

TRENDS IN LONG-TERM CARE

HEARINGS
BEFORE THE
SUBCOMMITTEE ON LONG-TERM CARE
OF THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
NINETY-FIRST CONGRESS
SECOND SESSION

PART 11—WASHINGTON, D.C.

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TRENDS IN LONG-TERM CARE

THURSDAY, DECEMBER 17, 1970

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 9:45 a.m., pursuant to call, in room G-308, auditorium, New Senate Office Building, Senator Frank E. Moss, chairman, presiding.

Present: Senators Moss, Saxbe, and Yarborough.

Also present: Congressman Pryor.

Staff members present: William E. Oriol, staff director; Val Halamandaris, professional staff member; John Guy Miller, minority staff director; Dorothy McCamman, consultant; and Peggy Fecik, clerk.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The subcommittee will come to order:

This is a public hearing conducted by the Subcommittee on Long-Term Care of the Special Committee on Aging of the U.S. Senate.

We are pleased to have with us this morning Congressman Pryor from the House of Representatives who will observe the hearing today and I am glad to have him sitting on the podium.

The hearing today is to receive information about a project conducted by Mr. Ralph Nader and a group of young ladies who will be witnesses today. This Nader task force was organized earlier this year and undertook this project.

Our committee, of course, has been very concerned with all these various problems of long-term care and therefore we think it would be of immense value to us to have the findings of this task force to consider as we prepare our report to the full committee and as we consider possible legislation. I will ask our witnesses, Mr. Nader and the young ladies who are to appear this morning, if they will come and occupy the seats at the table here before us. We will have an introduction by Mr. Nader and then proceed to hear the witnesses in whatever order they care to give their testimony.

Mr. Ralph Nader, Miss Claire Townsend, Miss Elizabeth Baldwin, Miss Lallie Lloyd, Miss Catherine Morgan, Miss Patricia Pitts and Miss Janet Keyes. It is my understanding that Miss Margaret Quinn is unable to appear this morning because of illness in her family. She was also scheduled to appear, however.

Would they come forward, please.

We welcome you ladies, and Mr. Nader, here this morning and look forward to this testimony that you will give us. I am sure that it will be very helpful and very interesting. Of course Mr. Nader needs no introduction, he is well known. I will just ask him if he would indicate to us how this task force came into being and what they did and anything else he cares to tell us about the participants in the task force or the report prepared.

STATEMENT OF RALPH NADER; ACCOMPANIED BY TASK FORCE ON NURSING HOMES: CLAIRE TOWNSEND, TASK FORCE DIRECTOR; ELIZABETH BALDWIN; LALLIE LLOYD, CATHERINE MORGAN, PATRICIA PITTIS, AND JANET KEYES

Mr. NADER. Thank you, Mr. Chairman.

I am going to introduce the members of the task force at this time. Claire Townsend is the task force director, Elizabeth Baldwin, Lallie Lloyd, Catherine Morgan, Patricia Pittis, and Janet Keyes.

Senator Moss. Welcome.

Mr. NADER. Twenty million Americans—10 percent of the population—are over 65 years old. Within a hyperbolic youth-oriented society and economy, these citizens are being increasingly “structured” out of their just share of material, psychological, and social benefits. “Out of sight, out of mind” is perhaps the most succinct description of the workings of institutional and individual forces on the elderly. More and more they are separated from the rest of society, a kind of geriatric segregation as consumers, residents, relatives, victims, and other roles which they choose or are compelled to assume.

The statistical profile of the over-65 Americans displays an aggregation of poverty, sickness, loneliness, powerlessness. In one routine category of standard of living after another, they register far below the average and often compare with the deprived or oppressed status of minority groups. The conventional injustices of the land bear down heavily on the elderly. Consumer fraud, inflation, fixed pensions, and Social Security benefits, street crime, absence of mass transit, spiraling rents and housing costs, swelling medical and drug bills, and the virtual end of the extended family unit have a severe discriminatory impact on old people.

The recent Senate report, *Developments in Aging, 1969*, provides such dismaying data in compelling fashion. But most gnawing and omnipresent is the psychological devastation heaped on the old by a society that lets them know in many ways, small and large, that they are no longer wanted, no longer useful, no longer filled with life's potential and warmth—in short, they're considered a drag.

There is a colossal amount of collective callousness that pervades the society from the organization to the individual levels. The most intense focus of what has been wrought for old people is the nursing home. The few homes that are humane, competent, and mindful of their residents' need for activity, and meaning to their day, provide a staggering gap between what an affluent society should attain and what is, too frequently, the reality for most nursing homes.

The full scope of nursing home abuses and profiteering has yet to be told. Although the Federal Government pours over a billion dollars

a year into this \$2.5 billion industry through Medicare and other subsidy programs, there have neither been the full-fledged congressional hearings, nor the enforcement of adequate Federal and State standards, nor the administrative inquiries and disclosures that are needed to reduce the institutional violence and cruelty that are rampant. Such moves have not occurred in spite of major fire disasters, fatal food contaminations, corporate manipulations, drug experimentation beyond proper medical discretion, kickbacks in drug sales for the residents, abysmal lack of medical supervision, and strong evidence that such abuses are more epidemic than episodic.

Early in 1970, six seniors and a young instructor at Miss Porter's School in Farmington, Conn., responded enthusiastically to the suggestion that they constitute a task force to study nursing home conditions and the responsibilities of the Federal Government therein. Starting work in the spring, they saw the heart-rending tragedies firsthand. During the summer, their work ranged from working experience inside several nursing homes to intensive study of documents and complaints, and interviewing officials.

What follows is their contribution, as young citizens reaching out to old citizens, coupled with their determination that something concrete will be done by those in authority to comfort the afflicted. How quickly such action will commence can be significantly affected by the needed emergence of a retired people's "liberation movement"—focusing on the economic, governmental and social injustices heaped upon them because they have grown old. Abundant experience, time and organizational talent can be mustered once the clarion call resounds through the land that retired people will no longer be phased out, manipulated, herded, patronized and rendered futile by a society insensitive to the diverse rights and potential contributions of older people.

Nursing homes are only one facet of the overall subculture for the aged, that is being created without their participation and because of their powerlessness. It is time for these retired people to become involved citizens for their own sake, and for those who come after them.

I think, Mr. Chairman, I would like to introduce for the record a series of articles that appeared in a March 1969 series in Barron's Financial Weekly dealing with the nursing home industry as a federally subsidized industry; and, an industry with all the characteristic big business attributes, and the problems thereof, that pervade financial and corporate manipulations.

Senator Moss. They may be printed in the record.

Mr. NADER. Thank you.

(The articles will be found in the appendix on p. 919.)

Mr. NADER. A few minor comments in addition.

Different people have been very, very productive of compassionate editorials and commentary but then nothing seems to happen. What these young ladies will describe before this committee is a pattern of massive illegality, massive nonenforcement of the law, a massive breakdown in law and order, if you will, and massive ignoring by most political personnel of these problems in the context of their rhetoric and, in the last year, concerning the rule of law.

The other aspect which the committee may want to go into further is the aspect of corporate manipulation—how corporations move into

industry that suddenly become a bonanza, because of the massive pay-offs by the Federal Government. This, I think, will tell us a great deal more about what the 1970's hold for the nursing home industry; as well as the insensitive control of people's lives by fast buck artists, who are developing a change in the nursing homes throughout the country.

Finally, I think the committee might well again progress in this area by putting relentless heat on the administration. This is a matter which involves tremendous expenditures of Federal funds that are being terribly wasted, and are not being accounted for adequately. When I say relentlessly, I mean the following: They should be asked very clearly why they should not be fired or prosecuted for willful nonenforcement of the law, and for refusing to uphold their own oath of office in the various departments that are relevant to this terrible problem.

If the committee approaches the problem in an institutional manner, it will not succeed in breaking through—where no other government oversight authority has yet broken through—it must be considered personal responsibility, it has to be considered in terms of personal sanctions to the officials who have, in effect, so seriously neglected their jobs or so willfully neglected enforcing the law—that their very tenure in office must be brought into question.

I was very pleased to see the statement that will be read shortly by the young ladies; that they focused very, very clearly on the issue of responsibility, and where it has to be located, and how insistently it has to be enforced and surfaced.

Finally, my recommendation of a retired peoples' liberation movement was a very serious one. Retired people are not as pathetic as many people would like to make them out. They become pathetic because people like to make them out as pathetic, and society, in general, puts these pressures on them—but of course we know that they have a great deal of time. We know that among them are people with considerable resources, and experience, and contacts in the society; and we know that they can mount a very strong movement on their own to deal with these problems.

I think that although this committee, and other forces and studies, can do a great deal to reveal the problems before the country at large; it is going to rest, as it always does in the final analysis, on the amount of resurgence and initiative shown by the victimized group. I would recommend that the committee try to seek out the leaders, the potential leaders here, and try to encourage this type of development.

I see, for example, some very active retired people in the pollution movement: very alert to the strategies that are necessary to deal with pollution. I am convinced, that if the committee exercises its leadership, it will find the leaders around the country here as a nucleus for a very, very necessary lobbying effort—both at the State level and at the Federal level, and in all councils of government where something needs to be done.

I would like now to turn the hearing over to Claire Townsend and her coworkers. I am sure she will be glad to answer any questions.

Senator Moss. Thank you very much, Mr. Nader, for that introduction and for pointing out to us the great problem that we know exists:

but, we perhaps have not ever defined it fully.

How did this task force come into being? How did you happen to get started on this?

Mr. NADER. I was spending an afternoon at Miss Porter's School earlier this year in Farmington, Conn., and the discussion ranged around the problems that the country is involved in, and a few days later I heard that a number of the students there wanted to work with us this summer. In fact, a great many volunteered to work from that school, which is a very small school in number of students. So it was decided that one of the best areas for them to work on would be an area that has been very much neglected by the younger generations, and I include people up through their forties.

The younger half, or two-thirds of the population, could really care less about the problems of old people—with very few exceptions. These girls displayed a very strong interest and began immediately, while they were still in school, in surveying the literature here and visiting a number of nursing homes to observe the conditions. Then they came down to Washington to work on a full-time period this summer, and they worked on it double time instead during the summer.

I might add that they went through a process of quasi-ridicule, themselves, for presuming to be able to document and to analyze this problem. I think what those who were a bit patronizing failed to realize is that, that presumption is the birthright of any citizen in this country; and, that the fact, that they have had to produce the first nursing home study—that was not done by people in authority, and people with greater resources. I think this entitled them to a state of considerable respect and subjects them, I think, to the process of admiration that other young people could well emulate.

It was not easy to expose their sensitivities to the kinds of conditions that they found in nursing homes. These are conditions, really, which can scarcely be described; they are so disgraceful—disgraceful to the senses, disgraceful to standards of ethics and decency. They persisted and went through that; and they are now interested in following through, and not just leaving this report as is and retiring to their respective schools. This is an indication, I think, again of the added dimension that some young people bring to social problems. It is not just the common disclosed exposé—but to try to afford some sort of power within their means to follow through and get something actually done.

Senator Moss. Thank you very much.

Congressman Pryor, did you have any comment?

Mr. PRYOR. I would only like to say, Senator Moss and Mr. Nader, that the young ladies you have working with you in this project, and who have prepared this project report, that we have become acquainted with in our own office. that we have been inspired by them. I think the work they have done has been splendid and they are, in fact, splendid young ladies in every way. I want to express my appreciation to them and to Mr. Nader.

Mr. NADER. Thank you, Congressman Pryor.

As you know, Mr. Chairman. Congressman Pryor began his inquiry in this area over a year ago, did it very empirically, and he himself was an inspiration to all of us.

Senator Moss. He was, indeed, and we are happy to have him sitting with the panel this morning.

We will now turn to the young ladies. Miss Claire Townsend is the task force director and I will ask her to continue in that role as director and designate which of the young ladies you would like to have testify and in what order.

MISS TOWNSEND. We are all going to speak in turn.

Senator Moss. You may do that. I suppose that we might like to ask questions as each one completes her statement though, because we may lose it all in the jumble, but then we could probably come back with questions to the entire panel. There will be an opportunity as each girl completes her statement for a few questions, perhaps, and then we will go on to the next one. Is that all right?

MISS TOWNSEND. All right. The other comments are mostly from the summary so they may not raise questions.

Senator Moss. All right. If none seem to fit at that point, why we will simply say for the next witness to proceed.

STATEMENT OF MISS TOWNSEND

MISS TOWNSEND. Thank you.

Mr. Chairman, my name is Claire Townsend. During the past summer, the six of us testifying before you today, and also Margaret Quinn, conducted a research project to investigate the nursing home industry in America today. We spent 12 weeks on the project, based in Washington, D.C. We utilized our limited time in the following ways:

1. We interviewed more than 85 people, ranging from government officials at the Federal and State level, and from officials within various State agencies, to spokesmen from the different trade associations involved within the nursing home industry; from representatives from the medical profession to people involved in programs for the elderly, as well as to old people themselves;
2. We read extensively from reports and literature on care for the aged;
3. We worked in three homes in the Washington, D.C. area;
4. We visited more than 20 nursing homes in Washington, D.C., northern Virginia, Maryland, New Jersey, New York, and Connecticut;
5. We read and answered more than 100 letters from concerned citizens of the Nation.

What we found in our study was horrifying, disillusioning, heart-breaking and totally inexcusable. The conditions in the nursing homes are terrifying enough in themselves, but together with the near total lack of Federal Government responsibility in enforcing even minimal high standards, the total picture presents an intolerable situation—one that is inhumane and a disgrace to our society.

The bedsores and perpetual boredom so plainly visible on the bodies and faces of our 1 million nursing home patients are only the symptoms of a national disease. The course of that disease can be traced

from government programs that are ill-managed, underfinanced and ridiculously fragmented to a failure on the part of our national leaders to make a firm commitment to the cause of adequate health care for our elderly citizens. The latter is exemplified by the fact that the U.S. House of Representatives does not yet have a committee specifically assigned to, or specializing on, the problems of the aged.

The national disease can be traced from a medical society, that places professional jealousy before professional responsibility, to a burgeoning nursing home industry that operates largely on a hit-or-miss basis—with careless management that means less care for patients. The disease can be traced from a society whose aversion to the very nature of old age, even in the best circumstances, has resulted in a tragic blindness to the needs of old age, to the crushing costs of medical care, and to the shattering psychological costs of retirement.

The needs of the elderly have been regularly documented, and reported, and filed away by various committees and commissions since the early thirties. More than a decade ago, in 1959, a study by the Department of Health, Education, and Welfare reported to Congress that:

The rising cost of medical care, and particularly of hospital care, over the past decade has been felt by persons of all ages. Older persons have larger-than-average medical care needs. As a group, they use about two and a half times as much general hospital care as the average for persons under age 65, and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population and in many cases are either fixed or declining in amount. They have less opportunity than employed persons to spread the cost burden through health insurance. A larger proportion of the aged than of other persons must turn to public assistance for payment of their medical bills or rely on "free" care from hospitals and physicians. Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate medical care for the aged will become more rather than less important.

That was in 1959. The situation is even worse today. Although a gesture has been made toward helping older people pay for the care they need, through Medicare benefits for all persons 65 and over, and through Medicaid benefits for the medically indigent, there is evidence that many older people are still unable to afford the price of care.

Of the 20 million persons 65-and-over in the United States, 7 million are impoverished according to Government poverty standards. Only 2,050,000 were receiving public assistance in April 1970; and HEW officials estimate that fewer than half of these who are eligible are receiving Medicaid benefits.

