal year 1966 to $286 in fiscal year 1967. There was a less sharp drop—from $294 per capita to $200—in expenditures classified as from private sources.

PART ONE

WHAT THE ELDERLY PAY FOR HEALTH CARE

In fiscal year 1966, just before the advent of Medicare, the elderly of the United States accounted for approximately 21 percent of the $36.8 billion paid for the health care costs in that year. A total of $7.8 billion was spent on the aged in fiscal year 1966, 69 percent from private sources and 31 percent from public funds. Seventeen percent of the aggregate was from State and local funds, 14 percent Federal.

As chart E makes clear, Medicare changed the situation dramatically. The total health bill for the elderly in fiscal year 1967 was $9.2 billion, up $1.8 billion. Private funds paid $3.8 billion (41 percent) of the new total. This percentage will only drop slightly when the aged use Medicare fully. Chart F shows how the per capita expenditures differ by age.

What are public funds now used for?

I. THE NATIONAL SCENE: PUBLIC AND PRIVATE SPENDING

The source of expenditures changed in character under Medicare. State and local expenditures for the aged dropped nearly $300 million; Federal expenditures rose by $3.3 billion so $3 billion more tax moneys were used to finance the aged's health needs. At the same time, private expenditures, by and for the aged, decreased by $1.7 billion. In the first full year of Medicare, fiscal 1967, public funds accounted for 59 percent [1] of the medical bill of the aged. (Table I and chart G.) For hospital care, 92 percent was financed by public funds. About 46 percent of the money spent on physicians' care on behalf of the aged, came from tax sources. That only 24 percent of the combined expenditures for dentists, drugs, eyeglasses, nursing home care, et cetera, was met by tax moneys, arises from the gaps in Medicare coverage.

[1] The Social Security Administration estimate of public spending includes the $4 monthly premium charge paid by Part B Medicare enrollees. Asked by the Senate Special Committee on Aging whether such payments might be listed as private expenditures, SSA replied: "It seems to us much more realistic to treat the entire program as a public program, and to treat the premium payments just as we treat employee contributions for social insurance." SSA acknowledged that the $300 million paid by enrollees, "if added to private outlays, would increase private as a percent of the total personal health care expenditures of the aged from 41.2 percent to 44.5 percent."

TABLE I.—ESTIMATED PERSONAL HEALTH CARE EXPENDITURES OF PERSONS AGED 65 AND OVER BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, FISCAL 1967

Type of expenditure	Total	Private	Public		
			Total	Federal	State and local
	In millions				
Total	$9,156	$3,774	$5,382	$4,331	$1,051
Hospital care	4,188	348	3,840	3,161	679
Physicians' services	1,602	864	738	675	63
Other professional services	425	383	42	30	10
Drugs and drug sundries	1,232	1,139	93	46	47
Nursing-home care	1,209	678	531	311	220
Other health services	500	362	138	107	31
	Per capita				
Total	$485.91	$200.29	$285.62	$229.85	$55.77
Hospital care	222.26	18.47	203.79	167.75	36.04
Physicians' services	85.02	45.85	39.17	35.82	3.35
Other professional services	22.55	20.33	2.23	1.59	.64
Drugs and drug sundries	65.38	60.45	4.94	2.44	2.50
Nursing-home care	64.16	35.98	28.18	16.50	11.68
Other health services	26.53	19.21	7.32	5.68	1.64
	Percentage distribution				
Total	100	41.2	58.8	47.3	11.5
Hospital care	100	8.3	91.7	75.5	16.2
Physicians' services	100	53.9	46.1	42.1	4.0
Other professional services	100	90.1	9.9	7.1	2.8
Drugs and drug sundries	100	92.5	7.5	3.7	3.8
Nursing-home care	100	56.1	43.9	25.7	18.2
Other health services	100	72.4	27.6	21.4	6.2

The $5.4 billion expenditures by public programs consist of Medicare (59 percent), public assistance vendor medical payments (20 percent), veterans hospital and medical care (10 percent), other public hospital and medical care (9 percent), and other (2 percent). Only 11.5 percent of the total is now derived from State and local funds, down from 17 percent.

Although the Federal Medicare program has replaced a large segment of private spending for health care, 41 percent [2] remains as a personal responsibility to be met out of Social Security benefits, other income, and assets, and by relatives and friends, and by their private insurance.

II. WHAT COSTS MEAN IN PERSONAL TERMS

However significant and imposing the national statistics are, they must be translated into individual terms, if we are to understand the grave medical cost problems facing millions of older Americans today.

The most striking attribute of such costs is their uneven distribution.

The amount of hospital care required annually varies from none for 87 percent to two or more stays for some of the elderly. Older persons with $10,000 or more income were heavier than average users of hospitals. Those with two or three hospital episodes required more than two or three times as many days of care as those hospitalized only once.[3]

[2] See footnote 1 on p. 13.
[3] Source: NCHS Series 10, No. 50, p. 5, "Persons Hospitalized" June-July 1966.

Visits to doctors also vary by age, sex, and by physical condition, as well as by city and by income. The per capita visits rise with age. This is one reason why aged females average more doctor visits than males. Only 27–30 percent of the population aged 65 and over goes through a year without seeing a doctor—7 percent see a doctor 13 or more times a year, or more than once a month.

Thus, costs can range from nothing to $400 or more, just for doctor visits outside the hospital.

Prescribed drug usage varies widely; those with chronic illnesses require more than the average number of prescriptions, so their costs can be sizable. This is one of the gaps in Medicare; it is one of the large segments of expenditures under Medicaid. And it is the largest area of per capita private expenditure by the aged.

A. Medicare: The Benefits, the Gaps

As Table 1 showed, Medicare pays a large portion of the hospital bills of the aged. The deductible of the first $44 of the hospital bill and the coinsurance in the later days of hospital and extended care facility stay do not affect many aged people in the course of a year. Under Part B of Medicare, however, enrollees not only pay a $48 annual premium but the first $50 of the insured services and 20 percent of the remainder of the charges. When a person sees a doctor, quite often other charges, such as for laboratory work, prescriptions, X-rays, and so forth, are also incurred. Some or all of these charges represent gaps in Medicare coverage.[4]

Still another kind of gap exists in Medicare which might be called a "communication gap" though some observers react with such disbelief that it might be labeled a "credibility gap" instead.

Only about half of the physicians caring for Medicare patients accept assignments of the benefits. "Assignment of benefit" means that the aged person has instructed the Medicare fiscal intermediary to pay his doctor directly ("assign his benefits" to the doctor). When a doctor accepts assignment, he binds himself not to send a separate and additional bill directly to the old person; he collects 20 percent of the bill from the beneficiary and 80 percent from the Trust Fund via the fiscal intermediary. Surgeons, whose bills are usually larger than those of other physicians, are more and more showing a willingness to accept assignment rather than to struggle to collect from the beneficiary who may only be able to pay after receiving the claims payment himself.