One million elderly people are in 24,000 nursing homes across the country; but few provisions are made for the other 95 percent of the

older population—many of whom would benefit greatly from home-health, homemaker services, low-cost community housing and other noninstitutional care that is woefully lacking today.

In addition, little is being done to insure that the elderly will receive adequate care, even when they can pay for it. The reluctance of the Federal Government to set standards for nursing homes, much less to enforce them, has resulted in a near-total failure of the nursing home industry to achieve proper levels of care. Eighty percent of the nursing homes that receive Federal tax dollars do not meet even minimal Federal standards.

Results of ineffective standard setting are not obvious to the visitor—one must look beyond the spacious, tidy front parlor with its grand piano, to the cramped, often filthy, bedrooms and bathrooms; which are, for most nursing home patients, the boundaries of their existence. One must look beyond the bright, clean beauty parlor, to the kitchen which too often fails to meet even minimal sanitation and dietary requirements.

Rarely are the consequences of a lax enforcement policy brought to national awareness; as they were in January 1970, when a fire in an Ohio nursing home took the lives of 32 patients. Only just recently has the Federal Government taken any steps at all to insure that unsafe carpeting, the cause of the deaths in Ohio, is banned from all nursing homes. And these recent Federal steps are far from adequate, covering only new carpets, not existing carpets. More recently, 25 elderly patients in a Maryland nursing home died of salmonella poisoning. This tragedy revealed not only a lack of enforced sanitary food standards, but also a failure on the part of the home's physicians and staff to report the fatal epidemic to State health authorities.

The failure to place, and accept, responsibility is endemic to the entire chain of health care for the elderly. Indeed, the main result of our study has been the conclusion that no one—not the Government, not the industry, not the medical profession—no one is truly dedicated to bringing about adequate health care for the aged in our country. Responsibility is spread throughout at least 22 Federal bureaus and agencies, with the inevitable results of poor communication, unnecessary overlapping, and a waste of manpower.

Three State-level agencies have a part in licensing nursing home facilities. There is not one person in the Federal bureaucracy who is responsible for overseeing rehabilitative or restorative care programs in nursing homes. Only five people are assigned at the Federal level to administer the Medicaid nursing home program when an estimated 16 to 18 people are needed. Efforts to upgrade standards, by requiring the licensing of nursing home administrators, have been effectively nullified—as the nursing home industry now controls the licensing boards in most States. Training programs for nursing home aides are nonexistent in most areas, and there have been no efforts on the required scale by either the Government, the medical profession or the nursing home industry to institute these programs. Each seems to expect the others to take charge.

Clearly, some people do receive the care and compassion they deserve in nursing homes. In addition to the many letters of outrage, we received some with equally fervent expressions of gratitude from

people whose relatives have found the health care and the meaningful environment all of us would want when we are old. One family wrote:

We are writing this letter as an official record to state our high opinion of the professional and efficient way you operate the _____ Nursing Home. To each and every member of the staff, all employees, we want to extend our many thanks for the excellent care and attention given to our husband and father. For all the kind acts, constant supervision and understanding of Mr. Q's long illness, we again say thanks from the bottom of our hearts.

But statistics indicate that such an experience is the exception, rather than the rule.

Why can't all elderly Americans expect the kind of care that Mr. Q received? Because they are poor? Because there are too few such institutions? Because the Government has not seen fit to insure that the elderly's needs are met? Because the medical profession has not provided the leadership nor the support needed to insure adequate health care for the aged? Because the elderly themselves don't have the resources to mount a sustained and systematic lobby for better care, while the outrage of their families usually dies with the older relative? Why must so many older Americans live out their "golden" years in pain and loneliness?

The following excerpts have been taken from our personal journals written during the summer.

STATEMENT OF MISS KEYES

Miss KEYES. Friday, June 26. "Forget it! I'm Never going back! I've just returned from my first night working as a nurse's aide in the _____ Nursing Home. What first strikes me as really bad is that instead of coming out with a crusader wish to help the nursing home problem, I've come out vowing to commit suicide before I get old. Wow, are these old people badly treated.

When I arrived, I was told to report for work to the intensive care ward. I reminded the head nurse that I had had no previous experience in nursing. She simply said, "You'll learn." The nurse I was assigned to was so nice to some patients, and then so mean to others. This favoritism was particularly cruel when the two extremes occurred in one room.

While the two of us were putting the favored patient to bed, with a lot of extra fussing and tucking in and smiling, the disliked patient, who was sitting in a chair in her own filth, kept calling to me, "Girlie, please put me to bed!" But I didn't know how to go about it, so I just stood there feeling helpless and horrible. Then the nurse finally ambled over to the second patient, jerked her out of the chair, slammed her against the bed, and roughly undressed her. The patient kept crying and saying that she was about to slip and fall, but the nurse just told her to shut up. When the torn nightgown had been pulled on, the nurse threw the old lady onto the bed, tossed the covers over the lady's head and left the room.

All we did for 8 hours was clean up the beds and empty the urine bags. We didn't even do a thorough job at that. It was just horrible.

This no-legged man died at 9 in the morning and they didn't remove his body until 11 that night. The RN said she had called the doctor to come over to pronounce the old man dead (that was what they were waiting for all that time) but the doctor never came, so finally the friendly neighborhood mortician picked up the body and drove it to a hospital where a doctor could be found.

On the lunch trays there were two dried fishsticks and some mashed potatoes and some pureed peas (everyone got pureed peas, regardless of whether they were on a special diet or not). There was also one chunk of very dry cornbread. While one nurse was wheeling several such trays down the hall to the patients' rooms (all of them were bed-ridden) another nurse walked by, swiped some cornbread off a few trays, and ate it.

This one man had terrible bedsores on both heels—they were large and black with this green ooze coming out, and I swear I could have stuck a fist into them. When I asked the nurse why the man had received no medication for his bedsores, she just smiled and shrugged her shoulders.

STATEMENT OF MISS BALDWIN

Miss BALDWIN. Saturday, June 27. The head nurse or supervisor, a licensed practical nurse, told us that she was glad we had come tonight because usually she had only three people to work her intensive care floor of about 54 patients. We sat around the nursing station, talking loudly and playing the radio, and drinking water and coffee and eating pizza for about half an hour right across the hall from a patient's room whose door was open.

The changing of beds and people was of course not very pleasant, but I kept thinking about how humiliating it must be for the patient. One patient was an old lady called Annie whose top half of her head had been eaten away by skin cancer and whose hands were tied down to keep her from scratching off the bandages. She had been waiting to die in this condition for 30 years.

Another lady was a large black woman in her fifties or sixties who kept saying she was burning "down there." It turned out that her skin had been split open as a result of an aide's carelessness in turning her over. This had happened before and she had been hospitalized as a result of it. This time all they put on it was a towel.

The sheets, the aides told us, were not washed with the right detergent, making them so rough, which is bad for old sensitive skin, causing bedsores. One lady, one of the few who could talk sensibly, said that the doctor comes in and just asks her how she feels and then leaves, charging her \$10.

Sunday, June 28. The second night there was only one other aide besides myself to take care of 50 patients. The air conditioning got the rooms much too cold and couldn't be turned off. Most of the patients were shivering, I was shivering, and when we came on the morning round there were not enough blankets for everybody. One lady, I was horrified to see, had a catheter tube in her but without a urinal bag attached to it. This could be dangerous and was at least an indication of sloppy medical care. One thing that surprised me was that the patients were allowed to smoke in bed at night, a serious fire hazard. The fingers and toenails of the patients were long and disgustingly dirty.

STATEMENT OF MISS LLOYD

Miss LLOYD. Wednesday, July 1. The head nurse said that in case of fire, we should get the extended care patients out first because they paid more. Either put them out on balconies or near the elevator or exits. Didn't seem to have any regular fire drills. The head nurse said the patients have no idea what they are supposed to do in case of fire. When some kids came in and pulled the alarm for fun, all the ambulatory patients stood out in the halls and wondered what was going on, and where the fire was. Would be a mad house if a true fire were to occur because all the aides and most of the other people have no idea of what is the best way to evacuate the building, and as far as I can see there is no organized plan. Certainly no plan of the building with the nearest available exits marked out is posted anywhere.

The nurse and I left at 11 p.m., before the next shift had arrived. I told her I thought we were supposed to wait. She said, "You can't count on the other nurse, sometimes she's half an hour late and sometimes she doesn't come at all. We can't be waiting up for her."

All the patients ever do is watch TV, eat, and sleep. Some don't even care what they're watching—they're not listening anyway. They just sit in their chairs and stare blankly at the noise coming out of the TV. The physical therapist is supposed to come in every Tuesday, but sometimes he never comes.

Friday, July 10. Mrs. C had fallen during the night. Lacerations all up her right arm. Her left arm already in a cast. Blood wounds had already dried and crusted around the edges. Must have been a long time before she called the nursing station to ask for help. When we arrived the room stank and the bathroom floor, sink, and bathtub, plus the bedroom carpet, were covered with blood and feces. She and her bed were, too. Ada gave her a quick bath, took her blood pressure, and I changed her bed. Both of us were nurse's aides and didn't know what else to do.

Nurse S was scheduled to come in that morning. Never showed up. Didn't call to give an explanation or anything. In fact, when we called her up, the phone was disconnected. She hadn't come in all week. We were not authorized to give medication. At 8:30 we called Mrs. R when the nurse had still not arrived. She was furious at us for not telling her sooner.

Aides do all the work around the home. Everything but medication. We do the baths, laundry, meals, dressing, cleaning, etc., and we don't even get paid minimum wage. Therefore, it's to the home's advantage to have lots of aides and only one nurse.

STATEMENT OF MISS PITTIS

Miss PITTIS. Saturday, July 11. The nurse had to lie and say that the old man had had a heart attack, so that he would be admitted to the hospital for a checkup. If the old man had not been able to get into the hospital on an emergency basis, he would have had to wait for at least 6 weeks to make an appointment in the outpatient ward for a simple checkup. The ambulance men were angry that the nurse had lied and that the old man hadn't had a heart attack at all. The hospital gave him a quick checkup—didn't ask him a thing—and sent

him back right away. The head nurse came in that morning and found a whole plastic jar of 1,000 aspirin capacity completely empty. Didn't know who had taken them and didn't bother to find out, either.

STATEMENT OF MISS MORGAN

Miss MORGAN. Mrs. M. is totally incontinent. Came in to put her to bed and found her already in her nightgown. She had not been dressed all day. Her nightgown was soaked, the pillow she had been sitting on was soaked, the chuck on the chair and the one between her legs were both soaked, even to the point where her urine had run down her legs through her stockings and into her shoes, which were now soaked also. No one had done anything or checked on her since she had been gotten up around 8:30. She should have called downstairs long before, but she hated to disturb the nurses, she knows they are so busy. All she does is sit in her urine-soaked clothing all day, watching television, but not really concentrating.

These were just a few of our own experiences this summer. From what we were told in interviews, and from what we read in the many letters sent to us, we assumed that our experiences were at least common, if not mild. We had experienced, on a very small scale, some of the most prevalent problems in nursing homes today.

The staffing shortages and lack of adequate training, much less orientation, were self-evident. But who is to blame? Good homes claim they always have enough trained staff, while the bad homes are always complaining. This is because a good home will attract trained personnel. If the owner or administrator of a home is only out to make some money off the chronic illnesses of our elderly citizens, a cold and unappealing attitude often prevails throughout the staff. For a good warm atmosphere to prevail, there has to be genuine love for the aged, and this love has to originally emanate from the top. But how can one legislate that there be love?

The Federal Government is doing a poor enough job legislating enforcement of good standards. The standards in effect now are often vague and more often are not enforced. Since Medicare began, the Social Security Administration has allowed homes to be certified for Medicare in substantial compliance, meaning that they don't really deserve certification. What are we supposed to think when the Government certifies 80 percent of Medicare-participating homes in substantial compliance?

Sixty percent of these homes are lacking in rehabilitation programs. Where are our incentives? The Government pays a home more to keep a patient in bed than to rehabilitate that same patient back to community living. And yet, it's not just the Government. Nursing home staffs ask themselves and others, "Is it really worth the effort? What good would these old people be to their community now, anyway? They're going to die soon."

That is not the point. The point is to make our aged as happy and as loved as possible, to make the community as good to the elderly as possible, to make their last years worth living. If science is going to lengthen lives, we're going to have to make living worth it.

Over 50 percent of the \$2.5 billion pouring into the nursing home industry every year comes from the Federal Government. Is the Federal Government doing 50 percent of the inspecting and enforcing? The answer is "no." Federal responsibility is minimal. Inspections are placed in the hands of the individual States, who further fragment the responsibility among health and welfare officials with separate responsibilities for Medicare and Medicaid programs. Most of the time, these departments don't even intercommunicate, much less inspect the homes together.

Also, the homes are warned ahead of time about the inspections, given ample time to prepare for them. After all, isn't it easier to inspect a good home than a lousy one? A mass cleanup is staged, and extra help may be hired for the day to meet the staffing requirements. If the inspections were any good, both the fire in Marietta, Ohio, and the food poisoning in Maryland could have been prevented.

Also, with the lax enforcement policy—that has been characteristic of the program since the very beginning, making it twice as difficult to tighten up now—it is the physicians who are profiting the most. They are getting away with the most, are shrugging responsibility the most, and yet go unharmed; for, if any pressure were applied to the medical profession a threatened strike would nullify any corrective measures.

Medicare requires that a patient be visited once a month by a doctor. The doctors visit all right. They stand in the doorway, ask how the patient is feeling, then move on to the next doorway, charging abominably at each stop. Who is footing the bill? The Government, or, more precisely, the taxpayers. There are cases of doctors allegedly visiting 75-90 patients a day. This is scandalous.

The fragmentation of responsibility prevails throughout the homes, too. The physicians shirk any true responsibility for the patients in the homes; the staff insists they're just doing what they're being told to do; the administrator complains that the Federal funds don't give him enough money to run a home properly—and the patients complain, but not as much, since they are old and weak and nobody listens to them anyway.

Patients must often pay much more for a prescription that could be obtained from the local drugstore at a lower price, only the homes won't allow patients to do that—their drugs must be bought through the home. In perhaps 50 percent of the letters we received there was mention of patients being put under sedation for no other reason than to simply keep them quiet and out of trouble.

Who is responsible for seeing that this is not done? Whose job is it to make certain our aged are receiving the care they deserve? If the doctors themselves can't be trusted, who can? If the Federal Government won't assume the responsibility to police the national health programs, who will? Someone has to be held responsible—the buck can be passed only so far before it falls into the lap of the Federal Government. Where is our national concern? Where are our guiding leaders, our social influences? Where is the health priority today?

OK, you say, the conditions in nursing homes are generally bad. So why do the old people and their families put up with it? Why? Be-

cause there are no other alternatives to the nursing home. It is virtually impossible to keep an older relative at home for most families. There just isn't enough room or money to do it. And the Government certainly isn't helping to keep older people in communities by pouring most of its money into institutional care.

Also, since the patient knows he won't be footing the bill, he probably doesn't feel any consumer urge to shop for the best service at the lowest cost; if one home advertises that its services cost the private-paying patient \$17 a day, when another home advertises \$32 a day, the patient is obviously going to apply for admission into the more expensive home while the Government picks up the bill. Sometimes the patient does not even have the opportunity to shop—there may be only one nursing home in his area.

Why is it that church-affiliated or church-run nursing homes in a Florida city have long, long waiting lists while neighboring privately owned, for-profit institutions run at only 30 percent of bed capacity? The public is trying to show that what it really wants is real love and good care, rather than cold indifference and packaged care.