Here is how a comparison of a surgeon's bill can work with and without assignment:

[4] The absence of prescription drug coverage is discussed in Part III. Coverage of mental illness under medicare is subject to special limitations on days of care (190 days in a lifetime) and on out-of-hospital treatment (50 percent coinsurance and a limit of $250 annually as well as the $50 deductible). While 68 percent of all mental hospitals with 74 percent of all mental beds, participate in Medicare, the proportions vary by region of the country and by sponsorship. The problem was described in some detail by Dr. Robert W. Gibson, representing the American Psychiatric Association and the National Association of Psychiatric Private Hospitals at U.S. Senate hearings on the Social Security Amendments in 1967:

"Under the supplementary medical insurance benefits for the aged, outpatient treatment may be paid for after a $50 deductible, with the patient paying 20 percent, and with no top limit. But, in the case of psychiatric treatment, the patient must pay 50 percent after the deductible, and there is a top limit of $250. This limitation seriously curtails outpatient psychiatric treatment for the aged patient. Many elderly patients can be successfully treated on an outpatient basis. *If such treatment is denied because of financial limitation, the inevitable result will be hospitalization. Such unwarranted hospitalization may not serve the best interests of the patient, and will most certainly add to the cost of the hospital insurance program.*"

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Case: A CATARACT OPERATION WITH OPHTHALMOLOGIST'S BILL AMOUNTING TO $700

WITH ASSIGNMENT

Fiscal intermediary finds $700 exceeds usual and customary by $150:	
Intermediary pays 80% of $550	$440
Patient pays 20% of $550	110
Total paid	550

WITHOUT ASSIGNMENT

Doctor sends bill to patient who pays $700 to doctor and sends bill to fiscal intermediary:	
Intermediary pays patient	$440
Patient has to pay balance	260
Total paid	700

Prior to Medicare, physicians often showed an understanding of their patients' economic circumstances and did not raise the fees they had been charging old patients for years on end. With Medicare, fees have been "adjusted" upward so that it is not too unusual to have the aged family spending as much out of pocket as before the program began, or even more, especially if the $48 in Part B premiums is counted among their expenses, as it should be.

The disadvantages of nonassignment are fivefold: (1) the aged person must pay the doctor's charges, whatever their level, without such deterrents as are imposed by having the fiscal intermediary screen for reasonableness and relationship to other doctors' charges; (2) the aged must themselves complete forms, submit claims, pay the bill, etc.; (3) the higher charges soon become the accepted level of charges and are subsequently paid by the fiscal intermediary; (4) the dollar cost of the coinsurance of 20 percent mounts; and (5) workers pay more social security taxes as demands on the trust fund rise.

Certain types of health care—notably long-term nursing care for chronic illness, as distinct from posthospital extended care—are almost exclusively the domain of the aged. In a 1964 survey, only 12 percent of the residents of nursing and personal care homes were under age 65. Forty-eight percent were females aged 75 and over. More than 50 percent were men and women in their eighties.

In Michigan, under Medicaid, nursing homes cost $420 a month on the average, or $5,040 a year. How can elderly people by definition long since separated from the labor market and entitled in the main to the minimal social security cash benefits afford the cost of nursing-home care? The average extended-care facility under Medicare[5] costs more than $500 a month.

Not surprisingly, the per enrollee benefit payments under Parts A and B of Medicare vary widely by State.

That the spread is as wide as it is, is as much related to the relative availability and use made of hospital and physician services as it is a reflection of geographic differentials in costs. For hospitals, the lower wage scales of the Southern States enter into the cost differentials.

[5] "Staff Data Relating to Medicaid-Medicare Study," July 1, 1969, Committee Print, U.S. Senate Committee on Finance.

Per Medicare enrollee, Part A benefit payments in fiscal 1967 ranged from $66 in Mississippi to $191 in Nevada. The national average was $134.

Part B payments varied from $23 in Alabama and $24 in Alaska, Kentucky, Mississippi, and South Carolina to $72 in California. The national average was $38 in fiscal 1967.

Differences of this magnitude cannot be explained solely in terms of charges per unit of service. Because of higher charges, more people in California meet the deductible, and thus a greater proportion of their cost is covered by Medicare than in the Southern States.

Some idea of the Medicare limitations can be obtained from the size of payments that must be made for old-age-assistance recipients after Medicare charges have been met. (Non-OAA recipients, of course, pay such charges from their own pockets.)

In one State, New Hampshire, welfare paid the following average amounts on Medicare bills:

Inpatient services	$59.75
Outpatient services	5.89
Home health agency services	47.88
Physicians' services	15.40

Thus, far more than the averages shown could easily be uninsured by Medicare for an individual beneficiary after his Medicare benefits were exhausted.

B. Medicaid: Uneven Protection and Uncertainty

Medicaid programs are designed individually by each State using certain minimal Federal criteria and guidelines. The majority of the 50 States have such programs and these provide the five basic services required; namely, inpatient hospital care, outpatient hospital care, skilled nursing home care, physicians' services, and laboratory and X-ray services.

Among the 40 States and three other locations 27 provide the five basic services to medically needy persons; 16 limit the benefits to the categorically needy.

Prescribed drugs and home health services are made available in 36 States, with 23 of the 36 paying for them for both categories of needy. Thus over half the States do nothing to help the low-income aged with drugs. Lesser numbers of States furnish dental services, appliances, and types of treatment not included as physicians' services. The medically needy aged citizen living in California or Connecticut, Minnesota, New York, or North Dakota is eligible for 19 or 20 kinds of services while his counterpart in Alabama or Tennessee, Alaska, or Indiana has not been eligible for any title 19 services.

Forty-one percent of the people eligible for Medicaid are at least 65 years old. Because Medicare absorbs much of the hospital costs and a share of physicians' costs, only 45 cents of each Medicaid dollar is spent on the elderly. Much of this expenditure is for nursing home care and drugs; these services are either limited or not included under Medicare.

The lack of coverage of many needed services that poor, ill people should have and the fragmentation in the delivery of the services that are provided are both disturbing. All too often, when a question

of funding comes up, cuts are made in Medicaid at the expense of the clients, not the providers.

Medicaid could be a useful vehicle for improving the delivery system for care of people were it not riddled with contradictory policies in its implementation.

III. CAN PRIVATE HEALTH INSURANCE HELP?

The Division of Research and Statistics of the Social Security Administration periodically reports on the extent of private insurance purchased by or on behalf of the U.S. population. According to this source about half the aged population has supplemented its Medicare coverage with some form of private protection. The private policies are financed by the aged themselves or result from employee benefit provisions continued after retirement. Like private insurance generally, these policies vary widely in the scope of benefits (table II) and in the cost of premiums.

TABLE II.—PRIVATE HEALTH INSURANCE ENROLLMENT AS OF DECEMBER 31, 1967: NUMBER OF PERSONS AGED 65 AND OVER WITH SOME COVERAGE OF SPECIFIED SERVICES OR EXPENSE

[In thousands]

Type of plan	Hospital care	Physician service: Surgical services	Physician service: In-hospital visits	Physician service: X-ray and laboratory examinations [1]	Physician service: Office and home visits [2]	Dental care	Prescribed drugs (out-of-hospital) [3]	Private-duty nursing	Visiting-nurse service [4]	Nursing-home care
Blue Cross-Blue Shield	5,410	4,413	4,081	[5] 1,925	1,208	----------	496	825	1,010	2,600
Blue Cross	5,241	275	218	266	105	----------	([6])	([6])	([6])	([6])
Blue Shield	169	4,138	3,863	[5] 1,659	1,103	----------	([6])	([6])	([6])	([6])
Insurance companies:										
Group policies	2,072	1,735	1,116	1,050	1,050	40	1,050	1,050	1,050	100
Individual policies	2,238	1,754	612	100	100	----------	100	100	100	----------
Unadjusted total	4,310	3,489	1,728	1,150	1,150	40	1,150	1,150	1,150	100
Less duplication [7]	263	210	83	----------	----------	----------	----------	----------	----------	----------
Net total	4,047	3,279	1,645	1,150	1,150	40	1,150	1,150	1,150	100
Independent plans	430	505	500	515	[8] 450	43	211	270	335	210
Community	110	170	170	175	170	3	25	85	175	70
Employer-employee-union	315	325	320	330	270	9	185	185	160	140
Private group clinic	5	10	10	10	10	10	1	----------	----------	----------
Dental society	----------	----------	----------	----------	----------	21	----------	----------	----------	----------
Gross total	9,887	8,197	6,226	3,590	2,808	83	1,857	2,245	2,495	2,910
Less duplication [9]	([9])	([9])	([9])	36	28	----------	19	22	25	29
Net number of different persons	[10] 9,085	[10] 7,568	[10] 5,905	3,554	2,780	83	1,838	2,223	2,470	2,881
Percent of population aged 65 and over [11]	47.8	39.8	31.1	18.7	14.6	.4	9.7	11.7	13.0	15.2

[1] In physicians' offices, clinics, or health centers. Excludes those covered only in hospital outpatient departments or those covered only in accidents or fracture cases or when services are followed by surgery.