What has the Federal Government done to help solve this many-faceted problem? Most recently, in an effort to appease the public, and perhaps in an effort to alleviate its own conscience, the House passed a bill, H.R. 17550, now pending before the Senate Finance Committee, that shows questionable motives. As it is now, Medicaid is an unlimited, open-end benefit. Section 225 of H.R. 17550 would cut Medicaid payments by one-third after the first 90 days of care.

The reason? Social Security Administration says: To instill an incentive to rehabilitate elderly patients fast, to get them into intermediate facilities, and then into the communities fast. The idea is kind, but, since it is actually medically unsound, and since most nursing home operators tremble at the thought of it, perhaps the real reason is simply to cut down on the program's costs.

However, if the Government is unhappy about the escalating costs of the health program they have only themselves to blame, for poor preprogram calculations and for fragmented management of the programs. The Government should either admit their mistake and seriously attempt to initiate a new program or they should keep quiet and pay out the money according to the original benefit promises. Simply cutting down on the costs of the program serves only to hurt the elderly patients involved, in the end.

At the request of this committee, we respectfully offer some personal recommendations based on our study, interviews, and observations. The overall theme is that someone has to assume responsibility for the health care of our aged, and it is our feeling that that someone should be the Federal Government.

STATEMENT OF MISS TOWNSEND—RESUMED

Miss TOWNSEND. We recommend strict Federal enforcement of present standards for nursing homes receiving Federal funds. This will mean elimination of the substantial compliance approval given homes that are in violation of the law. We recognize that cutting off funds to substandard nursing homes may leave some Medicare and Medicaid patients with no alternatives. However, the route of

expediency taken by the Federal Government has failed spectacularly to achieve the goal of upgrading these institutions. Stricter measures are in order, with contingency plans for caring for patients after cessation of payments to violators.

The necessary expenditure for placing displaced patients in hospitals or specially licensed private homes will be more than compensated for if nursing homes are forced, in the long run, to offer acceptable levels of care. Given vigorous leadership by Federal authorities, with elimination of discretionary clauses, local and State inspectors may be able to gain improvements in many cases without resorting to cutting off funds. Training of inspectors, as proposed by the Public Health Service, should be encouraged as a means of making standards uniform throughout the country.

As another incentive to homes to achieve high-quality care, the Department of Health, Education, and Welfare should consider publishing ratings for homes that receive Federal funds. Quality ratings, along with a label of the level of care offered by homes, should also help the elderly avoid an unfortunate choice through ignorance where a choice is available.

Medical review should be implemented by the Department of Health, Education, and Welfare. The medical profession should cooperate in developing the means for making medical review a viable and efficient exercise of professional responsibility in insuring adequate medical policies and practices in nursing homes.

Training of aides is another area where much remains to be done. The crucial role of the aide makes inservice education a priority item in any campaign for improving nursing homes.

As licensing of administrators get underway, State governments have the responsibility for seeing that high standards are set, especially for educational qualifications. The nursing home industry should use the licensing process as a means of attracting qualified administrators. They should also support educational programs for health administrators. To meet the goals envisioned by the licensing law, the Federal Government should tighten its regulations to insure, without doubt or evasion, that no single interest group dominates the State licensing boards.

Congress and HEW should also consider a better means of identifying owners of nursing homes and for holding them legally accountable for conditions in those homes. Public policy against entrance contracts, in which a patient irrevocably signs away his property, should be clarified through legal means if necessary.

The Food and Drug Administration should exercise stricter controls over experimental drug research on nursing home patients; it should require more rigid proof of consent from responsible persons; and full, direct involvement of physicians who, along with the homes, should be held accountable for the effects of drug experiments on patients.

Finally, the Federal Government should actively promote alternatives for the elderly outside the nursing home: "integrated" community housing through Model Cities and other programs, employment opportunities, service programs like homemaker, home health, and other services. At the present time, the Congress has not allotted the elderly their fair share of these public services.

There are some more recommendations in the statement.

We recommend that Congress, in its next session, make the elderly and the policy of a national health insurance both issues of top priority.

We recommend that the Federal Government require every nursing home, regardless of whether it is receiving Federal funds or not, to have either one resident physician whose only job is to oversee the care of the patients in that nursing home, or else strictly enforce the requirement for a physician on call 24 hours per day.

We recommend that the Federal Government grant funds for more low-cost community housing that could accommodate but not segregate the elderly; that, for example, any new housing projects to be built in the future have ramps as well as stairs, for those in wheelchairs; that telephone booths be low enough and wide enough for those in wheelchairs (as it is now, public telephone booths are exactly 1-inch too narrow for access by someone in a wheelchair); that nonslippery rugs be used in the bathrooms, and that handgrips be placed conveniently in the bathrooms, along the halls and down the stairways. It isn't all that much more difficult or expensive to avoid "architectural barriers" and to build with the least able people in mind.

We recommend that high schools across the Nation offer courses in basic first aid, most specifically in the area of home health care for the aged, in recognizing certain symptoms, and knowing what procedures to take.

We further recommend that a course similar to the one explained above be broadcast nationally on TV at least once a year.

The point here is that our first reaction when, let's say, our grandmother gets sick is to rush her to the hospital. If we were trained in minimum basic first aid we could take care of her at home. Our first reaction is to go to the institution, when it should be trying to take care of her at home.

We further recommend that the Federal Government subsidize more training courses for nurses and nurses' aides and that the minimum-wage law be enforced for nurses' aides when full coverage goes into effect early next year.

We recommend that the medical profession encourage medical schools across the Nation to require their students to spend significant time in a geriatrics ward, or in a nursing home, or in some other way be exposed to the health needs of the elderly.

And, perhaps most of all, we recommend that the citizens of America provide active, vocal support for the cause of the elderly; that they conduct their own investigations, publicizing their findings in the local newspaper; that the plight of the elderly become a major concern of all Americans, and that we work together to gain the kind of care our older citizens need and deserve.

There is no question that the Congress and the country must invest more resources in improving the lot of the elderly. But this cost should not be an overwhelming burden, we believe, for the following reasons.

At present, millions of dollars are wasted by the chaotic government apparatus that administers programs dealing with the elderly, particularly health services. A clear national health policy and centralization of programs for the elderly can eliminate waste as well as provide better services for the public.

Expenditures to enforce standards in nursing homes, mainly for increased manpower, will help insure that the already massive public support of these institutions is actually buying good care and not merely enriching the coffers of private industry. It will also help eliminate abuses, such as higher charges for government-subsidized patients, outsized drug charges, and others.

A new emphasis on preventive medicine and rehabilitative care in these homes, costly in the short run, will be offset in part by reducing the high costs of caring for persons who become incapacitated and critically ill. More psychiatric treatment for the elderly, for example, can reduce personnel problems as well as many medical costs for disturbed older patients.

Already, administrators of Medicare and Medicaid are finding that strict enforcement measures, including medical review, are well worth the investment in terms of better and more efficient care.

Service programs outside the institution will add rich new resources to communities where the elderly become participants. A budget-conscious Congress should be aware of the fact that today the elderly represent some of our most wasted human resources.

In human terms, a national commitment to serve the elderly, whatever the cost, can meet a serious national problem—the demoralization of becoming old. No Nation can afford to throw away 10 percent of its population as we tend to do today.

Government reorganization to improve public health services is one of the first requirements in an effort to help the elderly. In our report, we outline recommendations of task forces and others that seem to us of special importance. They are important because we believe that the Federal Government is going to have to answer the problems of care for the aged. The default of private interests such as the medical profession and the nursing home industry means that the effort must be a public one; the reluctance, or inability, of the States to lead in this matter means that the problems must be solved at the national level.

Thank you, Mr. Chairman, for allowing us to express our views before the committee.

Senator Moss. Thank you, Miss Townsend, and all the other young ladies who have testified here.

This is, indeed, not only a moving and sometimes shocking report but it indicates a great devotion and application that you ladies have given to your task during the summer, and we are glad to have this before us.

I noticed when you were giving the recommendations there were some in the mimeographed text that you skipped. Is that just in the interest of time? Should we put them all in the record?

Miss TOWNSEND. No, they were in the book form. They are incorporated.

Senator Moss. They are in the book form. Very good.

We think that undertaking a project of this sort, by you young ladies, indicates a great devotion to getting at some of our serious social problems; and, I want to commend you all for doing it.

Now, I can observe you are all rather young ladies. Do you think you are particularly handicapped in making this sort of a study because of your youth?

Miss TOWNSEND. Absolutely not. As Mr. Nader said, it is just a job that any citizen of the United States can do, and age really has nothing to do with it. It is your devotion and dedication that counts.

Senator MOSS. Well, I think that is a good answer, and I believe that myself but I wanted to have it on the record because the people that are a little skeptical find a way of brushing it off by saying this is just youthful enthusiasm and not mature judgment.

As a matter of fact, in what I have seen of your documents that have been prepared, they have been very thoughtfully done and indicate, I think, a very mature and competent consideration of the problem.

Now I have a few questions I would like to ask, and I would like whoever on the panel particularly wants to respond, to do so. They may come in the various recommendations generally that you made; and, mostly, it may be an explanation of the recommendation.

First of all, you recommend the elimination of the "substantial compliance" approval given to nursing homes—allowing them to participate in the Federal programs. Can you explain why you made that recommendation?

Miss TOWNSEND. I will take that question.

Our point here is, that we understand, that in the beginning when the substantial compliance clause was put in, we understand that at first it was an emergency situation, and stopgap measure, to catch the patients receiving benefits from the hospitals; but the nursing homes have had plenty of time to correct whatever was wrong with them. And, I think it is inexcusable that only one-fifth of all nursing homes, that are receiving Federal funds, are in full compliance.

We also feel that since the Federal Government is shelling out two-thirds of the money going into nursing homes, they have the right to enforce their regulations and they are just not doing it. Substantial compliance means that they are letting nursing homes get away with murder, literally, and we feel that the patients deserve better care. That is the most important.

Senator MOSS. The word "substantial" is too inexact and allows too much leeway, is that what you are saying?

Miss TOWNSEND. It sure does.

Senator MOSS. You recommend the implementation of the provisions for medical review which were part of the so-called Moss amendments of the 1967 act. I was highly disturbed that the legislation had not been implemented and point out that 3 years have gone by since this legislation was enacted. Will you state the reasons for the conclusion—why we should have a medical review?

Miss TOWNSEND. Well, I will take that one again. Further, besides taking 3 years to even get preliminary regulations out on this medical review law, there is some new proposal in H.R. 17550 calling for Professional Standards Review Organizations under Medicaid, a program that is so similar to your medical review it is ludicrous; that you have already gotten the law passed; but, since it never was implemented, they are trying to get it passed again. It seems ridiculous to me.

We think it is important the medical review be established because it benefits the patients and in the long run, it would save the States money to have the professional board be constantly reviewing the pa-

tients' needs for the care they are getting; because, on any given day, 50 percent of the 1 million patients in the 24,000 nursing homes are misplaced—they are in the wrong place. They are either not getting enough care or they are in a place where it is too expensive for the care they are receiving. Therefore, a lot of money is wasted. So if this board was effectively used, and would go around and check up on the patients, make sure they are in the right place, in the long run the States would be saving a lot of money.

Senator Moss. I notice you recommend a crash training program for nursing home personnel. Do you consider this the most important problem that we have in our nursing homes—lack of trained personnel?

Miss PIRNIS. Senator Moss, I would like to take that question.

Senator Moss. All right.

Miss PIRNIS. Yes; I think we do consider that this is the most important problem for one simple reason, if not others: That our elderly citizens are most in contact with the personnel in the nursing homes. They may not see their children as often; but the people that are taking care of them are the personnel, and they should be qualified.

One of the problems is that, for example, nurse's aides can be taken off the street; and, anybody can come and apply for a nurse's aid job simply because there is much demand and high turnover so they cannot screen the nurse's aides, it is such an undesirable job. Their pay is low, and they have to work hard, and they have to do all the work that the nurses don't want to do.

So, I think not only trained personnel; but, just as important, it is the duty of the Government to make jobs more desirable for them, and they should do this by making higher wages and also less work—therefore, a higher ratio of nurse personnel versus patients.

Senator Moss. Two incentives you think we need are higher pay for the aides and also less work; that is, shorter hours and not as heavy work.

Miss PIRNIS. Yes.

Senator Moss. Now, is there any way we can do that? Should we set up training schools, or anything like that, to try to get these people trained to operate as aides?

Miss PIRNIS. No, I think that this can be an in-service training program and I know this is being done in some hospitals and nursing homes already. It is not too much of a demand to ask—and it can be done. One of the problems is, just that the personnel don't understand the needs of the patients; and, therefore, it is hard for them to empathize with them and enjoy their jobs.

Senator Moss. Is this a rather difficult and sort of unglamorous, and unsavory, kind of work that people turn away from, do you think?

Miss PIRNIS. Well, certainly it is indicated by the change in employment which is very high in the lower jobs in the nursing homes and it is not a desirable job, unless you are a very dedicated person to that.

Senator Moss. So, some way or other, we need to find those that are dedicated, have the empathy or sympathy for the patients, and they are not just filling in on the job to make so many dollars a day. Is that what you are trying to say to me?

Miss PIRNIS. Yes.

Senator Moss. I wonder about this, too, because I have not had the firsthand experience as you girls have had. But it seems to me that this is the kind of a job that can't be handed off and done in so many hours, a person has to really devote himself, or herself, to it.

Miss PITTIS. Well, it can be done badly by being given a job and doing it as fast as possible, and it does not turn out the better for the patient.

Miss TOWNSEND. I would like to point out, here, that in the better homes we visited this summer, the aides were really enthusiastic about their job, they really liked it. The point is, not that these people were especially dedicated, it was the atmosphere in the home that made them like their job. So the home has two responsibilities: Trying to find dedicated people; and, also, assuming the responsibility of making a place that people like to work in.

Senator Moss. Sort of a development of esprit, or sort of pride, in having a good home and having the people there happy, and all that sort of thing, is that what you are pointing out?

Miss TOWNSEND. Exactly.

Miss BALDWIN. Could I add something else?

Senator Moss. Yes, you may.

Miss BALDWIN. While you are talking about the ratio of aides to the patient, I just wanted to bring up that we need higher standards in nursing homes. Only one RN is required in a home during the day from 8 a.m. to 4 p.m. and only one LPN, licensed practical nurse, for the rest of the night; and I really don't think this is enough, because this applies for a home of any size.

Some States may make further standards and require more registered nurses or more licensed practical nurses, but many homes only barely meet this minimum Federal requirement; if at all. I think that, really, more professional people are needed on the scene; because, if any emergency arises, one licensed practical nurse or registered nurse cannot be everywhere at once and oftentimes that is exactly what happens.

Senator Moss. There should be some rather fixed ratio of staff for the number of patients; is that what you are saying?

Miss BALDWIN. Yes, that is what I am saying.

Senator Moss. I wonder what you young ladies think of the idea of using a number of our elderly people to work in nursing homes. One thing that you have said, and that has constantly come up, is the idea that our elderly people need to have involvement, and feel needed, and that sort of thing. I wonder if we could not use a larger number of older people, who were well enough physically, to work in nursing homes and, thereby, utilize their talents; and, at the same time, they would have sympathy with the patients that they deal with. Do you have any comment on that?

Miss PITTIS. Senator Moss, I don't know what you mean by doing jobs in the homes because I don't think that elderly people, even if they are physically healthy, would be able to make the beds, and dress the other people, and do the jobs that the nurse's aide does—like giving baths to old men, et cetera.

I do think that, in good homes, the elderly patients who are healthy are encouraged to form their own programs, like musical concerts,

or talk about something that was of interest to them in their youth, or anything that is interesting to them now—such as books and music, records, and put on movies. If that is what you mean, then I think this should be done more.