[2] Number covered for all conditions. Excludes those eligible for care only after hospitalization.

[3] Excludes those covered for drugs only after hospitalization.

[4] Assumes that all persons covered for private-duty nursing are also covered for visiting-nurse service.

[5] Approximately 0.8 million additional persons are covered for X-ray examinations only.

[6] Not estimated separately; in many cases coverage is jointly written.

[7] As estimated by HIAA for first three services; considered insignificant for the other services and hence shown as zero.

[8] About 15 percent of this number not covered for home calls.

[9] Duplication for hospital care, surgical services, and in-hospital medical visits not calculated by ORS since the HIAA estimate of net number of persons covered is used.

[10] HIAA estimates.

[11] Based on Bureau of the Census estimate of 18,994,000 as of Jan. 1, 1968.

Source: Reed, Louis S., and Carr, Willine, Social Security Bulletin 32, February 1969, p. 6.

While 47.8 percent of the population aged 65 and over has some coverage for hospital care (where Medicare and Medicaid leave little for the individual to pay in ordinary circumstances), much lower proportions of the elderly have other kinds of private insurance protection.

Only 15 percent had obtained insurance for home and office care from physicians; only 10 percent had insurance for out of hospital drugs. Fewer than 83,000 aged had any dental insurance.

Many of the policies the aged hold are designed to pay the two deductibles and the Part B coinsurance of Medicare and not a great deal else. Some apply only to hospitalized illness in the traditional Blue Cross-Blue Shield posture.

The Blue Cross Association recently reported [6] that prior to Medicare there were 5.6 million people aged 65 and over among 57 million Blue Cross members or about 10 percent of their enrollment. They also reported that by the end of 1967 some 5.2 million aged had enrolled for their coverage which complements Medicare. Statistics prepared by BCA on just under 2 million such enrollees in 28 Blue Cross plans showed that a total of 233 per 1,000 aged enrollees used the benefit in 1967. There was almost no need for full-pay days (days beyond the Medicare benefit of 90 days)—only 5 days per 1,000 enrollees. The deductible and co-pay benefit applied to 167 days per 1,000 enrolles. Since Medicare is used at a rate of at least 3,100 days per 1,000 beneficiaries, the Blue Cross benefits are not heavily used except for meeting the initial deductible of $40 of the hospital bill (now $44).

Other insurance policies provide straight dollar indemnities for each day in the hospital, sometimes increasing the amounts at the 21st and 90th days.

Usually incompletely, other cash indemnity plans cover ambulatory care and include prescriptions, eye examinations, physical examinations, etc., that are excluded from Medicare.

Prepaid group practice plans have worked out ways of dovetailing benefits so that their Medicare members can continue to receive routine physical examinations, eye examinations, prescribed drugs, and other services not included in Medicare's benefits.

Overall, however, it is apparent that many of the same reasons why voluntary health insurance could not provide the kind of protection the aged needed still hold.

Premiums for adequate benefits are beyond the means of many; the complementary coverage purchased is more often than not limited so that benefits are paid only when the Medicare patient is in the hospital. It is true that a number of the collectively bargained health plans have provided for benefits indefinitely, for pensioned union members and their spouses, but other older people have felt that the premium they are obliged to pay for Part B Medicare benefits was as much as they could spend. The sum of $8 monthly or $96 annually for a couple, in addition to the deductibles and coinsurance the beneficiary must meet, and the expenses for drugs, etc., takes all their modest budget can manage.

[6] "Blue Cross Reports," December 1968, pp. 7-8.

PART TWO

HOW MEDICAL COST INFLATION INTENSIFIES THE PROBLEM

Health care expenditures per aged person in fiscal 1967 averaged two and three quarters times those of people under age 65. (Chart F.) It becomes clear, then, that inflationary tendencies in the health field will have intense impact upon care provided for the elderly, and that public and private sources of this support are certain to be strained during periods of dramatic cost increases. When medical care is excluded from the general price index, medical care prices rose two and a quarter times as fast as other prices in the period since 1957–59.

I. EXTENT OF TODAY'S HEALTH CARE INFLATION

During the period 1960–65, when prices generally were rising less rapidly than at any time since 1946, the Consumer Price Index for daily service charges of hospitals also slowed down—from an annual 8.3-percent rise to a 6.3-percent rise.

In that year—marked by the beginning of Medicare in July—medical care prices rose nearly twice as fast as the annual rate for the 1960–65 period.

But the deceleration stopped abruptly in 1966.

In 1967 the index for hospital charges rose by 19.1 percent and in 1968 by 13.2 percent.

Physicians' fees rose 7.1 percent in 1967 and 5.6 percent in 1968. In the 3-year period ending December 1968, hospital daily charges have risen 52 percent and physicians' fees 21 percent. Overall, medical care services had risen 25 percent.

FIVE SPECIAL PROCEDURES

The Social Security Administration arranged with the Bureau of Labor Statistics in the summer of 1965 to collect prices for three surgical procedures (cholecystectomy, prostatectomy, and fractured neck of femur) and two in-hospital medical services (myocardial infarction and cerebral hemorrhage) that are common among older persons, though not necessarily limited to them. Prices are collected for these five procedures but are not incorporated in the regular sample of the CPI. It was believed that fees for such services might be sensitive to the new Medicare program and hence would provide baseline data to assess the impact of the program on physicians' fees.[1]

These five special procedures are the reason for hospitalization for many elderly people. The average increase of 21 percent found for doctors' charges generally for the 36 months ending December 1968, compared closely with increases of 17 to 21 percent for the five procedures.

[1] As reported in Research and Statistics Note No. 6, 1969, Social Security Administration, Office of Research and Statistics.

Inflation of medical care services and supplies not covered by Medicare affect the elderly on fixed income directly and completely. The 25 percent increase in such items and services can bring real hardship.

DRUG COSTS FOR THE ELDERLY—HAVE THEY RISEN?

While the CPI for drugs and prescriptions shows little change between December 1965 and December 1968, there is a real question whether the surrogate items priced for this index are representative of the kinds of drug therapies the elderly require.[2]

RISING MEDICAL COSTS: IS MEDICARE RESPONSIBLE?

An Estimate of the "Inflationary Flames".—A high level appraisal of rising medical costs was provided on December 31, 1968, when Secretary of Health, Education, and Welfare Wilbur Cohen decided that he would not raise the monthly premium aid by 19 million Americans enrolled in Part B of Medicare.

Secretary Cohen had been advised by the Social Security Administration's Chief Actuary to raise the premium from $8 a month ($4 from Federal sources, $4 from each beneficiary) to $4.40 from each, or $8.80 a month, total. Among the reasons given by the Secretary for his decision were the following:

—The Actuary's estimates of future need were based on estimates that physicians' fees will rise about 5 percent in calendar year 1969 over 1968 and 1½ percent in 1970 over 1969 and that medical utilization under the program will increase about 2 percent in 1969 and 1½ percent in 1970. Thus, the $8.80 premium level was suggested, even though $9 would have been preferable.[3]

—But, said Secretary Cohen: "Any increased premium based on an assumption of as much as 4½ percent increase in physicians' fees is likely to act as a further inflationary factor. Any such estimate is likely to be viewed as a minimum prediction of increase—one which the Federal Government has approved. No one can say with any reasonable degree of certainty what the effect of the proposed increase would be on other parts of the $40 billion medical care industry. Thus, any increase under Medicare also may be reflected in an increase in Medicaid costs and in the premiums that people have to pay for private insurance. Insofar as it is humanly possible I want to avoid further fanning the flames of inflation throughout our entire medical care system."

[2] "*The Drug Users*," one of the reports issued by a HEW Task Force on Prescription Drugs, reports: Although only three of the 14 products in the CPI list are available solely under brand names, and are therefore immune from price competition by chemical equivalents, about three-fourths or more of the most widely used drugs are available only under brand name. Two of the 14 drugs listed in the CPI "market basket"—penicillin and tetracycline—have shown substantial price decreases, largely the result of intense competition from generic-name products, while the other 12 products have shown little or no price change. Finally, the CPI index is so designed that it does not reflect the impact of new and costly products which may be introduced on the market and replace older and less expensive drugs.

The CPI is thus not relevant to the changes which have been occurring in the average price of all prescriptions purchased by patients.

The irrelevancy is indicated by changes shown by three independent indices—the "Lilly Digest Index," the "National Prescription Audit," and the "American Druggist Index"—which demonstrate that the average prescription price has been increasing at the rate of about 2 percent per year during the past decade.

[3] The Actuary's estimate thus included a 10-percent rise in the 2-year period; the extra 20 cents was evidently a margin of safety in the estimate.

—The Secretary also noted that Medicare was enacted during a period of relative stability in the relationship between physicians' fees and prices for other items and wages. During 1965–67, however, the annual increase in physicians' fees was 7 percent, compared to average hourly wage increases of 4.3 percent and a cost of living increase of 2.8 percent. He pointed out:

"A very marked imbalance has developed between the rate at which the physicians' fees have been escalating and the rates at which other indicators have been moving during these years."

—Even more significantly, said the Secretary: "total physician net incomes have increased even faster than the increase in fees for particular services. Based on data from 'Medical Economics,' median physicians' incomes increased 11 percent in 1966 over 1965 and 8 percent in 1967 over 1966. Physicians have not been economically disadvantaged by Medicare."

—Secretary Cohen said he did not believe it is necessary for utilization to increase 2 percent in 1969 and 1½ percent more during 1970. He added:

"I especially urge physicians, patients, families and friends to cooperate in eliminating unnecessary utilization of physicians' services, and I am asking the carriers and intermediaries in their professional review of claims to exercise special diligence during this period."

Medicare and inflation.—As the Secretary's comments make clear, Medicare can generate powerful inflationary forces in the health care market, but, in the Advisory Committee's opinion, and more positively, it can also be a force against runaway costs. The following excerpts from the first annual report of the Health Insurance Benefits Advisory Council of the U.S. Department of Health, Education, and Welfare give a balanced view of what may be possible in either direction:

"In its deliberations, and in drawing up its recommendations, the Council has tried to keep before it two major sets of facts about Medicare.

"On the one hand, this is an insurance program. It finances, for older people, the purchase of services from the providers of health care, most of whom also supply services to all other age groups in the population. As a consequence, Medicare by itself cannot exercise a dominant influence over costs and standards in the health care field. At the same time in exercising its obligations to beneficiaries in the provision of high-quality medical care and its obligation to taxpayers in securing care at reasonable costs, Medicare can, in a limited but important way, indirectly affect the standards and costs of health care for the population at large.

* * * * * * *

"While all third-party payers should have an important role to play in seeking and applying cost restraints, this is particularly true of Medicare. The scope and coverage of the program are so large that what Medicare does may set a pattern for many other third-party payment programs.

"One of the reasons that third parties have an important role to play in controlling cost is that most of the forces of typical marketplace situations which act to control costs for nonhealth services cannot perform effectively in the health field. Cost

reimbursement to hospitals offers no built-in incentives to cost restraint. Charge reimbursement to doctors, as well, does not provide the protections against increasing charges that are present in many other economic areas.

"The Council, in common with other parties, is concerned that medical care expenditures and Medicare funds in particular should be spent most effectively in order to maximize the benefits received for the funds expended. The Council is very much aware that there are limits to the time during which medical cost can continue to rise as rapidly as in recent years without creating serious issues of the priority of allocation of further resources to medical care rather than to housing in the inner city, to education or to the multitude of other demands not now fully satisfied. The ways that Medicare sets the amount it will pay for covered services may have very important effects on the entire health care industry.

"*The escalation of physicians' charges.*—The medical insurance program (Part B) is designed to reimburse the beneficiary, or pay on his behalf, reasonable charges incurred for physicians' services, and certain other medical services, subject to applicable deductible and coinsurance amounts.

"The law does not contemplate that reimbursement of physicians will be based on a fee schedule. Nor was it expected that an individual's income would determine the amount of the payment to be made. It is also clear, however, that Congress did not contemplate reimbursement of physicians without controls of any kind over the costs of the program or without limit to the liabilities it assumed. The law thus provides that only reasonable charges shall be reimbursed. To implement this reasonable charge limitation, the law calls for individual determinations or reasonable charges for specific services by the Medicare carrier which may not exceed the amount the carrier customarily pays under its own program under comparable situations and which take into account:

"(1) the customary charges of the physician, and (2) the prevailing charges in the community. The concept of customary charges incorporates the idea that physician's fees to Medicare beneficiaries for a given service should be no higher than his charges to other patients for the same service. As the program has developed, it has become clear that effective administration of this concept requires recognition of the idea that the physician's charges should not be higher than those that have been applicable in his practice for some time—in short, that customary fees should be those that have in fact been established by custom. The concept of prevailing charges incorporates the idea that a particular physician's fees to a Medicare beneficiary for a specific service should not be out of line with the level of fees generally charged in the locality.

"The statute, therefore, is based upon the view that reasonable charges by physicians and other persons under the program include only those which stay within the bounds marked out by the criteria of customary, prevailing, and comparability.

"Enforcement of these concepts, under the Medicare program, is in the hands of the insurance carriers, operating within the regulations and under the supervision of the Social Security Administration. They are required to assure that the charges determined to be reasonable for Medicare meet the customary and prevailing criteria. Comparison of individual charges with a profile of charges derived both from their Medicare records and the records relating to their own policyholders and subscribers, and with other data on physicians' charges are the primary means of determining that the Medicare reimbursement conforms to the statutory requirements."

II. THE QUESTION OF CONTROLS UNDER MEDICARE OR MEDICAID

The Advisory Committee has grave doubts as to whether, in the absence of a free market as is true in the health field, the concept of allowing the providers to control their own reimbursement is susceptible to the imposition of controls. The terms "prevailing" and "customary" are imprecise and hardly made less so by setting the computer to record the 82d percentile. Limits on frequency of allowing individual physicians to raise a fee merely shift to the patient the amount denied and postpone for a period the day when the higher fee is recognized as the particular doctor's customary one.

The Committee has followed the efforts to find incentives that will induce hospitals to operate more economically. It is not difficult to recognize the truth of the situation—that there is little reason to control costs if your largest customer will pay costs, however unjustified they actually are. Neither carrots nor clubs are effective for long in such inflationary settings.

We are also somewhat discouraged at the reports received from Canada that prior budgeting has not met with any great success as a way of containing costs. Nevertheless, we urge some U.S. experiments along these lines.

Noting the interest of the Administration in the prospective influence of the voluntary sector of third-party purchasers on cost, one of the largest private purchasers—the United Auto Workers—has been frustrated in its efforts to maintain standards in the nursing homes it uses. Furthermore, a 20-percent escalation in premiums has occurred in this large nationwide program since the concept of variable fees was adopted.

We note that standards for quality of care for physicians' services outside the hospital can be developed. New York City has done this and it must be done elsewhere.