MISS TOWNSEND. Another point is, that you cannot deny the fact, that the residents in the nursing home really enjoy seeing a lot of young faces around. I think they enjoy that more than they resent it. Another thought we had for elderly people, who are able to do some sort of social work, or be employed, was in day care centers for kids—so they would be around young people, and taking care of baby sitting while the mothers work.

Senator Moss. I am glad to have that suggestion. Of course I recognize that the older people, if they didn't have strength and health enough, could not do the heavier duties that you were talking about; but I wondered if there might not be a larger role for them to play in the homes—although I like that suggestion you put in, that the older people do like to have young people around, too. I think maybe that is one of the mistakes we sometimes make by grouping all the old people together, and, actually, they enjoy having young people around. They like to see young people and feel that they are mingling with them.

Miss KEYES. Going back to using the elderly from the community; so often the residents of nursing homes get in a rut intellectually, emotionally, and creatively—they don't progress any further. So, if you bring in their peer group from the community, they would be bringing in fresh ideas, and fresh plans for activities.

Senator Moss. Thank you.

Now, one of your recommendations suggested better methods of identifying nursing home owners, and holding them responsible for bad conditions. What specifically do you have in mind on that?

Miss BALDWIN. I will go into that.

Well, one thing, I think this is a very good idea. The Kennedy amendment of 1967, which requires the licensing of the nursing home administrator, provides for the setting up of licensing boards in each State—which was a very good idea, except for the fact that the Nursing Home Association in many States has been allowed to walk right over this amendment by gaining control of the licensing boards; or, at least they are attempting to, and in many cases they have succeeded, so that they are, in fact, licensing themselves.

Senator Moss. And you think that this is rather widespread—that we don't have good licensing procedures in the States and that there is insufficient public information as to who owns the nursing home?

Of course, your experience is limited to a few States, but I just wondered if you have a feeling that this is rather a widespread situation.

Miss BALDWIN. I think it is widespread enough to be alarming. I think, in some cases, it has actually happened where, as you say, there are a few cases; but, I think, that there is a danger of it continuing. I think in many States the Nursing Home Association is attempting to gain control: or, at least, more control than is supposed to be their share, on the licensing boards. I think it is a threat, and I think it ought to be looked into and checked out just how far this is going.

Senator Moss. Besides disclosing and knowing who is the operator of a nursing home, is there any other way of assuring that the people who go into administration are really well qualified and that they go into it for motivation other than just quick money?

Miss BALDWIN. Well, I know that this is really not my area of the report, I am just filling in some knowledge that I picked up from the other girls, but I know that the licensing boards are supposed to, I think, arrange a test—isn't that it?—

Miss TOWNSEND. Yes.

Miss BALDWIN (continuing). Which the nursing home administers or the applicants take, and they are judged on the basis of that, and not on their good character. Their good character is sort of a wishy-washy term, I think. You can take that any way you want.

Senator Moss. Thank you.

I was a little bit startled by the sharpness of your criticism of the use of drugs, experimentally, on the older people without their consent. Do you have, actually, incidents of this occurring; that you witnessed, any of you?

Miss TOWNSEND. Margaret Quinn's area is drug abuse and she is not here. I would like to read an excerpt from our reports, if I may, page 198. This is a recent example of experimentation.

Senator Moss. All right.

Miss TOWNSEND. Drug companies frequently carry out experimental drug research on nursing home patients. One woman's report of an experiment involving her mother is a striking example of the opportunities for abuse that can occur. The case is unusual only in that the family of the patient made exhaustive inquiries following her death and found that no one—the Government, the attending physician, or the home—was adequately protecting the patient.

According to an FDA report, made at the family's insistence after the death of the patient, the G. D. Searle & Co., Chicago, Ill., gained FDA permission to test "Anavar," a drug supposed to increase appetite and retard deterioration of bones. The drug was already approved for use in doses of 2.5 milligrams two to four times a day for no more than 3 months. Searle wanted to test its usage over a period of time at doses of 10 milligrams once a day.

Unknown to the family (the daughter had expressly told the attending physician not to allow her mother to be given experimental drugs), the nursing home and attending physician approved the patient, among others, for the experiment. The patient's "consent" was gained; she marked an X on a consent statement.

After taking the drug for about 6 months, the patient became critically ill. Medical diagnosis never confirmed the cause of the illness; no move was made to find out whether the experimental drug had caused or contributed to the illness; the drug continued to be given.

Two months later, the woman died. Both the home and the coroner who filled out the death certificate refused to tell the family exactly how or why the woman died. The home has refused to release the woman's medical records to her family.

The family did obtain a record of the drugs given the patient and discovered that she was taking an experimental drug. When they demanded to know why they had not been consulted, the home produced

a "consent" document marked with the patient's X. The patient had been judged senile by her doctor who recommended that she live in an institution. Nonetheless, the home maintained and the FDA concurred, that the "consent" of a person medically diagnosed as senile was sufficient.

The family further discovered that the woman's doctor believed the drug was given as already approved and not as an experimental drug. He, therefore, made no attempt to see whether the drug was having ill effects on the patient. In this case, according to the daughter, certain allergies and an edema condition made it possible that the drug could have been highly dangerous for her mother.

Senator Moss. Well, that is a concrete example.

Mr. HALAMANDARIS. Claire, in other words, you are saying that you have uncovered concrete evidence through the FDA that patients are given drugs without their effective consent. Do you want to go into any specifics? Do you want to give names, addresses, other than just the name of the drug company that you have mentioned and the name of the drug which I believe was Anavar?

Miss TOWNSEND. Anavar, a-n-a-v-a-r. I just found out that the woman wants her name to be kept secret.

Senator Moss. Now you recommend alternatives to the nursing home and I think we all wonder about that. What specifically do you have in mind as an alternative to the nursing home for our elderly citizen?

Miss BALDWIN. Well, one idea would be to subsidize the patient or the individual's family. This would prevent a patient from ending up in a nursing home just because he cannot afford the extra care he needs, and could obtain outside the home because of financial reasons. In other words, the Federal Government instead of subsidizing the nursing home care for the patient would subsidize his own family; therefore, he could remain outside the home.

The nursing home is for those who are ill and in need of care; I mean it is not supposed to be an excuse to stick people, who don't really need that extensive care, in the nursing home for petty reasons.

A few other ideas which have already been mentioned are; the home care services, and the homemaker services. These need to be extended because they are not reaching half the people that need them. Now home care services provide medical care in the home of the individual. In other words, a professional person comes to them maybe two or three times a week, depending on their need, and administers medical care. The homemaker service is when someone comes to the individual's home to provide services such as cooking, feeding, bathing, shopping, companionship for as often as the individual needs it. These programs need to be extended.

Another idea is campuses for the elderly. Now, this could be done on an experimental basis by building dormitories for the elderly on college campuses. Now, you could have the graduated system of going towards this; one being more like indoor apartments where the elderly person would be fairly independent. Another dormitory, maybe, would have a cafeteria attached to it; and, it would be more like a boardinghouse, and they would eat their meals there; but, otherwise, they would be free to roam around the university as they pleased.

Then, maybe you could have an infirmary, where patients could stay to receive, maybe limited medical care, and then, maybe, a hospital. This is following the normal university dormitory system. In this way the older persons could enjoy the benefits of a large university—such as concerts, guest speakers, theatrical performances; and even continue their education, which, I think, is a great idea. At the same time, you would be attempting to close the gap between the very young and the very old which I am interested in.

One more idea would be mobile health units in urban areas that would be run on a neighborhood basis; in other words, bringing medical care to the neighborhood of highly concentrated older persons so that they could receive checkups. This is sort of an idea that would help stop serious diseases before they really begin to develop.

Senator Moss. Thank you. This concept is one that I have turned over and thought about for some time, this idea of elderly people on, or adjacent to, college campuses. We have something akin to it up at Syracuse, where I held a hearing about a year ago; and, it seems to me, that is a pretty imaginative and interesting goal to pursue.

Miss BALDWIN. You should get the credit for it.

Senator Moss. Well, it offers so much opportunity for the older people and, as the same time, it offers opportunity for the younger people, as well, to mingle with the elderly and to be of assistance in a number of ways.

One thing I wanted to ask about was your recommendation—that psychiatric treatment ought to be provided more fully. How significant is this problem?

Miss KEYES. I would like to answer this one. The fact that only 1 percent of all psychiatrists specialize in the problems of the aged is significant, as well as the fact that 25 percent of mental hospital admissions are the aged. Eighty-six percent of nursing home patients suffer from some sort of mental disorder. A common misconception, among nursing home staffs, is that senility is a mental condition, but it is not; it is a physical condition, hardening of the arteries or arterio sclerosis. And the rate of suicides goes up in nursing homes, too, something like 55 percent.

Under the new regulations as they came out from HEW there are no more matching funds for mental patients under intermediate care so, therefore, the States are beginning to put their mental patients in nursing homes where they can get to be backed by 50 percent of the cost from the Federal Government. So, definitely, nursing homes need more psychiatric attention from psychiatrists and specialists.

Senator Moss. Of course none of us are experts in this; but I have heard doctors testify that senility is not necessarily a condition to occur in an older person, that with appropriate attention, that they do not become senile. I wondered if this might be what you were driving at—in saying the person should have early and sufficient care.

Miss KEYES. Yes, sir. If it is watched, and the nursing home personnel know what to look out for, it can be arrested before it becomes too serious.

Senator Moss. Just one more question and then I will permit my colleagues to have an opportunity.

In talking about nursing homes, and pointing out that those run by religious institutions generally seem to be much better than the proprietary, are you recommending that proprietary homes be abandoned and we go to a nonprofit or group oriented nursing homes entirely?

Miss TOWNSEND. I would like to get around answering that directly by saying that we don't think that for-profit institutions should be done away with; but, rather, use the example of the Connecticut point system—where good homes that achieve a good level of care are rated high on a scale A, B, C, D and receive compensatory, whatever the word is, money for doing a better job of treating their patients, so the incentive is to do a good job.

That can happen within a nonprofit or a for-profit home just so long as the incentive is to take care of the patient, and not necessarily to make the most money off of them. The point is that we don't think we should do away with for-profit institutions; but help to encourage the incentives to be for the patients' benefits and not from the owners.

Senator MOSS. I agree we should have incentives that would stimulate better care, try to get patients up out of bed rather than keep them in bed. In some places you know the rate is higher for patients that are bedridden than for those that are ambulatory, and it would seem to me the incentive there would be the other way.

You are suggesting a "point system" that reverse these incentives, in effect, if they were able to get the patients up and around they could get a higher rate of return. Is that right?

Miss TOWNSEND. Yes. Connecticut has a very good reputation for good homes and you can probably give credit for that to Dr. Franklin Foote for coming up with the rating system. It has been in effect for 10 years now.

Miss KEYES. Also, it would help the whole image of the nursing home industry if they were able to return more of their residents to society. As it stands now, you friend goes into the hospital and you expect to see him out in 6 weeks, but if your friend goes into the nursing home he may never come out. Therefore, people dread nursing homes, they have a bad image. But, if they did return more patients to their full capacity—then they would have a better image.

Senator MOSS. Thank you.

I am told, Miss Townsend, that your parents are here in the audience today. What are you going to do with them when they get old, send them to a nursing home?

Miss TOWNSEND. Absolutely not. First of all, one thing I would like to bring up is that it seems that when we mentioned the idea about old people on college campuses, it seems that we are implying that it is a privilege for old people to be around young people. I want to emphasize the fact it is also a privilege for young people to be around old people—they are the most fascinating people I have ever met. I am ashamed to admit that I never thought this before this summer, it took 12 weeks of horrifying work to figure this out.

I definitely plan to take care of my parents myself, I think they are pretty good people. They will be healthy for a long time. If you start planning early to take care of your parents, it is something that should be planned ahead because to work effectively it just can't be a spontaneous, all of a sudden, impromptu thing; but, like you can bring

up your kids excited about the fact that some day grandmom and grandpaw are going to move in with you. You know, you can just really gear your family and plan for it. I may be selfish, but I love my parents and I want to keep them around as long as I can.

Senator Moss. That is a very admirable answer and I would hope that most people felt that way, but of course there are circumstances where families do not exist, children have moved away or other reasons. So I guess we are going to have nursing homes for a long time, and that gets us back to the focus of the problem that we have—of how we can improve the present system.

Senator Saxbe of Ohio may have a question or two and I turn the time over to him for a minute.

Senator SAXBE. Thank you, Senator.

I would like to compliment these young ladies for this very interesting presentation and, even more, for their dedication and their work this summer; because this is, as you stated, something that you don't think about. Once you have entered into it, it is hard work.

Did you get a chance to make an assessment of the difference in quality of the for-profit and the nonprofit and the, more or less, public installations?

Miss TOWNSEND. That is a very difficult question to answer; first of all, because of this limited time we have. The only evidence we have is our own personal feelings of walking into this one home in particular in Connecticut, and I am going to mention its name, it is St. Joseph's Manor in Trumbull, Conn., and it is run by the Carmelite nuns and the atmosphere is what really did it. Those people, that is their job. They take on the order of taking care of the aged, so they are not in it for anything else, they want to take care of old people and that just changes their whole attitude; whereas, in other homes that are good you still get the feeling of money, you know.

Also, the public seems to feel that way—the fact that a lot of the church-affiliated homes have long waiting lists, 2 and 3 years' long waiting lists; where right next door there is a for-profit institution and it is not even running at full capacity.

Senator SAXBE. Did you get a chance to talk to some of the managers about the financial problems or go over their books? We are talking particularly in regard to compliance with standards and so on. Did you get a chance to discuss this with any of these homes where you were?

Miss TOWNSEND. Yes, and strangely enough we were especially impressed by this new chain of nursing homes which we went into during the summer; thinking they were probably the worst, but they turned out to be pretty sincere to supply the best care for the lowest cost—not just to get away with the lowest cost; but, because they are real businessmen, they want to see if they can do it—I mean, it is something they want to achieve.

They were explaining it is almost impossible to make money—it is almost impossible. One sort of ironic conflict I discovered, in the summer, is that with the church-affiliated institutions they run at a loss; but it is their diocese that picks up the tab and pays for it then. And, these are the taxpayers—so why aren't they putting that money into taxes? I mean, they are willing to pay this to the church, because they

know the church will handle it well, but they are not willing to give it to the Government to do the same thing.

Senator SAXBE. On that very thing, through examination and visits you hear this terrible tale of woe that they just can't comply—because they are bankrupt, or they are going bankrupt. I have had a chance to look at some of their books and I know that this is true, that they are losing ground. This is not just old homes that try to make it, but some brand new homes.

I can give you the names of several corporations whose stock is now practically worthless and they went into this with this idea. They also tell me that they cannot operate on the public patient alone, they have to have a certain percentage of people who can pay their own way. So you have two rates, you have a rate for the people who can afford to pay the full rate and then you have the public patient who makes up the balance. They have to take those because they have to keep the beds full.

So you have a public patient, either through old-age pension or Medicare, and this person helps to carry the load; but, overall, the homes cannot put in a new sprinkler system, they cannot put in the new alarm system, they can't hire the additional nurse, they can't pay enough to keep good help—simply because the dollars aren't there and it is a losing thing. They also tell me that pay alone is not the only thing that attracts staff people. It takes a certain type of person. As you pointed out here, to handle these people is a distasteful job, as you found out, and some people would not do it if they did get \$5 an hour.

We have run into this in our State institutions and many of them are terrible because of the turnover of personnel. It is a situation that seems to pyramid because of our bureaucracy.

I am disturbed about your continued recommendation that only the Federal Government can do this; and, yet, where the Federal Government has gone into it they have not done a very good job. [Applause.] Bureaucracy itself is its own worst enemy, and the nursing home operators that I talk to tell me that there is one inspector from the State who comes along and tells them one thing; and there is their county inspector who comes along and tells them something else. One of the silliest things I ran into was: The Medicare patients' laundry has to be separated from everybody else's laundry; because, it has got to be done, and accounted for, in a certain way apart from the regular patients' laundry—which has got to be done another way. This is a ridiculous expense. And the medication has to be separated and all these things.

It seems to me that we have to get one group of inspectors who are going to stay there, and have the same instruction so that they are all telling administrators the same thing; and, when you get a new inspector, he should not feel that he has got to change everything. This attitude that the inspector who is a new man on the job has got to find something wrong—that's the old Army way, that he has got to find something wrong—or they don't think he is doing his job.

Now, I think you have hit on the real key issue, which is that the concern must be there before anything else works. If patients are approached just as so many bodies to be looked after, they never get adequate care. I am of the opinion that our whole national attitude has to change because we have neglected these people for so long.

Now, one other thing. Did you get a chance, any of you, to come in contact with people who are not in nursing homes; who are trying to make it in a flea-bag hotel, or in a roominghouse, or in a place where they get their Social Security, and they try to do it on a hot plate and not under an organized program? Did any of you come in contact with this?

MISS BALDWIN. I did. That was my area.

Well, that is one of the great problems. The first great problem of all, almost every old person in the United States that is not in the nursing home is in financial trouble because as the lifespan lengthens the retirement age is going down, which is completely ridiculous, and you have a longer and longer period in which you have lost your original paying job. If you do need to find some work to support yourself, you have to go down the ladder to lower and lower paying jobs which are difficult to get. I mean, this is discrimination of the aged.

Aside from this, Social Security benefits are lagging way behind the cost of living. I really think it makes so much sense to adjust the Social Security benefits so that they rise and fall automatically with the cost of living. It has been explained to me why this has not been done, but I fail to understand. It just makes so much more sense, because Congress is lagging behind in raising Social Security benefits to comply with the rising cost of inflation and rising living costs, et cetera.

I would like to answer you on the question of the Federal Government taking over. We heard some applause back there.

I would like to explain that. What happens in the system is, the Federal Government passes a law and it is a crude instrument, and it is not enforced, and the responsibility is then passed on to the Government agencies or the administration to enforce this law, to develop regulations and standards to sort of break it down so that we can make it applicable in the States. Responsibility always goes to the States, right.

OK. Now it is up to the States to enforce the law and the regulations. The Federal Government sends them a blank check and we wish they would make use of it the way they see fit to enforce the standards and regulations. Therefore, the Federal Government has no control over that money, that blank check. Some States do a good job, some States don't. What you get is 50 sets of enforcing standards. Do you get my point?

This lack of uniformity has to be corrected, and who else but the Federal Government has the power to do this on a national scale? We are not making this judgment on the basis of past performance, just out of the process of elimination. Who else can do it?

SENATOR SAXBE. This is certainly a reasonable assumption and I wish that we did better.

You commented about the medical attention. Do you think, under our present system of medical distribution, there is any way that we could do the things that you suggest? I am talking about a full-time doctor on 24-hour call and all this.

MISS KEYES. There definitely should be a doctor able to be called 24 hours a day. The home I worked in, this woman was in great agony and she needed an appointment. The nurse said, "It is Friday night

and we cannot possibly get hold of a doctor until Monday morning." Here is this woman crying in pain.

Also, I would like to emphasize the fact that there should be more RN's on duty because, oftentimes, the RN's are busy with paperwork, and filling the little medicine cups, and the only contact they come into with the patients is to give them the cup, and maybe take their temperature—or something.

Senator SAXBE. What I am particularly getting to is the fact that we have standing offers, for doctors, of \$28,500 in Ohio, and we cannot get takers. Now, how in the world can we get a doctor to go into a 100-bed or 200-bed nursing home on a full-time job, with the present shortage of physicians and the present method of health distribution?

Miss BALDWIN. One problem is that, in the education of doctors, geriatrics is very much left out. I think, that, if part of the intern's course of education would be to—I don't mean to serve time in any bad way—but, to work in a nursing home and to make a study of geriatrics, while they are still in the textbooks, and get a feel of the place so that it is not sort of a dreaded myth, you know, the dying patients in the nursing home; that no doctor just because of his own morale concerns—I mean his own sense of self-worth—would want to go into. This is not true.

I mean nursing home patients can be rehabilitated; maybe not as much as children, but I think if, in their education, doctors or interns were introduced, as well as nurses, to the situation in the nursing home—and had some practice there—it might help.

Miss KEYES. Also, pediatric medicine evolved out of a need and geriatric medicine must do the same.

Senator SAXBE. Develop this as an attractive area for a doctor.

Miss KEYES. Yes.

Senator SAXBE. This is enlightening. I am, personally, of the opinion that we have to, as I have indicated by my sponsorship of bills and so on, overhaul our medical distribution system radically or we are just not going to get the attention that is required. I cannot help but feel that, under our present system, it is almost impossible to keep people out of these nursing homes and to keep them out of the beds; because, the only way they can get paid for looking after them is to get them in that bed—to get them in the hospital.

We must have some system that we can have our major thrust on keeping people ambulatory and keeping them healthy; because, once we get them in that \$80 hospital bed, or in the nursing home, it does not seem that we can get them out again—then we have this tremendous expense which continues to build up. Our health insurance systems, our systems of paying for care, all of them are geared to getting that person in the hospital—at the most expensive place we can put them.

Well, again, I want to thank you for your presence here and for your fine testimony.

Thank you.

Senator Moss. Thank you.

Senator Yarborough is chairman of the Labor and Public Welfare Committee and a member of this subcommittee. He also is chairman of the Health Subcommittee of that large committee of the Senate. Although he was not able to be here for the full time of the hearing,

I want him to have an opportunity to ask any questions or make any statements he would like to make to you young ladies.

Senator YARBOROUGH. Well, I want to congratulate you on your study and on going into the field; not merely reading some reports but getting a firsthand look. I have been reading these excerpts from your journal of what you saw, and heard, and felt, in those nursing homes. That was probably a pretty traumatic experience to most of you, was it not?

Miss TOWNSEND. Yes.

Senator YARBOROUGH. I'll bet you didn't sleep very well the first few nights. I hope you never get to where you could sleep soundly and easily and never be affected; though people who work under those conditions, nature enables them to build a protective mechanism against what they see. They would go crazy if they worked there and saw that every day, if they didn't develop that protective mechanism to screen out some of what they saw.

Reading your statements, there is one problem that I think is going to be more difficult to cure than all the others. You mentioned the bedsores and the boredom. As chairman of the Health Subcommittee we have worked for years to get more money into medicine in this country. There are not enough doctors to go around and you have a shortage of doctors.

You mentioned one doctor seeing 60 or 75 to 90 patients a day; and, another man laying there dead from 9 in the morning until 11 at night because they could not move him until the doctor came, and certified, and signed the certificates and things like that—such a terrible shortage of physicians. We have been trying to alleviate that through legislation for more medical schools. Two-thirds of every dollar that goes to support a medical school comes from the Federal Government.

We have tried many other programs. This is an investigatory committee on the aging but it has no legislative powers. The Labor and Public Welfare Committee of which I am chairman has a special smaller aging subcommittee which takes the recommendations of this committee and writes them into law. A number of us are on both committees and we take this great work, at the hearings that the committee does not have time to do, at this hearing.

You point out there is no comparable committee to the Committee on Aging in the House. Conditions of the elderly, conditions of hospitalization, conditions of the many who are not immobilized, like many of these are, but have a potential for earning money not only for living expenses but for being productive, there are separate subcommittees. There are subcommittees on the frauds committed on the elderly. They have a machine that runs electric current through the body that will return all their youthful vigor and not deteriorate so rapidly.

You have mentioned what we can do with money—if we just put money in this. Frankly, the main reason we have not is the \$110 billion, in my opinion, that was squandered in Southeast Asia in the past 10 years. What that would have done for America if we had put it into education, health, and all these things that you see the need for. I think that is the great roadblock to progress, as long as we keep pouring money into that fruitless adventure.

Now back to this problem of boredom. To me, that is going to be the most difficult of all; because, in my own life, I have seen the evolution of our society—from a society that needed these elderly people to a society that does not need them, unless we develop new needs and uses for them.

To take the example of my own State of Texas in 1940, 45 percent of all the people of Texas were rural people. In 1970 only 13 percent live on farms and ranches, but the need has changed as much as the percentage. In the 1930's, before mechanization, these grandparents were needed on the farms; they looked after the cows, and the chickens, and the hogs, and the other animals; and, when their parents worked in the fields they took care of the small children. The small children grew up with the grandparents really more than they did with their parents. This was the agriculture life.

Now mechanization changed all of that so those grandparents are no longer needed on the farms, and the farms don't need them either—they are mechanized. They get on their tractors and work and nightly drive 50 miles to the picture show, or a church social, and are gone weekends to the mountains or somewhere. The farmers have a flying farmers' organization in this country, a lot of them have planes and fly off to ski resorts—like other people in the society.

So we have to do something, to not only make this life available medically and nutritionally for a lot of these people—on those beds because they have not had a nutritious diet to keep them going, but to make life meaningful for them. To me that is the most difficult problem.

You mentioned the teaching of children by living with those grandparents. That is an important part. I grew up with grandparents; it was an exciting age, it was a time when the grandparents had lived through the making of America. I personally knew, in the little town of 500, old men who had fought in all the major battles of the Civil War. I knew one old man who charged with Pickett's brigade at Gettysburg who described how 67 charged in that company in the Civil War. They read the muster roll every night and that night only four answered muster. I know men who have seen buffalo by the millions in a place called Buffalo Gap—where the buffalo migrated.

I have talked to old men who, when young, would hear that thundering herd coming, scramble and ride their horses high up to the hills and watch the buffalo 2 miles wide—packed so close together that a man could walk on them across their backs, if he were nimble enough and an acrobat.

I have talked to men who heard the thunder of passenger pigeons, hundreds of millions of them, so many they broke the limbs off the trees with their weight. I talked to one elderly gentleman who had seen some of the Carolina parakeets before they became extinct.

When boys are growing up with men who had lived with the making of America, who were on wagon trains, they know that not all people who went west in wagon trains came back; a few did, some were so broke they were stuck and they could not come back.

That kind of life, being around grandparents was a thrilling experience. Now we take the grandparents and look at the way of life now. At one time the grandparents were needed in the rural areas,

now they work with computers and what have they got to tell a grandson—about how he sat at that computer desk all day long? It is a changed society and we need to take care of these people. We have got to think. It is going to take all your best talent the rest of your lives thinking out how to make this interesting for the grandparents and for the grandchildren. It is not enough to tell them that you're grandparents. This is one of the tasks I have worked on the committee for years, and on the legislative committee. We know what to do about medicine, we know what to do about a diet, we know what to do about care—we just have not spent the money.

How do we relieve this boredom? How do we make the mechanization interesting for a person after they have been fiddling with machines? I could talk for hours. [Applause.]

Old men have told me about it, seriously. We see on the television all the Indians and cowboys killing each other. If they had been killed off that fast, there would not have been any Indians and cowboys. In most of those wars they didn't get killed, that is why they lasted for decades. And the whites didn't always win, though they appear to—if you read the literature at the time.

I remember one old cowboy telling me of a story when he was young; when, all of a sudden, in a gap in the west Texas hills there were five Comanches on horses coming toward them. Neither had any idea of the other. The cowboys generally had better horses than the Indians; and the Indians, on a race, would generally be overtaken unless they could get into the brush. They stood there watching each other trying to decide what to do. (I had an uncle of mine, who was a trail driver into Oklahoma, who told me once that cowboys were not afraid of anything—except Indians.) Suddenly five arrows came through the air and one came through his shoulder; and they had to leave and go hunt a doctor. The bullets from the guns could not reach the Indians, but the Indians shot arrows among them.

Then nobody was killed, but they learned that the Indians knew the principle with bows and arrows and of trajectory fire.

I know other things that old men have told me; they lived it, they knew it. It was better than television and movies because it was real.

Well, I have taken too much time. We need you with your youth and brilliance to help us figure out this problem of boredom; on how to use this time meaningfully—how do you stimulate them by looking at television all day? That won't do it. How do you relieve boredom? We have to find the means to keep people more alert longer than we do now. [Applause.]

Senator Moss. Thank you, Senator Yarborough.

Girls, you have now been exposed to the older generation, and you can see what Ralph experienced when he was a boy. [Applause.]

I might point out that Senator Yarborough is the best historian in the Senate. He knows more about early American history, and particularly western history, than anyone else in the Senate without any question; and, he can tell stories like that all day, and they are very authentic. He is really a scholar in this area as well as being a great legislative leader, and I am glad he let himself go a little and talk to you a bit about what he really feels in his heart.

Senator YARBOROUGH. Senator Moss is exceedingly modest. I have known him longer than I have known any other Member of the Senate because we entered the Army and the same company on the same day in World War II. I want to say his grandparents were pioneers who pushed the handcarts to Utah and he could tell actual stories, too. He could tell things that would make my tales seem dull, indeed. He is too modest.

Thank you, Mr. Chairman.

Senator Moss. Thank you. We will defer that to another time. I do want to give Congressman Pryor an opportunity.

You girls mentioned the Congressman in your report. I am sure you are acquainted with him. He is a leader in this field in the House of Representatives and we are glad he came over to join us at this hearing this morning.

Representative PRYOR. Senator Moss, you are very kind. I hate to follow Senator Yarborough, that is an impossible challenge. I would like to comment on one or two things that he said.

He said that you girls had mentioned, this morning, very eloquently that the House of Representatives does not have a counterpart such as the Committee on Aging, as you have on the Senate side—in the other body—as we refer to it. I do want to say that, about the 1st of February, we are introducing legislation to create such a committee.

At this time we have about 102 cosponsors of this legislation, and I am taking off now about 2 hours every day, Senator Yarborough, going door to door. I feel like the wanton child of the House of Representatives, going door to door, seeking cosponsors of this legislation. I hope the House, in its wisdom, will come forward and create such a committee—for such a great need in our Nation.

Second, I would like to say, again, to the young ladies who have given us this great report; that, I think, had the President of the United States appointed a blue-ribbon task force, and probably spent \$10 million on a study of the nursing home situation, and gathered in all the Government officials that he could find, and all those with big titles and big salaries, and brought them all together, and had given them 3 years to do what you have done, I think that this report that they would have brought out would not have been, in any way, equaled by what you have done—because yours has running through every sentence a deep compassion, a deep and true, sincere compassion for the elderly of this Nation.

Thank you very much.

Senator Moss. Thank you, Congressman Pryor. That is a well-deserved compliment to you young ladies. You certainly have done a very fine job and we want to commend you.

Now, there are nursing home people, of course, who are anxious to tell their side of the story; and, they are entitled to tell it. We will hold hearings early next year in which we will have before us representatives of the Nursing Home Association. I have received a request from them that they be permitted to respond to the testimony and the records that you have presented us here today. That is the way we try, in hearing all sides, to make our decisions so that we can do the best we can.*

The things you have pointed out in your report, however, are deficiencies that we have, and we recognize many of them. Others, you

* See statement by the National Council of Health Care Services, Appendix 4, p. 96S.

are just bringing them to our attention; and, to the extent that we have power to do so, in the legislative body, we intend to address this subject and to continue to press on others, who have responsibilities in the field, until we can make some significant changes in the way that our elderly people are now treated in this country.