We must be innovative and active in seeking ways to keep the cost to all—the aged, the remainder of the population, and public and private insurance programs—within bounds.

III. THE QUESTION OF "CHEATING" UNDER MEDICARE AND MEDICAID

As the foregoing discussion suggests, there are serious voids in present-day cost controls under Medicare, and much more must also be done in the setting of standards for services rendered. The same is also true of Medicaid.[4]

There needs to be a reexamination of the use of fiscal agents and intermediaries in these programs from the point of view of their capability and willingness to promptly supply the data necessary to police the providers. There is a real or potential conflict of interest in expecting intermediaries to control utilization and costs in the public interest.

As long as such voids exist, there is always the opportunity for the kind of overcharging and other forms of cheating which are now the subject of intensive investigations by congressional units. Close attention to all such practices is vital, and it is overdue. Profiteering on programs meant to improve health care—and to make it available to people who might otherwise be denied such care—is a moral outrage, as well as an inflationary force in an already volatile market.

It should be remembered, however, that in terms of the sheer dollars-and-cents impact upon individual elderly consumers of medical products and services, overcharging and outright nondelivery of billed services may not be as significant as other factors.

Under Medicare, physicians' charges come to approximately 25 percent of all charges. In fiscal 1968, this meant that $1,291 million were involved; it is too early to say how much of that sum has been absorbed by fraudulent or questionable practices.

Clearly, investigation in this area must continue. But hard analysis must also be provided on matters that in the long run are of more far-reaching importance to individual patients and the health industry itself.

Such matters mentioned here and elsewhere in this report, include:

—Overutilization of expensive and inappropriate facilities.[5]

[4] It is equally true of other Federal programs that purchase services, including CHAMPUS (Civilian Health and Medical Program of the Uniformed Services); only because they serve other age groups than the aged are they elided here.

[5] Many studies indicate needless hospitalization. For example, a survey in Rochester, N.Y., recently showed that 14 to 18 percent of hospital beds were usually occupied by patients who did not require that level of care. They would have been more appropriately served by less expensive long-term care, home care, out-patient care, or even no care at all. A recent study showed that in New York City the average length of hospital stay of those 65 and over with specific surgical diagnoses increased by 3 to 4 days in the immediate post-Medicare period. Much of the increase occurred between admission and surgery rather than in the postoperative stay.

—The lack of adequate and informative standards for services performed.[6]
—Uneven impact of the deductibles and coinsurance upon those most in need of help and least able to pay.
—The dangers arising from fragmented treatment including failure to coordinate drug prescribing for a patient.

There is some danger that the current investigations of fraud and near-fraud in Medicaid and Medicare may lead to a defeatist or negative attitude toward each program. There is also a danger that such emphasis may well thwart efforts to deal with more fundamental deficiencies in each program.

Reform is needed, but it should be thoroughgoing and it should be positive. This Nation has declared that high-quality medical care is the right of every American. We should be innovative and positive in making changes; we should be as insistent upon upgrading quality as we are insistent that wrongdoing be recognized and punished.

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[6] The case for setting quality standards was vigorously expressed by Dr. Martin Cherkasky, administrator of the Montefiore Hospital in New York City, during 1968 hearings before the Senate Subcommittee on Executive Reorganization. Here is an excerpt:

"Equally disturbing and certainly more dangerous is the total lack of quality standards for physicians treating Medicare patients. Here Congress should act and act quickly. For example, provisions for payment could require that major surgery only be paid for if carried out in an institution fully accredited by the Joint Commission on Accreditation and carried out by a surgeon who is either Board qualified or Board eligible.

"In other words, major surgery should not be paid for by the Government except in unavoidable circumstances unless the surgeon has evidence of the qualifications he should have.

"And, you know, Senator, this is not an insistence upon standards which are meaningless. Cancer of the cervix is a very dangerous and deadly illness. When early cancer of the cervix is operated on by qualified Board-certified gynecologists, there is 80 percent cure rate. When it is operated on, as it often is, by people who don't have these qualifications, there is a 50 percent cure rate. The difference between insisting upon qualifications and no qualifications is the difference between 50 and 80. We are talking about human lives, not about money or anything else.

"Where a Medicare patient has a major medical problem, a consultation with a qualified specialist should be required."

PART THREE

SPECIAL NEEDS OF THE ELDERLY AND THEIR EFFECT UPON MEDICAL COSTS

I. EXTENT OF DISABILITY

As we get older, those of us who survive have increasing need for medical care. Evidence of our increasingly disabled state is not hard to find. For example, 34 percent of the population 45–64 has no chronic conditions, while only 20 percent of the population 65–74 has none, and less than 13 percent of the population 75 and over responds that they do not have one or more chronic conditions.[1]

Among those 45–64, only 3 percent are unable to carry on a usual major activity, such as working, or keeping house. In the 75 and over age group, the figure is 24 percent so disabled that they cannot work or keep house. Bed disability days as well as days of restricted activity increase as age rises.

Per person per year, those 45–64 spend 7.2 days in bed; those 75 and over, 19.4 days. Days on which activity was restricted were twice as high for the oldest group as for the age group 45–64 and three times as high as for the population as a whole. The age group 65–74 was intermediate.

PHYSICIANS' SERVICES

Other kinds of evidence of poorer health include an expanding volume of doctor visits and hospital care as age advances; only in exposure to surgical intervention is there a decline in the rates. Doctor visits outside the hospital rise from an average of five annually for the 45–64 year group to 7.2 for those 75 and over. There is an increase in the proportion of doctor visits to the home—a fourth of all visits for those over age 75 are to the patients' residence [2]—which has cost implications since doctor charges are generally higher for home visits.

HOSPITALIZATION

Hospital admissions and discharges also rise as age increases, as the following tabulation [2] shows:

	Discharges per 1,000	Days per 1,000	Average length of stay
All ages	128.3	1,065	8.3
45 to 64	147.9	1,627	11.0
65 to 74	181.3	2,284	12.6
75 and over	195.6	2,484	12.7

[1] All the data in this section are derived from NCHS series 10 No. 32, *Age Patterns in Medical Care Illness and Disability*. July 1963–June 1965.

[2] NHS data vary slightly depending on the year in which the data are gathered. These figures are for July 1963–June 1965.

More time spent in the hospital connotes larger hospital and doctor bills as a concomitant of aging. As a result, the portion of any medical bills not met by Medicare benefits would also be larger for the oldest ages since the 20-percent coinsurance would be applied to a larger base.

II. LONG-TERM CARE

By definition, a long-term care hospital is one in which the length of stay exceeds 30 days on the average. Such beds are in short supply in the United States except for those in mental hospitals. Tables III IV indicates the national and regional averages in bed supply and demonstrate once more the uneveness of the distribution of facilities. The New England region (region I) has one long-term bed per 1,000 population of all ages and in addition has 2.2 extended-care-facility beds. The only other region coming close to this supply is the Pacific Coast region (region IX), where extended-care facilities are relatively abundant.

The right side of the table relates the bed supply to the population 65 and over. For short stay beds, the figures are relatively meaningless (since the aged compete with the younger population) but for long stay and extended care facilities, the aged occupy 90–95 percent. So the variation in supply from 11.1 to 33.8 per 1,000 means there will be problems in obtaining care in many places.

Nursing home care for the aged cost the Nation $1.2 billion in fiscal year 1967. A little more than half of this amount came from private resources.

With Medicare and the Federal share of title 19 paying for ECF care for 6 months of the 12 months of 1967, the Federal tax dollar paid for 26 percent of the total; State and local funds financed 18 percent. The public share will be rising as Medicare pays more throughout each year and more extended-care facilities and skilled nursing homes are constructed. Quite apart from inflation, to meet desirable standards established for acceptable care, costs will rise with expanded employment of better trained nursing personnel.