As Senator Yarborough said so eloquently, it has come about largely through the shift of mode of life that we have; which is all the more reason, however, that we should give our attention to it, and find out how we can find solutions for the problems.

We do thank you all very much for coming here, and thank you, especially, for the devotion you gave to this project during the summer. If it did nothing else, it has given you an education and a background in an area that we hope you will continue to pursue, and try to continue, from your position, to find adequate solutions to these problems.

Thank you very much.

Mr. HALAMANDARIS. Mr. Chairman.

You just heard Senator Moss say that he would be very happy to hear from the Nursing Home Association and all other interested parties. No doubt they will be anxious to respond to this report. My request is that the reaction be on a high level. Let's respond, if we will, please, to the issues; let's respond to the recommendations of the report. Let's avoid any attacks on personality.

It is not very meaningful to attack personalities—such as criticizing these girls for their youth. Let's have it on a high level. As you know, this response will be part of the public record. We will structure our report from the information that is submitted to us. So I ask you that the response be prepared with great care.

Thank you.

Senator Moss. Thank you, young ladies.

Now we do have two other witnesses that we were going to hear this morning, and I think we can press on and hear them. It may not be possible for all of the Senators to remain for the full period. If that becomes the case, why, we will ask the staff to continue since they both have appeared.

Senator YARBOROUGH. Mr. Chairman, it is going to be necessary for me to leave at 12 but I am leaving a staff member here. I have had the staff member here all the time.

Senator Moss. Thank you.

Mr. HALAMANDARIS. We will make one more announcement. At 3 o'clock this afternoon we are showing two films. One of them was made by Westinghouse, "When You Reach December," and the second an FHA film, "People Helping People," will be shown at 3 o'clock. All of you are invited to come back. It will be right here.

Senator Moss. There will be films at 3 o'clock this afternoon on this general subject for those who are interested in coming to see them.

Dr. Robert N. Butler, research psychiatrist and gerontologist, the Washington School of Psychiatry.

We are pleased to have a distinguished psychiatrist with us, Dr. Butler. We will ask you to come forward.

Our other witness will be Mr. William R. Hutton, executive director of the National Council of Senior Citizens. Perhaps Mr. Hutton

would like to come and sit at the table now. We will hear from Dr. Butler first and then Mr. Hutton.

We are pleased to have you, Mr. Hutton.

Dr. BUTLER. Do you wish me to proceed?

Senator Moss. Yes, if you will.

STATEMENT OF ROBERT N. BUTLER, M.D., RESEARCH PSYCHIATRIST AND GERONTOLOGIST, THE WASHINGTON SCHOOL OF PSYCHIATRY

Dr. BUTLER. I thought perhaps I might take the liberty, with your permission, to simply enter into the record the statement that I had prepared and then offer some highlights that may be of some particular significance.

Senator Moss. We would be pleased to have you do that. The statement in full will be printed in the record and you make the highlights you would like to.

(The statement follows:)

I am very pleased to testify before this Subcommittee and its distinguished Chairman who has worked long and hard to bring about reform in the long-term institutions where some one million older Americans spend their last days. I am most discouraged with progress and I would guess that Senator Moss must be most disheartened by the weakening of the important Amendments of 1967 to the Social Security Act that bear his name.

I am greatly concerned over the emasculation of Medicare coverage of so-called extended care and the efforts by the Administration and by Congress to reduce federal support of long-term care by Medicaid cutbacks. I am deeply troubled that we can still have terrible fires like that in Marietta, Ohio that took 31 lives and Salmonella epidemics in Baltimore, Maryland that killed 25 human beings. I am distraught that in our Nation's Capital a federal institution, St. Elizabeth's Hospital, could indiscriminately "dump" some 600 vulnerable people with chronic mental illness into the "community"—that is, when translated from the euphemism, into unregulated boarding-house-like tenements called "foster care homes" where \$4 per day is made available for care that not only often lacks social amenities and medical-nursing coverage but where there are deficiencies in nutrition and insecurity with respect to fires and personal safety.

There are "facilities" that have even lower standards than nursing homes and most studies by scientists and by elected representatives have not even examined these places which are another category of terminal storage bins for the late life casualties of our society.

I shall not catalogue the ills of the nursing home industry and of related "facilities." We have all heard that litany too often. Rather I wish to offer the beginnings of a specific program for fundamental reforms which I believe are mandatory if we are ever to provide humane, decent and innovative care for those elderly and chronically ill who need it.

This program will be discounted as "unrealistic" and "Utopian." To move in these necessary directions there must be a basic change in our national sensibility toward the old, the chronically ill and the helpless. Required is the substitution of human values for marketplace values.

After fifteen years of research and practice, I come now to believe that the profit motive must be eliminated from our care systems including medicine and institutional care and its alternatives. There are many fine and well-intentioned nursing home owners. They are not all miscreants. There are many fine physicians. But the conflict between profit and service is too great to overcome.

Only in the United States and Canada (to my knowledge) is there "commercialization" of the aging to use the word of Representative David Pryor (D-Ark.). It is now time to construct alternative systems by the massive infusion of federal money into voluntary, non-profit systems. Since 1965—with the advent of Medicare and Medicaid—and with federal construction monies—we have

poured millions into profit making systems. Look what we have! That, then, is proposal number one.

1. Public monies, the federal tax dollar, should be diverted from the commercial "nursing home industry" to the creation of multi-purpose centers, or galaxies. These should be established as public (or as I prefer) *social utilities*. They may be established as cooperatives, as the creations of religious organizations, unions, fraternal orders, as expansions of non-profit hospitals, as components of municipal care systems, as public corporations. Consumers, especially old people, in the area, should participate in their control.

Federal funds should be transmitted directly, excluding the expensive middleman insurance industry. Religious and other groups should be encouraged to join together, share and pool their resources, in a practical ecumenism to move beyond traditional institutional care to the provision of services in the community.

All persons regardless of income should be eligible to use the social care galaxies.

2. These new forms must proceed from a vision of comprehensive planning that emphasizes social and personal as well as medical care. By the year 1975 there will be more patients in so-called nursing homes than in hospitals. The medical profession, however, has shown a disinclination to involvement in long-term care. It is therefore just and wise to move beyond medicine to the total care approach.

3. The galaxies must be related to other components of our Nation's care system—social agencies, hospitals, information and referral centers, community centers, health and mental health centers.

4. These galactic clusters must relate to a variety of residential facilities. In short, there must be a range of facilities and services in accordance with the reality of levels of need.

5. The right of *eminent domain* must be constructively used for the public's health. The galaxies should be geographically located with reference to the demographic and personal characteristics of our population. Land-use in the United States must begin to follow human needs and not the market place. Expensive downtown real estate must be made available. Physicians would no longer have the excuse that they can not follow their patients to nursing homes set in the pastoral distant. Families, including grandchildren, can easily visit. In our Nation's Capitol, D.C. Village for the elderly was built in 1909 miles from center city. There should be perhaps 20 or 30 components of this home (with some 50 residents each) rationally distributed in neighborhoods throughout the city.

6. Development within these galaxies of comprehensive diagnostic and treatment programs to avoid the common, tragic mistake of failing to recognize and treat reversible disorders and misplace people in varied and poor settings. Adequate evaluation is the predecessor of treatment. Programs must be "categorical" that is, specific and characteristic, and requiring skilled management.

There should be three parts to each galaxy—Service, Training and Research. We have great manpower needs. The enormity of the present and future problem of old age and chronic illness demands basic and clinical research. There is always a need for in-service education.

7. Inauguration of a federal inspection system for surveillance and enforcement of standards of care, of administrators and of personnel. There must be adequate numbers (not like under Medicare and Medicaid). Inspection must be open to all—the press, the public, families. Unannounced inspections are an absolute.

8. Pressure must be exerted upon medical, nursing, social work, physical and occupational therapy, nutritionist, sanitarian, and other schools to develop curriculum in proportion to the epidemiology of need for care in this country. Two-thirds of our 1969 health bill of \$67 billion went to chronic illness. Yet, geriatrics is not well-represented in courses of study.

9. Among components of community services should be included the following—day care centers, the expansion of the Foster Grandparent Program so that such centers operate from a life cycle perspective and give useful roles to old people; outreach programs modeled after Medicare Alert; a National Hot Meals and On Wheels Program; special payments to families who otherwise could not care for their own at home; and so forth.

10. Creation of a National Personal Care Corps. Such workers would perform many of the duties that are now inefficiently spread over existing categories of visiting nurses, homemakers, occupational therapists, and others. They would be jacks-of-all-trades, performing nurse's duties, escorting the patient to the

doctor or to recreation, shopping for drugs or groceries. Teaching members of the family to change dressings, and so on. They must be decently paid—more than presently paid in our institutions and there must be a New Career incentive rather than a dead-end ahead.

When, finally, as is evitable, custodial care is necessary, let us not treat disability, aging, and dying by various forms of national denial. Let us elevate the meaning of the word custodial to signify the highest quality of personal and humane care.

Dr. BUTLER. I would like to draw particular attention to the fact that there are a great many older people living in firetraps, tenement types of institutions which we do not cover in our considerations of nursing homes. I think this is very important to bear in mind. We know that certainly we have 1 million older Americans in what are referred to as nursing homes, but much neglected is this other group.

Furthermore, I think it is important to recall a comment that was made earlier this morning with respect to the interests of psychiatry in the older patient. It has been, I am afraid, quite negligent. I think it is important that we bear in mind that some 50 to 60 percent of the patients in nursing homes and other types of facilities in fact have many emotional reactions as well as specific types of psychiatric disorders, including mental disease relating to mental function, deterioration of the brain, loneliness.

I think it is very important to bring together the American Association of Medical Colleges to pressure the deans of medical schools to put their heads together. They must come up with some realistic changes in the medical school curricula to meet an overwhelming need. In this last fiscal year, as I understand it, approximately two-thirds of \$67 billion was spent on chronic illness. I am very sorry to say that teaching in our medical schools certainly does not reflect the extent to which chronic illness occurs in our country. Nor does it reflect the extent that we see mental problems in older patients.

I have to say that I see the neglect of the aged and the chronically mentally ill right here in our Nation's Capital, Mr. Chairman. I speak as chairman of the District of Columbia Committee on Aging. I am sorry to say that we have seen the indiscriminate transfer of older patients out of the mental hospital and into so-called institutions where \$4 a day only is made available for their total care. I cannot even imagine adequate food let alone any kind of social amenities—and let alone any kind of effort to end the boredom that was referred to earlier.

I am very struck by and would like to commend the young ladies that represented the Nader organization and I would like to say that as perceptive young people they are not alone in their observations. A very distinguished psychiatrist, Dr. Zigmund Lebensohn's 21-year-old daughter, Lucia, wrote of her experiences in a psychiatric ward. I will quote: "It is too bad that television sets cannot reach out to people." Television is about all that is provided in a great many of those places. A blank-faced television set facing blank-faced people.

I want to make a few more comments. One is the question of peer review which we hear about so often. Consumers—including old people—should participate in reviews. I think it is extremely important that we bear in mind that we cannot depend as yet upon medicine to meet the needs of our older citizens. This is mainly because of educational deficiencies and disinterest. This is also partly—but only

partly—because we do not have the rational distribution of our institutions according to the needs of patients, the location of hospitals, and the like.

I think the right of eminent domain should begin to be utilized for public health reasons. For example, the average physician may have seen a patient for 20 years, say in the city of Washington. That patient now lives in some pastoral glen out in Montgomery County, which presumably is a very nice place to go for a nursing home. However, the physician will not follow the older person.

Now we could be very critical of the physician or we could say that this is the nature of things. This is the way in which he can allocate his time. I think we need to distribute our institutions much more reasonably throughout our cities, our suburbs, and our rural areas and we must use the right of eminent domain to do this.

Families should be closer to the older person. This, too, would help reduce the boredom. There is no reason why in downtown Washington, despite the high real estate cost, you could not have adequate care facilities for older people. Day care, of course, is very important and it has already been emphasized.

As we plan to have massive day-care programs—I hope—for children, I think it would be most useful to simultaneously expand the Foster Grandparent program to help give old people a sense of purpose and some roles in working with children. Here we would be having a unique opportunity to increase the relationships between both ends of the life cycle in a way that is not fake, not made up. There are so many talents among old people that we must not just make new work. We should see that the roles of the elderly are extremely meaningful.

I would like to close with just one other suggestion; and that is the possibility that some of our retired military physicians, as well as some of our retired medical teachers, might have a very natural reason to be interested in this age group and might be available to become principal physicians in institutions of this sort. I would like to say that the role of the principal physician really has to mean something. It has to mean, for example, that in the fall considerable thought be given as to whether there should be flu vaccinations for all of the old people in the home.

Periodic examinations have to be conducted. Medical rounds should occur very much as they do in a hospital setting. It is estimated now that in 1975 we will have more patients in our nursing homes than we do in our hospitals, so it is imperative that medicine get into the mainstream of chronic-disease care.

I guess that is really enough at present * although I certainly have a great many other things that I would love to be able to express; concerning the quite enormous problems of our older citizens not only in care facilities but outside of them.

Senator Moss. Well, thank you, Doctor. We appreciate your remarks in highlighting your testimony which is in the record in full. We do appreciate your coming. We wish we had time to talk more fully.

Interestingly enough, in the hearings that we held earlier this week involving Maryland, this idea of a medical director in the nursing

* See appendix 2, p. 947, for added information by Dr. R. N. Butler on his testimony.

home was talked about—and Maryland is moving in that direction—which seems to me is one of the answers to the problem we have of doctors not seeing their patients or simply standing in the doorway as one of the young ladies described—and ask the patient how he felt and walking on—that kind of constituted a visit.

I could see how that would happen if you have 40 M.D.'s perhaps each with a patient or two in the nursing home. Of course they cannot allocate their time to make many visits. Perhaps a medical director who had responsibility for the whole group would assure a much better attention and also planning and direction and the feeling of responsibility. That is an excellent idea.

Do you have any comment or should we go on, Senator Yarborough?

Senator YARBOROUGH. The time is so short, 2 minutes to 12. I want to compliment you on this paper. I will carry it with me. I have been glancing through it. I am impressed not only with the depth of many things you go into, but how you condense it in two pages and two short pages on the other.

I am interested in your 10th point, the creation of a personal care corps. People buy symbols a lot, always have in civilization or before man was civilized, too. The Peace Corps is an example, or the VISTA volunteer program. People go for a name. I think this committee should give serious consideration to this matter.

Thank you for what you have brought here to us, Dr. Butler.

Dr. BUTLER. Thank you.

Senator YARBOROUGH. I agree with you on the medical schools. Senator Moss mentioned about the family position, four out of five in 1931, only about one out of five now. They say you have to decide to be a specialist to a surgeon, and they don't have any dignity or standing in the medical school. I think this family practice bill will help on that.

They stressed they are to be able to go in and counsel with the family from the babies through the grandparents, but it does not go through all of you. Having worked on that Health Committee for 13 years, I realize the validity of everything you say about medical escalation. I wish I had more time. Unfortunately, I must leave.

Senator Moss. Thank you, Senator Yarborough.

We will hear now from Mr. William R. Hutton who is the executive director of the National Council of Senior Citizens and whom we have known, and depended on, in this committee for a long time. We get a lot of counsel and help from Mr. Hutton.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Thank you, Senator.

Again if I may, in the interest of brevity, I would like to just, perhaps, hit a couple of highlights; but I would at this time, sir, request that you might consider putting the entire paper in the record.

Senator Moss. That will be done.

(The statement follows:)

Mr. Chairman: Those who undertake to provide care for the chronically ill or infirm aged assume a heavy responsibility.

The responsibility for improving this care is too heavy to be carried merely by the proprietors of nursing homes—whether they be commercial homes or organized not-for-profit by churches or other institutions.