TABLE III

PHS regions	Beds per 1,000 civilian population			Beds per 1,000 Medicare Part A beneficiaries		
	Short stay	Long stay	ECF	Short stay	Long stay	ECF
United States	4.0	0.2	1.7	41.0	2.2	17.6
I	4.0	1.0	2.2	36.6	8.8	20.0
II	4.1	.2	1.5	39.1	2.2	14.5
III	3.5	.1	.9	42.8	1.4	11.1
IV	3.6	(1)	1.5	37.6	.4	15.7
V	4.2	.2	1.5	44.3	2.1	15.4
VI	5.2	.1	1.5	43.8	.9	12.3
VII	3.9	.1	1.6	44.0	.6	17.3
VIII	4.1	.2	2.5	46.7	1.7	28.8
IX	3.3	.3	3.0	37.5	3.4	33.8

[1] Less than 0.05.

Source: Based on data from Social Security Administration and Bureau of the Census, prepared by Community Profile Data Center, Public Health Service.

THE NURSING HOME POPULATION [3]

Who are the people in nursing homes and personal care homes with nursing? By and large they are old—the median age is nearly 80—and unwell: 85 percent have two or more chronic conditions or impairments; nearly 25 percent have at least five such conditions. Only 10 percent have a living spouse; the balance are widows, 63 percent, divorced, separated, or never married. Nearly six in 10 were not living with their family or even a relative prior to admission to the home.

The leading conditions and impairments afflicting the residents of these institutions in descending order are (1) vascular lesions affecting the central nervous system, (2) diseases of the heart, (3) arthritis and rheumatism, (4) chronic brain syndrome, and (5) hearing impairments. Together just these five conditions are found 1,249 times in each 1,000 residents, because the residents have more than one condition.

Not surprisingly the residents may spend years in the home. The median stay is about 18 months, the mean stay at least 3 years. Some 17 percent had been in residence 5 or more years.

Only scattered information came to the Advisory Committee's attention regarding monthly charges for care in nursing homes. We are of the opinion that charges have risen sharply from the level indicated by the NHS survey in May–June 1964.

At that time the average monthly charge in a proprietary home was $205, but 48 percent of the residents were paying more than this and 15 percent were spending $300 a month or $10 a day. A $10-a-day charge had become a relatively low charge by 1969.

An indicator of widespread variations in availability of extended-care facilities is given in this table of ECFS now participating in the Medicare program.

TABLE IV.—REGIONAL DISTRIBUTION OF EXTENDED-CARE FACILITIES AND BEDS, PERCENT INCREASE, AND RATIO TO BENEFICIARY POPULATION, JULY 1968

Geographic division	Facilities		Beds		Ratio of beds to 1,000 Medicare enrollees, July 1968
	July 1968	Percent increase since July 1967	July 1968	Percent increase since July 1967	
Total	4,702	+13.0	329,621	+13.2	16.9
United States	4,696	+13.0	329,353	+13.2	17.2
New England	378	+3.3	25,195	+8.7	20.1
Middle Atlantic	562	+16.6	52.131	+14.1	13.5
East North Central	738	+12.7	54,474	+11.0	14.5
West North Central	437	+17.5	23,132	+11.2	12.2
South Atlantic	479	+15.4	36,815	+15.5	14.0
East South Central	226	+22.8	14,456	+27.0	11.8
West South Central	470	+11.1	30,173	+18.1	17.4
Mountain	281	+7.3	16,384	+.5	25.4
Pacific	125	+13.1	76,593	+14.3	33.9
Other areas	6	0	268	−35.3	1.7

Source: "Health Insurance for the Aged: Number of Participating Health Facilities, July 1968." R. S. Health Insurance Statistics, HI-14, June 20, 1969, p. 11; Office of Research and Statistics, Social Security Administration, D/HEW.

[3] Data in this section are from NCHS series 12, Nos. 8, 9, 10, and 12 where the findings from the May–June 1964 survey are set forth.

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III. OUTLAYS FOR OUT-OF-HOSPITAL DRUGS

"There are many elderly men and women who have some income and some savings—who may even have sufficient Medicare or other insurance to protect them against the bulk of hospital and medical costs of a brief illness—but who cannot pay for the out-of-hospital drugs and other costs of a long-continuing chronic illness without seeing their financial assets eroded or totally dissipated."—HEW Task Force on Prescription Drugs, final report, February 7, 1969.

Drug costs rise sharply with age (Chart F). Like other medical needs, both the quantity used and the cost per acquisition is likely to be above the averages for younger persons. The situation is illustrated by the following table:

	Number of drug acquisitions	Average cost per purchase	Yearly average cost per person
Age group:			
All ages	4.7	$3.60	$21.00
Under 15	2.8	2.60	10.40
15 to 24	2.7	3.40	12.50
25 to 44	4.2	3.70	20.00
45 to 64	6.6	4.10	31.80
65+	11.4	4.00	50.20

Source: NCHS series 10 No. 33 "Cost and Acquisition of Prescribed and Nonprescribed Medicines, United States' July 1964–June 1965, PHS Publication No. 1,000, 1966.

Averages, however, tell only a small part of the story of drug use and costs among the elderly. The HEW Task Force report makes it clear that the costs fall heavily upon those likely to be already under heavy financial pressures.

Highlights from the report

—Per capita expenditure for the elderly with severe disabilities was nearly three times greater than that for those with none.

—A 1968 estimate indicates that 20 percent of the elderly have no drug expenses, while the costs will be less than $50 for 41.5 percent, between $50 and $99 for 19 percent, between $100 and $249 for 15.5 percent, and $250 or more for 4 percent.

(*NOTE: Half of all older people living alone or with nonrelatives, during 1967, had annual incomes of less than $1,480; one in four had as little as $1,000 or less.*)

—The average number of acquisitions for elderly women was nearly 50 percent more than for the men, and the per capita expenditure for elderly women was more than one-third higher than that for elderly men.

(*NOTE: Six of ten of all widows and other aged women living alone have incomes below the poverty line.*)

—For the elderly with one or more chronic conditions, the annual costs of prescribed medicines was $48.80; for those with conditions which limit major activity completely, costs averaged $78.80. Prescription expenses of those of the elderly with severe chronic conditions—*about 15 percent of all elderly persons*—were over six times as great as the expenses of younger people.

—Only 10 percent of the 65+ population had private health insurance for out-of-hospital prescription drugs at the end of 1966. Where such coverage is purchased, it is financially helpful only in so-called "catastrophic illnesses." It is generally included only in major medical policies involving deductibles of $100, $250, or $500 which the aged must pay himself.

—Income tax deductions provide relief for only an estimated 8 percent of drug expenditures of the elderly, and such relief benefits only those elderly individuals who receive enough income to income tax payments.

After surveying such data and studying the patterns of drug use among the elderly—for "therapeutic," "diagnostic," or "maintenance" purposes—the HEW Task Force concluded that the disproportionately high expenditures among the elderly, combined with a widespread inability to pay for such drugs "may well be reflected in needless sickness and disability, unemployability, and *costly hospitalization which could have been prevented by adequate out-of-hospital treatment.*" [Emphasis added.]

Futhermore, declared the Task Force, the problem is destined to become increasingly serious as unit prices of prescriptions increase, and the armamentarium of useful drugs expands.

This Advisory Committee emphatically agrees with the Task Force conclusion that "there is a need for an out-of-hospital drug insurance program under Medicare."

This Advisory Committee also must point out, however, that while such action is vital for a significant number of high-risk elderly individuals, it will not materially reduce the overall medical expenditures facing the great majority of the elderly.

IV. DENTAL CARE

National Health Survey data[4] show that over half of the 65+ group have not seen a dentist in more than 5 years, and that even in high- or middle-income groups the average number of visits to the dentist is no higher than among those with less adequate income.

One explanation for the limited demand for dental visits may be that the older population—after decades of inadequate care in the past—includes a large number of persons who are toothless.

Among those 65 and over, between 50 and 60 percent have lost all their teeth; the proportion increases as age advances.

Another reason may be that many older persons regard visits to the dentist as unnecessary once they have made the sizable outlay necessary to acquire dentures.

There is little doubt, however, that neglect plays a large role. And, as a result of earlier neglect, 42 percent of the visits to dentists that those age 65 and over do make are for denture work, compared to 11 percent for the population under 65. This finding only emphasizes that those who still have all or some of their teeth are not taking adequate care of them, Further evidence to support this thesis was provided by a recent survey of dental services carried out by the Council on Dental Health and the Council on Hospital Dental Serv-

[4] Series 10, No. 29

ice of the American Dental Association with the cooperation of the American Nursing Home Association. Forty-four percent of the nursing homes surveyed indicated that none of their patients had received any dental are. More than 63 percent of the homes for the aged (those without nursing care) reported that none of their patients received dental treatment.

"Although dental care is needed by a significant percentage of these people, there was no demand for care," reported the American Dental Association, which also concluded: "* * * the attitudes and motivation of older persons toward dentistry need to be examined."

Conditioned as we in this Nation are to dental care neglect among the elderly, we give too little heed to what may be a growing demand for dental services for individuals in the upper age groups. This demand could be a natural component of the current insistence on high-quality medical care for all, and it is a health demand which should be met.

Such prepayment of dental care as there is, holds little promise for those whose teeth have been neglected over the years.

PART FOUR

DEFICIENCIES IN DELIVERY OF SERVICES

As the preceding chapter suggests, Medicare and Medicaid helped create inflationary pressures by raising new demands for medical services that were unavailable or in short supply.

Thus, deficiencies in the delivery system for health care services played a direct role in creating dollars and cents problems now encountered by elderly people who need medical care.

Less apparent, but certainly of considerable impact, are other difficulties caused by faulty organization or nonexistence of services.

Tables and statistics can tell only part of the story here. Perhaps several examples can make the following point:

The elderly, along with other age groups, suffer, not only in terms of inconvenience, but also in terms of direct dollar outlays because of irrational or outmoded delivery systems for medical care and services.

EXAMPLES

Multi-Problems Cause Multi-Stops: Ill, elderly persons usually have more than one ailment at a time. If they cannot get "one stop" service for examinations or treatment, they become prime victims of a health care system recently described by Social Security Commissioner Robert Ball [1] as "largely decentralized, largely uncoordinated, and largely voluntary." Surgeon General William H. Stewart calls it a nonsystem.

One poignant example, provided during a hearing by the U.S. Senate Special Committee on Aging, is repeated here because it offers a classic study of an aged man who, even with financial resources for treatment, paid a heavy price for having multiple health problems. It is a story of a patient who:

> * * * had a serious eye problem—actually two diseases: glaucoma and keratitis—for which he received care at a nearby medical center, in the department of ophthalmology. His personal doctor, a good internist, however, had diagnosed a mild diabetes, and for this periodic visits were necessary to an office 8 miles away. Painful corns and bunions, impairing the ability to walk, were not within the speciality of the personal doctor, so these required periodic visits to a podiatrist at an office 6 miles in another direction. Dental care, in an effort to save the few remaining teeth, so that dentures would fit more firmly and food could be more properly chewed, required numerous visits to a dentist at still another location.

[1] In speech Jan 9, 1969, before the New York Regional Health Care Cost Conference.

Then a bladder problem developed and prostatic disease was suspected. At about the same period, the patient showed lethargy and confusion, suggesting a mild cerebrovascular accident. The personal doctor made a home call and the decision was to hospitalize. A bed was not immediately available—except in a small proprietary hospital which the family refused—and it was not till 10 days later that he could be admitted to a good voluntary general hospital 15 miles away. After X-rays, cystoscopy, and other examinations there, his treatment was stabilized. In the workup, it was discovered that a drug the ophthalmologist had been prescribing for many months was causing serious side effects, which had been missed by the internist since these two specialists had never communicated with each other. The patient was then admitted to a sanatorium, selected for its closeness to the family home, so that visits from the patient's children would be possible daily.

This was one of the "better" nursing homes—it was certainly expensive enough at $32 a day paid by Medicare—but this was evidently not costly enough to support a proper staff. After a few days, because of lack of proper surveillance, this aged patient was found roaming on the street. When this happened a second time, the commercial proprietor decided to discharge the patient as "too difficult to care for." It took 5 weeks of nursing care at home, with daily problems of incontinence of urine and feces, before a bed in another nursing home became available.

The latter facility proved to be better managed and the patient improved. After only 2 weeks, however, he was getting up from a chair one day, when he fell and fractured his left hip. This required an orthopedic surgeon, readmission to the hospital, and preparation for a major operation. But then complications to the diabetes set in, because of the traumatic shock of the fracture. A delay of over 24 hours in reporting a critical laboratory test nearly cost the patient's life at this time. Had the hospital been adequately staffed, this delay would not have occurred. A skillful operation, with a pinning of the broken bone, was done. Special-duty nurses costing $111 per day—over and above the Medicare coverage of the hospital bill—had to be hired because of the shortage of regular hospital nurses.

I have not recounted the other details of multiple-drug prescriptions, special services of an appliance shop to adjust the bed at home, the physical therapy required for a knee injury, and much more. This patient was my widowed father, who lived with my wife and me for 9 years after his retirement from 51 years of medical practice. My abbreviated account of his medical care problems applies only to the last year, or it would be much longer. Accounts like this could be told thousands of times over, each day in the United States, and would doubtless be more complex and disturbing for a family less well informed about the jungle of medical care delivery. * * *

The witness before the committee was a professor of public health and a doctor of medicine.

Even with Medicare, even with sympathetic and knowledgeable guidance, the patient in this case encountered expensive, disturbing obstacles to swift and appropriate treatment. For the low-income

elderly, the problems can be even more intense, so much so that the health problems may reach the crisis stage before help is sought, thus increasing the dollar expenditures paid from public or private sources.

Among the problems faced in poverty areas: [2]

—There is a dearth of health personnel in neighborhood settings, and unavailability of transportation to health resources.

—Physicians' services are often not available on nights and weekends.

—Hospital emergency services become more and more the only resource available, and often the quality of care suffers because of fragmented attention.[3]

Uneven distribution of physicians.—Many urban and rural areas are so bereft of physicians that the elderly must either do without their services or make tiring journeys for treatment or tests, such as eye or foot examinations. One response to this problem has been establishment of Office of Economic Opportunity neighborhood health centers in poverty areas. For those slightly above the poverty level, even the help of an OEO center may not be available.

As the following table makes clear, physician availability varies widely in the United States.

PHYSICIAN AVAILABILITY BY REGION, DECEMBER 1967

PHS region	Total physicians [1]	Number per 100,000 population
Region I	17,896	159.0
Region II	60,747	163.8
Region III	23,275	108.8
Region IV	21,114	93.4
Region V	44,497	113.9
Region VI	17,143	107.8
Region VII	18,881	95.9
Region VIII	5,732	122.4
Region IX	39,897	148.8
United States	249,182	125.5

[1] Excludes physicians in Federal service and those whose major professional activity is other than patient care.

Source: Based on data from American Medical Association, prepared by Community Profile Data Center, PHS.

Uneven distribution of facilities.—Enrollment in Medicare does not guarantee that an older person will necessarily receive the most appropriate kind of treatment. Hospital beds, for the most part, are in good supply. But wide variations exist in the availability of extended-care facilities and other forms of long-term care. It is a sad but prevalent truism in many parts of the United States that large numbers of elderly patients, including those on Medicare, stay on in expensive hospital beds longer than they need because of shortages of nuring home accommodations and absence of home health programs.