Responsibility for improving the care of our chronically ill older people must be borne by all of us—by government, by industry, by labor, by churches and other eleemosynary organizations—and by the middle-aged and the young.

The National Council of Senior Citizens—which I serve as Executive Director—wants to play its part in assuming some share of the responsibility. As a national organization—and as an affiliation of independent older people's clubs with autonomous statewide and area councils of clubs, we wish to accept responsibility, on all levels, for seeking to find better ways of taking care of our elderly people than the current system which leaves so many of them "buried alive" in dreary institutions.

Though we are the nation's largest assemblage of elderly people organized in older people's clubs, many of our nearly three million members are quite poor. We have no mandatory dues system for our individual members and the National Council of Senior Citizens gets no financial benefits whatsoever from the direct services we have been able to organize for members so they can get substantial savings in the areas of supplemental insurance for Medicare, low-cost travel and discount drugs, etc. We are an issue-oriented organization, not a business outfit.

What the National Council of Senior Citizens lacks in financial strength, however, it more than makes up in its enthusiasm and willingness to work to build a better America.

These senior citizens, Mr. Chairman, are not interested in establishing a patriarchal society. All they want is for America to recognize that many elderly have much yet to give to their country, that many of them represent a vast, untapped, national resource which can be utilized in many areas of community service, not the least of which could be considerable involvement in new programs helping other older persons to enjoy longer and better living in the mainstream of society. Those who are well seek to help these who are confined in institutions.

Some of our members are involving themselves in the practical nursing home problems of their communities. Others demonstrate their "Senior Power" in involving themselves in political and social action, asking questions of their state and community leaders, urging consideration of new ideas, exploration of new ways for rehabilitation of the elderly.

We are grateful for the opportunity to appear before you today and we are appreciative of the fact that there is such a sub-committee unit of the United States Senate concerning itself with the tremendously important area of nursing home and other long-term care.

Leaders of our senior citizens groups in other states have asked me to say how grateful we are to the voters of Utah for returning the sub-committee's chairman, an expert on long term care, for another six-year term.

We are conscious of the need to limit our observation to just a few specific areas of the broad subject of long term care.

WEAK HEW POLICY

We are concerned, Mr. Chairman, that the Department of Health, Education, and Welfare (HEW) still appears less than enthusiastic about protecting the interest of the patient in today's nursing homes. State and federal expenditures for nursing home services have reached over \$1.5 billion annually—and one would assume that the burden on the federal exchequer alone would be sufficient to demand intensive oversight, adequate inspection and the necessary experimentation to find at least a better mousetrap.

But two years after enactment we are still waiting for introduction and enforcement of all of the Moss Amendments which were added to the Social Security Act in 1967. We hope the Medical Assistance Advisory Council, which has been reorganized, will prod the Department of HEW's Social and Rehabilitation Service (SRS) into strong policy decisions on nursing home care.

Perhaps, the most glaring failure to enforce the Moss amendments to the Social Security Act lies in the area of medical review. The Moss amendments require States participating in the Medicaid program to have a professional medical review program under which evaluation of the quality of care under the Medicaid program is made periodically.

Such a medical review is needed to guarantee proper return in services for tax dollars allocated under the Medicaid program but, of far greater importance, it is needed to help nursing home patients get well and, to the extent possible,

care for themselves either at home or in a facility where cost of care is less than what it is in a skilled nursing home.

ADMINISTRATOR LICENSING BOARDS

Some vested interest groups have opposed higher nursing home standards in their respective states—and they are likely to get their way because commercial nursing home administrators have gained predominance on at least half of the State Boards responsible for licensing nursing home administrators.

The regulations developed by these boards have been weakened through lack of uniform, clear, forceful, policy by the Federal government. Interpretations by HEW Regional Administrators and Regional Attorneys have been the subject of vacillation and delay and will cause serious problems in connection with future plans for reciprocity between the States for administrator licenses.

We have asked the Senate Finance Committee to introduce legislation requiring that *less* than a majority of such boards shall be representatives of a single profession or institutional category, and that less than a majority shall have a financial interest, directly or indirectly, in nursing homes.

LAX STATE INSPECTIONS

In many states, it is the opinion of our senior citizen club leaders, that Federal inspections and State Health Department inspections of nursing homes or other health facilities are often infrequent and woefully inadequate. In some states there have been charges of political pressures on the State Health Department to interfere with inspections.

It should be noted that Section 1908 of the Social Security Act—enacted with the Social Security Amendments of 1967—nowhere related “administrator” licensure to “facility” licensure. In most states the nursing home facility licensure lies with the State Health Department while administrator licensure was purposely vested in the newly-created Board of Examiners.

However, the enabling laws of many states failed to provide sufficient funds for the State Boards to undertake continued study of homes and administrators for purpose of collecting adequate data on administrator behavior for licensing purposes. As a result, licensing Boards will largely need to depend on the State Health Department for this data *which is contrary to the intent of Congress.*

“DUMPING” STATE MENTAL PATIENTS

Another area about which we would like to comment concerns the “dumping” of aged mental patients from state institutions into commercial nursing homes—many of which are ill-prepared to take care of them.

If we're ever going to lick the problem of mental illness and the problems of aging we cannot afford to take the mentally ill out of the mainstream of our care system.

It seems fairly obvious that the trend toward moving aged patients from state institutions to commercial facilities has been done by some states merely to attract larger federal payments.

Experts have reported that all too often these patients have been placed in nursing homes that provide no psychiatric care at all. And psychiatrist Margaret Blenkner has reported that even with careful preparation of an older person before his being moved, mortality has increase in the relocated population.¹

INSTITUTIONALIZATION IS NOT BEST ANSWER

Most of the medical people who really know the health problems of the aged recognize that older people do best at home.

The best doctors realize that institutionalization is not usually the best answer—that most success comes after the doctor has made a serious effort to discover the extent to which his patient's mental disorder is reversible.

Whether the patient remains at home or is hospitalized, contact with persons close to him can be the single most important factor in his environment. This crucial contact may be provided by a relative, a friend or neighbor, a visitor to whom the patient responds, or a nurse or aide in the institution itself.

To the elderly person this contact signifies that he is not totally isolated, that

¹Toward a Public Policy on Mental Health Care of the Elderly. Nov. 1970. Group for the Advancement of Psychiatry.

he still participates in the world of living people—not yet discarded as being not dead but no longer truly alive.

Our senior citizens organizations—our churches and every kind of voluntary association of people, must encourage Friendly Visitors to the so-called “nursing homes” of America. Unfortunately, there are still too many institutions where the standards of nursing care are minimal and which, by no stretch of the imagination, deserve the title “home”.

A ROSE BY ANY OTHER NAME

Incidentally, the association of commercial nursing homes in my state of Maryland now calls itself the Maryland Health Facilities Association. When I first heard this title I thought it referred to a chain of steambaths, gymnasium or weight-loss establishments, which seem to be springing up all over the country.

Actually the Maryland Health Facilities Association establishments are not for healthy people. This is another version of the propaganda approach that is used by the commercial insurance industry. When it talks about “health” insurance, it really sells sickness insurance.

This is not to say that there are not some well-run facilities in Maryland—whatever that means—though this subcommittee heard in other hearings this week how a distinctly unhealthy tragedy in one modern and expensive Baltimore health facility caused the deaths of 25 older patients and serious illness of a 100 more.

IMPROPER USE OF TRANQUILIZER DRUGS

You will recall, Mr. Chairman, that we recently sent you a message condemning improper use of tranquilizer drugs on nursing home patients who do not require this type of medication. I would like to include for the records today a copy of the press release which was the subject of a particular complaint we made.

The National Council would appreciate any help on the part of this or other Congressional committees to bar this barbaric practice of using tranquilizer drugs as chemical straightjackets for patients who are not in medical need of such sedation.

DISENCHANTMENT WITH PRESENT SYSTEM

All across America our club leaders report a growing disenchantment with our current inadequate system for the health care of our elderly people.

The present exposés of the horrors in many of our nursing homes which are becoming increasingly frequent in newspapers, in magazines, on radio and television—and in fact in the U.S. Congress—are not the result of some carefully plotted consumer group campaign to bring on “socialized medicine.”

These stories are coming out because the cost of care in our nursing homes is going up and up while the quality of care seems to be going down. And the technological advances in communications are helping many more people to see this clearly.

SEE THEMSELVES IN THE FUTURE

People are disturbed because they feel they cannot cope with the staggering costs.

They are shocked when the television camera takes them into the realistic horrors of old people waiting for the end of their lives in dreadful institutions.

Some young and middle-aged people, who never saw the inside of a nursing home before, have been taken there by television and they do not like what they see. Now they are beginning to ask us to do something about cleaning up these conditions and changing the system so that things may be different when they reach the “golden years.”

90 PERCENT FOR PROFIT

But the National Council of Senior Citizens is concerned that the heavily weighted profit motive in our nursing homes—ninety per cent of them are organized for profit—is a built-in barrier to change.

Nevertheless, we are encouraging the medical profession and the health officials of the federal government, states and counties, to explore the use of geriatric departments concerned with the investigation, treatment and social management of elderly patients.

NEED FOR NEW IDEAS

Recently, we joined the Montgomery County Commission on Aging in nearby Maryland in co-sponsoring a seminar conducted by Dr. Lionel Z. Cosin, clinical director of the geriatric unit at United Oxford Hospitals of Great Britain. Cosin's "continuous care" concept of treatment for elderly patients includes what he calls a "dynamic quadruple assessment" of patient condition—pathological, psychological, physical and social factors.

His approaches have formed a foundation of modern geriatric practice and the background of the development of geriatric departments in several countries—notably in Israel, Italy, Morocco and now—this past year—at the Cherry Hospital in Eastern North Carolina.

Dr. Cosin has visited the U.S. many times and talked about geriatric rehabilitation in the many countries in which he has worked. But there were some in America who believed his concept would not work under the U.S. medical system.

A START IN THE UNITED STATES

Last year he left his beloved Oxford to take a one year's sabbatical at Chapel Hill, North Carolina. He returned to the United Kingdom a few days ago, confident about the progress being made in rehabilitation, re-settlement and social re-training of the mentally sick aged in Eastern North Carolina.

Dr. Cosin's concept of continuing care of elderly patients has now been thoroughly aired at two recent seminars in Maryland and is being widely discussed in other areas of the country.

MAINTAINS SOCIAL COMPETENCE

Dr. Cosin's concept replaces the inadequate episodic care which ends when either finance or tolerance is exhausted. The program facilitates the maintenance of social competence which itself must be recognized as one of the main objects of a medical care program with the correct social orientations.

This integration of preventive, therapeutic and rehabilitative social and medical services for elderly patients utilize the appropriate type of facility for each patient's current problems—based on the dynamic quadruple assessment.

It is most economical and effective by reason of its relatively short duration, its rehabilitation potential and its resettlement program for most patients who survive. In this way, they can be as independent as possible for as long as possible in their own homes.

SUGGEST SUBCOMMITTEE INVITATION TO DR. COSIN

This is a concept in which America must become more deeply interested. I hope your Committee, Mr. Chairman, might have an opportunity to hear Dr. Lionel Cosin when he returns to the U.S. on brief visits next year. However, I have brought with me today three papers written by Dr. Cosin before he left and which he has authorized me to offer this Committee for the record.

These papers are:

"Care of the Aged Mental Sick"

"A Philosophical Concept and Architectural Development of the Psychogeriatric Service of Eastern North Carolina"

"The Philosophical Concept and Functional Use of the Day Hospital"

Mr. HUTTON. In particular, sir, I wanted to talk about the hope for the future about which you have heard briefly in the testimony of Dr. M. Tayback, Maryland Assistant Secretary of Health and Mental Hygiene, during your committee hearing on Monday.

The responsibility for improving the care of the chronologically ill is obviously something which must be borne by all of us and by the Government, by our industry, by labor, by churches, by the young and the old. The National Council of Senior Citizens, which is the largest group of aged people organized in older peoples clubs, wants to assume its share of that responsibility. We want to assume it on all levels, as we are organized on all levels as a national organization with a headquarters here in the Capital, with State groups in most of our

States and with some 67 area councils and clubs, some of them quite large.

For example, in New York City the Congress of Senior Citizens of Greater New York is 250,000 strong with more than 220 clubs. In the Detroit metropolitan area the Affiliated Council of Clubs is 150,000 strong with some 112 organized clubs. These have a great impact in their communities and they want to do something.

While we are the largest organization, many of our members are quite poor; we are not a healthy organization. We have no mandatory dues system or anything like that and our citizens organization gets no financial benefits from any of the direct services which it runs.

We are an issue-oriented organization, as you know, and not a business outfit.

What we lack in financial strength we more than make up for in the enthusiasm and willingness of our members to work to build a better America. However, we have been slow in paying attention to the problems of the chronologically ill, to the problems of our elderly sick who we are beginning to get organized.

We are interested in using our senior power, and that power is very real as you know, particularly at election times. However, we are not interested in establishing a patriarchal society, Mr. Chairman. We want America to recognize that older people out there have much to give to their country; they are a vast untapped natural resource of this Nation and we believe that they can and should be used in the nursing homes that I mentioned.

One of the real tragedies, of course, is that I had hoped that this new Employment and Manpower bill, which has been successfully enacted by the Senate and the House, would enable many of our elderly to be trained to do this kind of work. However, I am shocked and horrified, sir, by the veto of that bill by the President yesterday.

Some of our members are involving themselves in the practical nursing home problems of their communities. Others are demonstrating their senior power and involving themselves in political and social action, asking questions of their State and county officials.

In the testimony which I have submitted I have made some criticisms of our present system but I do want to emphasize another area. Recently the National Council of Senior Citizens joined the Montgomery County Commission on Aging in nearby Maryland in co-sponsoring a seminar by Dr. Lionel Z. Cosin, the Clinical Director of the Geriatric Unit at Oxford Hospital in England, Great Britain. Cosin has a continuing care concept of treatment for elderly patients which involves what he calls a dynamic concept accessible of patient condition.

It is an assessment of the pathological condition—psychological, physical, and social factors. His approaches have formed a foundation for modern geriatric practice and the development background of geriatric departments in several countries of the world, notably in Israel, Italy and Morocco, and at Cherry Hospital in eastern North Carolina.

Dr. Cosin has visited the United States many times and has talked on geriatric rehabilitation. There were some in this country to whom he talked who believed that it would not be possible to organize this kind of concept outside of a Nation which didn't have a national health

insurance plan but he is already making some impact. A few days ago he left this country to go back to his beloved Oxford after conducting a sabbatical for 1 year at Chapel Hill, N.C., at Cherry Hospital and he now is very confident of the progress being made in rehabilitation, assessment and social training.

I would like to submit three papers on his behalf, for the information of this committee, which deal with this exciting technique of providing care for the elderly. The papers are entitled, "Care of the Aged Mental Sick," "A Philosophical Concept and Architectural Development of the Psycho-Geriatric Service of Eastern North Carolina," and "The Philosophical Concept and Functional Use of the Day Hospital."

I think within these three papers, sir, there is something for those who are genuinely interested in the care of the elderly to take at least some chance of hope. I would like to see them thoroughly explored by health authorities everywhere.

Senator Moss. We will be pleased to have them submitted and they will be printed as part of our record.

(The three papers will be found in the appendix, p. 953).

Mr. HUTTON. Thank you.

Senator Moss. Thank you very much, Mr. Hutton, for your appearance and your submission of testimony. We wish that we had time to spend talking with you further because of your great experience and, of course, deep interest in the problem that we are trying to examine here. I look forward to reading your statement in detail.