Central urban areas are especially hard hit and as a result elderly patients may be sent to nursing homes in distant suburbs or even farther out to rural areas. In such cases, nursing home care may be lower in cost than in the cities, but the effect upon the patient—who is quite often thus isolated from family and friends—can be disastrous.

[2] Summarized from statement to the Senate Committee on Aging by Dr. Frank Furstenberg, medical director of the Sinai Hospital of Baltimore.

[3] A social worker for a citywide health service project in New York City reported to the committee that, "Different medications and courses of treatment are prescribed by individual doctors," as elderly patients receive fragmented care at clinics, hospitals, or emergency rooms.

SUMMARY: THE NEED FOR ALTERNATIVES TO HOSPITALIZATION

Clearly, since hospital charges are the fastest rising component of medical costs today, any strategy directed at reducing those costs should be aimed at offering less costly alternatives wherever possible.

The Social Security Administration—before and since the Medicare program began—has recognized this fact, at least in expressions of official intent. But, in a recent analysis[4] of existing and potential resources, SSA reached the following major conclusions:

1. In many communities the less costly alternatives to inpatient hospital care, such as hospital and other outpatient services, home health services, extended-care facilities, and nursing homes are often in short supply.
2. In some communities, there is often an excess in supply—resulting in wasteful duplication of certain services and facilities, including some very expensive hospital services that involve heavy stand-by costs. Health facility planning is not now performed adequately.
3. Services, especially costly hospital services, are sometimes utilized unnecessarily; i.e., they are not medically necessary.
4. Many private health insurance plans produce undesirable incentives to use the most expensive methods of care.
5. Many possible hospital management improvements have not been adopted.
6. The growth of group practice has been retarded by legal bars and restrictive attitudes.
7. Productivity in the provision of medical care has not been defined and measured.
8. Insufficient attention is given to financing preventive care and health education.
9. There are insufficient financial incentives to restrain mounting hospital costs while maintaining high-quality medical care.

Similar conclusions were reached in an annual report issued in June 1969 by the Health Insurance Benefits Advisory Council. HIBAC, discussing utilization of health services under Medicare, made the following points:

—Use of health services for the aged increased significantly under Medicare, but utilization rates vary widely from State to State and area to area, in a pattern which confirms the view that utilization of a particular service depends to a significant degree on its availability.

—In the case of hospitals, the variations in use, payments, and in hospital admission rates appear to be, in part, associated with the number of available hospital beds per 1,000 population.

—"However," the report, added, "such factors as the availability of physicians in a community, their staff privileges and the geographical proximity of other health services and local customs on use of extended-care facilities and home health agencies (their use varies widely) must also contribute to these variations in both the hospital and medical insurance programs."

—Home health agencies, in particular, offer uneven coverage. Scattered among 25 States are 99 counties with populations over 40,000 without a home health agency; in Rhode Island the "start of care" rate per 1,000 beneficiaries was 34.3 at the end of June 30, compared to 3.2 in Mississippi and 3.3 in North Carolina; and there are wide variations in the range of services offered.

Each organizational deficiency listed above, together with others described in this section, causes financial, social, and moral problems not only for governmental agencies, but also for elderly individuals. Until the problems of persons needing direction, understanding, and treatment, rather than delay, confusion, or indifference are resolved, the economic problems of the elderly will be needlessly intensified.

PART FIVE

CONSIDERATIONS FOR FORMULATION OF PUBLIC POLICY

The Advisory Committee believes that a comprehensive, compulsory health insurance program [1] for all age groups—a program with built-in cost controls, standards for quality care, incentives for prepaid group practice, and other badly needed reforms—offers the best hope this Nation has for living up to the oft expressed declaration that good health care is the right of every man, woman, and child who lives in this land.

As a vital prerequisite for establishment of a national health insurance program, and while there exists a dual system of financing through social insurance and by general revenues, public and private efforts should immediately be made to deal with demonstrated deficiencies in Medicare, because:

1. Health-care problems of the elderly are still widespread, and they remain urgent.
2. Three years of experience under Medicare have provided invaluable lessons in the operation of a major public health insurance program. The time has come to heed those lessons.
3. Current investigations into profiteering under Medicaid and Medicare have helped focus attention upon the need for cost controls and establishment of uniform standards of care. Such reforms can have a beneficial effect upon the entire health industry and can combat medical cost inflation.
4. Success in improving Medicare will lead to more general acceptance of steps necessary to provide higher quality health care to our entire population.
5. The lack of sufficient consumer representation in Medicare and its almost total absence from State advisory committees for Medicaid is deplorable.

It is not the function of this Advisory Committee to offer a detailed program for action, but it can offer some general recommendations:

- **The Advisory Committee believes Part B of title 18 should be recast, to bring it under the social security payroll tax and do away with premium payments by the aged. This rearrangement would then make possible several simplifications of benefit administration, including:**

  (1) Permitting capitation payments to group practice plans providing hospital and physician services.

  (2) Fostering use of home health services without reference to coinsurance.

[1] Approximately 160 million Americans have some form of health insurance but such coverage pays for only about one-third of all consumer expenditures for health care. Medicare pays less than 50 percent of the medical costs of the elderly.

- **The Advisory Committee believes Medicare benefits should be extended—**

  (1) To include other services and supplies not now covered, and especially those drugs that are important for the treatment of the chronic diseases that commonly affect the aged. Eventually all prescribed drugs should be included.

  (2) To eliminate the deductible and coinsurance features of both Parts A and B.

  (3) To do away with the 3-pint deductible for blood and the 3-days-in-the-hospital requirements for admission to an extended-care facility, and the lifetime limitation on the mental hospital benefit.

  (4) To include preventive and diagnostic services more fully, and eye and foot care.
- **No matter how much money we pump into Medicaid, a mechanism that simply pays bills is not the answer to a problem that calls for improving the delivery system.**
- **Nursing homes must be brought into the mainstream of medical care by truly being adjuncts of nonprofit hospitals. Standards for nursing home care must be constantly raised.**
- **Every encouragement should be given to the expansion of prepaid group practice, a demonstrably more economical and efficient method of using our health resources. In addition to the higher quality and more comprehensive health care provided by such means, the team approach to delivering medical care would permit essential supportive services for the aged in relation to their social and financial problems. For example, the elderly need a place to turn for information on supplementary insurance.**
- **Another kind of social service would recognize problems connected with discharge from hospital. As a condition of participation in Medicare, every hospital should have a discharge planning committee.**
- **The Advisory Committee considers that Medicare has established itself in the daily lives of millions of Americans; physicians should no longer be permitted to refuse to recognize it by not taking assignment of benefits.**
- **The Advisory Committee believes that physicians' fees cannot remain subject to the whims of individual providers of service, if Medicare and Medicaid are to be fiscally predictable and gross abuses are to be stopped. The same is true of hospital costs.**
- **The Advisory Committee believes that standards for physicians' qualifications should be promulgated by Medicare to require that qualified surgeons alone be allowed to perform operations.**
- **The Advisory Committee hopes to see greater emphasis on prior budgeting and controls of costs for hospitals, extended-care facilities, home health agencies, and on more meaningful utilization review than is often the case.**
- **There should be more consumer participation in the decision-making processes under Medicare and Medicaid.**

Since the Advisory Committee anticipates a universal program of health insurance, programs of public medical care based on a means test would disappear. In the interim, while reliance must be placed on Medicaid to help with the problems of the younger poor, there must be far more coordination of the two programs than presently exists.

Each can thus benefit from the activities of the other in areas of cost control, quality control, sanctions against abuses of the programs, etc. These coordinated activities will smooth the transition to a program of high quality care for all Americans.

Submitted by the Advisory Committee:

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