In the problems of the elderly, you can get off just on the medical side or you can get off on another side, but one thing that you said, that I always come back to and it seems to me is true, you said we have a vast untapped natural resource in our older people and that is so true. After all, there is more experience—and this is somewhat what Ralph Yarborough was talking about, being able to talk with people who had lived in another age—but there are so many with an experience, and background, and knowledge, that these older people have; and, our tendency to segregate them and put them aside and, also, just to have entertainment of some kind for them—as though that were the only thing left for them to do—it seems to me is one of the greatest wastes of society in the world.

These elderly people can contribute immensely to our culture and our practical day-to-day problems; and, we ought to be making use of it, not just to accommodate the old people—but it would be fine because then they feel needed, and wanted, and have a reason for living, an all of that—but, what society would gain, if we could continue to use their resources and mental skills and whatever else, is another matter.

Mr. HUTTON. I believe also, sir, that we could stimulate the private sector to a greater interest and encouragement in the use of elderly people if the Government would encourage categorical programs. Unfortunately the manpower programs of this and previous administrations with regard to the elderly people are not just merely incredible, they are shameful—utterly shameful.

There is so much that older people in this country can give if we can just stimulate opportunities for them to give. We have to provide the right setting, the right encouragement. Many of them need just a lit-

tle lunch money, perhaps the transportation there and back to a job, and they are willing to work just for the therapy of working, the therapy of doing something for themselves and others.

Then there are others who need that \$2 an hour, perhaps for 4 hours a day for 5 days a week, and what a wonderful contribution they could make. There is not a city in this country that could not benefit immensely from the services of all kinds of older people.

Senator Moss. Well, thank you. I feel strongly about that, and the few programs, that we do have, have been so successful. I think of the one where the elderly people in rural areas have been employed in beautification projects. Now this is something they know how to do. They plant shrubs and beautify the sides of the highways, and the parks, and areas, and they are just so delighted; because, they can see the worth of the work they are doing—they know it is valuable. At the same time they earn some income, too, and that is very helpful to them. This is marvelous.

Mr. HUTTON. Sir, we have a program going with the Department of Labor, a small one, a demonstration program. It should be in more cities but in one of them some older people are working inside the mental institutions of the State. These older people work for \$2 an hour, 4 hours a day, 5 days a week and they are doing a marvelous job.

When the elderly people who have been in mental institutions for say 30 to 40 years become acutely ill they have to be taken from that setting of the State mental hospital and taken into acute general hospital. Of course this is extremely disturbing for them, they are unsettled, they become much more confused.

One of the quick habits of course in many places is just to load these people down with tranquilizers and take them to the acute hospital, which course can also affect their cure. But by having older people accompany the patients who have been working with them in the State mental institution, this has been very beneficial. The director of the State institutions in St. Louis, for example, where we have seniors working, has said that the rapport of the older people with the other mentally sick in that hospital is much better than that of some of the psychiatrists working there—experienced professional people. The director asked one elderly lady, a senior aide, "What was your previous training? How come that you understand confused people, and you have done so well though not having done any of this before?" And she said, "Sir, that is very simple; for 20 years I was employed as a barmaid and listened to everyone's problems!"

Senator Moss. Thank you. I certainly do appreciate your testimony.

Mr. HALAMANDARIS. Mr. Hutton, I believe you mentioned a report you have. I just wondered if you have submitted it for the record. I refer to your study of the State's effort to comply with the Federal requirements for the licensing of the nursing home administrator.

Mr. HUTTON. I just briefly mentioned it in the report. I would be very happy to submit that in detail, I have it available. It is a report of the study of the situation regarding the boards of examiners of licensing for nursing home administrators throughout the country.

This report, which the details were collected by my own people, our own club representatives in many States and also from the Department itself, the SR's, certainly shows there are 27 States already where the

complete documentation of the licensing boards has been achieved by proprietary nursing home administrators. The National Council of Senior Citizens have requested the Senate Finance Committee to introduce new legislation so that no one discipline of any kind, either private nursing home or nonprofit or doctors, could dominate a board in this way. Nor do we think it right that those who hold financial interests in a nursing home, either directly or indirectly, be permitted to dominate a licensing board.

I would be very happy to supply the details.

Senator Moss. If you will, please.

(See appendix 5, p. 976.)

Senator Moss. Thank you very much, gentlemen. We appreciate your testimony.

The subcommittee is in recess, subject to the call of the Chair.

(Whereupon, at 12:45 p.m., the subcommittee recessed, to reconvene at the call of the Chair.)

APPENDIXES

Appendix 1

ARTICLES* SUBMITTED BY RALPH NADER

ARTICLES DEALINGS WITH THE NURSING HOME INDUSTRY APPEARING IN BARRON'S FINANCIAL WEEKLY, FEB.-MARCH 1969

BARRON'S, Feb. 10, 1969.

UNHEALTHY GROWTH?

The Nursing Home Business Is Expanding at a Feverish Pace

By J. RICHARD ELLIOTT, JR.

One morning late last month, the American Stock Exchange delayed the opening of an issue called Lilli Ann Corp., pending an "important announcement" from the company. On the frantic floor of the Curb, however, scarcely anyone batted an eye. Lilli Ann, listed since 1965, had been a singularly unspectacular maker of ladies' fur-trimmed cloth coats and suits. Seldom had the stock—with 51% of some 500,000 outstanding shares held by the founding family—wandered out of its narrow range of 15 to 20, and then only in the wrong direction. For the last time Lilli Ann had done anything of note was back in 1966, when management decided to add a low-priced line to its stylish collection. The move was a bust. After a series of woeful write-offs in 1966-'67, Lilli Ann only lately had begun to regain its original form.

Then came January's stunning news: the ticker carried word that Lilli Ann's directors had approved the formation of a new "real estate division" which would seek entry into the field of "convalescent-care homes." With that, all else about Lilli Ann became ancient history. By the end of the trading day, the stock (already up 5 points on the week) had shot up another 10% to close at 35 $\frac{3}{4}$ and the Amex governors had stepped in to place it on 100% margin. By week's end, Lilli Ann had posted a net gain of 50%; what's more, in five days' time an astounding 250,000 shares—equivalent to the entire floating supply—had changed hands.

THEY GOT THE FEVER

Lilli Ann's fever chart is not unique. Of late, the same kind of frenzy seems to grip the stock market at the merest mention of those magic words: "convalescent care," "extended care," "continued care." All euphemisms for the services provided by nursing homes, they stand for the hottest investment around today. Companies never before near a hospital zone—from builders like ITT's Sheraton Corp., National Environment and Ramada Inns, to Sayre & Fisher, Irvington Place and Computer Research—have been banging on the industry's door. More significantly for investors, nursing home operators have been selling shares to the public at a dizzying rate, while promoters from Wall Street (and elsewhere) are out beating the bushes for other prospective offerings.

Almost without exception, these so-called nursing-home stocks come to market at high price-earnings multiples—and move straight up from there. At latest count, at least 50 such equities were on the market or in registration; new filings currently average one or two a week. The 50 can lay claim to nearly 800 homes for the aged and infirm (including units on the drawing board), with

* See Mr. Nader's testimony, p. 873.

total patient capacity approaching 100,000 beds. Yet since the most recent industry figures show that about 20,000 facilities all told are operating or under construction throughout the U.S., with accommodations for over 750,000 patients, apparently little more than one of every 10 operators—perhaps only one in 20—so far has gone public. Despite all the sound and fury, in short, the end may be nowhere in sight.

RX FROM UNCLE SAM

Until recently, such goings-on were about as far removed from the serenity of the nursing-home business as a boiler shop is from a Tibetan monastery. What shattered the peace and quiet was Medicare. This 1966 amendment to the Social Security Act, which helps to defray the staggering costs of hospital care for patients over 65, was amplified in 1967 to cover convalescing patients in approved extended-care facilities outside the hospital. The nation's hospitals, of course, long since have been jammed beyond capacity; many patients occupying critically needed beds, however, can get sufficient medical care from institutions less expensively equipped and staffed than the full-scale general or acute hospital. In most cases, the differential in daily cost between a hospital and a nursing home or convalescent center runs about two-to-one.

The federally funded Medicare program—and a follow-on welfare scheme called Medicaid, in which both U.S. and state money is used—had the effect, of course, of vastly increasing the demand for institutional medical care. At the same time, the over-65 population of Americans continues to explode. Accordingly, an already apparent shortage of beds in most U.S. markets suddenly has become even more acute. Most estimates place the need at between 250,000 and a half-million beds—figures that, indeed, seem to resist reduction even by the mushrooming construction of new facilities because of the equally rapid rate at which older (and usually non-approved) homes grow obsolescent. New units—and those modernized with the aid of investor, and federal, funds—thus seem to have every prospect of unlimited demand.

HAVEN FOR ALL?

"Nobody," a new-issue underwriter said the other day, "can lose money in this business. There's just no way." As it happens, however, the sure-thing prognosis is hardly more applicable to nursing homes than to any other enterprise, particularly one so new—in terms of the basic economics wrought directly and indirectly by Medicare, and the overnight competition for public investment capital. For one thing, few firms as yet show anything approaching a fair return on equity (or the kind of profit margin on revenues usually considered adequate), much less a sustained record of profitability; they are, of course, too new. Furthermore, a number of companies now public (and at growth-stock multiples) actually have suffered earnings relapses. Here and there, too, are cases of operations apparently successful in every way but—like the proverbial one in which the patient dies—they're losing money rather than making it.

Beyond such problems, frequently attributable to growing pains, are several current and prospective headaches which may well turn out to be more serious. One is competition: even though overall demand-supply conditions unquestionably are bullish, certain local markets already are being crowded by the expanding chains. In that contest, management variables come into play; most of the publicly held nursing-home companies today are run by men with little or no experience in this field. Cost factors vary as well. Some concerns enjoy a demonstrable edge in mass construction, none in medical-center operations; the disparity in a given market area may be as wide as \$25 per bed per day. "Nobody can lose" because so far, Medicare has paid all such bills without blinking.

Not all nursing home patients (even in the extended-care, post-operative category), however, are covered by Medicare. The average ratio of occupancy at accredited institutions runs around 30% to 40%; Medicaid, for its part, in most states pays only about half the Medicare rates for welfare patients. Hence, private patients remain the industry's long-term source of greatest profit (per bed), and here the skyrocketing costs of care threaten to squeeze projected profitability even for the established, fully occupied homes. To cite only the major factor, labor (mainly professional nurses and aids), which accounts for upwards of one-half of total operating expenses, nurses' salaries currently are rising by 7% a year, and national unionization seems a near-term likelihood.

HEALTHY AND WEALTHY

Finally, both Medicare and Medicaid are destined for tighter regulation and revised budgeting. State houses are in an uproar over the latter program's soaring costs; as for Medicare, its bounteous cost-plus formula (which, to date at least, has underwritten the start-up costs of all new, accredited facilities) almost surely will be replaced in the current Congress by a maximum scale of reimbursable costs, as well as an incentive plan to encourage economies and a more frequent (and rigid) system of audits.

What all this suggests, then, is that the road to health in nursing homes is paved with stumbling blocks. Of course, it's also paved with the best intentions, and investors can be forgiven if they see the route richly lined with gold. To date, the weight of evidence is on their side. Beverly Enterprises, a California chain in the process of doubling its present 3,000-bed capacity, was worth \$1 a share just two years ago, went public last May at \$16.50 (actually \$31, before last month's 2-for-1 split), and trades today at around \$42. Its co-founder and president, a CPA named Roy Christensen, has watched his original \$5.700 investment mount in just five years to a current value of \$10 million (roughly 9% of the outstanding stock), making him, by his own recent admission to a group of New York institutional investors, one of the more affluent accountants in the business.

Examples like this are almost as common as bed pans. American Institutional Developers, a firm with 33 facilities (nearly 5,000 beds) in operation or under development—and with its headquarters crowded into a makeshift office on the ground floor of an apartment building in suburban Philadelphia—went public at \$10 a year ago last May, and currently is quoted above \$80. Medicenters of America, headquartered in Memphis (where it was formed several years ago by the same management team responsible for the proliferation of Holiday Inns), is the most ambitious developer in the industry, with some 90 "Medicenters" on the ground or on paper; investors who got in at \$10 on the first offering (July '66) or even at \$25 on the second (June '67) now have holdings worth (after a 2-for-1 split) over \$50 a share—200-odd times the latest reported 12-month earnings.

FROM PLAIN TO FANCY

Still more "giants"—each with dozens of facilities and thousands of beds in the works—can be singled out for similar performances. Thus, Four Seasons Nursing Centers of America, probably the best-publicized (and first to list its shares on a major exchange, the Amex), came out of the plains of Oklahoma (as a former builder of housing) just last May at \$11 a share, subsequently running up to well over \$100 (a split's in the offing). Another, a Louisville concern called Extencare (formerly Heritage House), brought out one year ago at \$8 a share and busily expanding via both construction and acquisitions ever since, ran up to \$40 before backing off a few points—where it still commands a multiple (on declining earnings) of 200-plus. Another biggie, New York-based Medic-Home Developers (19 units, nearly 3,000 beds) broke the ice last summer at \$10 and has moved up to around \$35; one reason Medic-Homes now boasts a P-E ratio of nearly 200 may be its imminent merger with Care Centers, a Florida operator of 13 units which managed to lose 33 cents a share last year.

SO MUCH FOR OLD AGE

What sets each of the aforementioned firms apart is, relatively speaking, a degree of seasoning; among nursing homes now going public, a year's experience in the market is rare indeed, and two or three virtually calls for gold watches. Breath-taking indeed are some of the latest offerings. To illustrate, Geriatric & Medical Centers, proud owner of a pair of homes in Pennsylvania (285 beds), came out last December at \$7 a share and so far has made the price stick—a mere 100 times latest 12-month earnings. Last month, another called Geri-Care Nursing Centers (eight units, 1,000 beds planned) came out at \$10, then tacked on a 35% gain in the first week of trading, reflecting a modest multiple of around 70.

Metrocare Enterprises also made the scene last month. Its main distinction—though it is by no means unique in this respect—was its plan to use the proceeds to get its start in the business, via projected acquisitions of a half-dozen homes; investors greeted the new arrival, at \$12 per share (35 times

"pro forma" earnings), by boosting its price and multiple 50% the very first day. And there's much more to come. In registration now, for example, are Professional Care Services (two units, four cents a share earnings) at a proposed \$5 per share (P-E:125), and Professional Nursing Homes (32 units, five cents a share net) at a proposed offering price of \$10 (P-E:200). Neither of the foregoing, incidentally, should be confused with Professional Health Services, also going public; the latter is a bookkeeping concern which specializes in "accelerating payments" to nursing homes under New York State's Medicaid plan. Nor do even these few cases stand out as exceptional in the current epidemic. New market arrivals like Hy-Lond Enterprises (16 units) and Unicare Health Services (18), have gained multiples literally in the multiple-hundreds.

So intense is the bidding that an established, listed (Amex) company like Ramada Inns (the motel chain) can announce acquisition for stock of one of the biggest remaining privately-held operators (Americana Nursing Centers, with over 30 units up or abuilding), then watch its own shares jump 20% on the news; yet the offer by Ramada's directors (as yet unreported) almost certainly had to be fat enough, in effect, to dilute the stock's underlying value. Perhaps the best indicator of the general frenzy is the experience of Bio-Dynamics. Hot on the acquisition trail, its shares lately have been in a severe slump (Barron's, December 9).

Last November, the Indianapolis medical-equipment maker, announced an "agreement in principle" to take over three nursing homes in the Detroit area, in a deal estimated to involve some \$4 million of Bio-Dynamics' stock—but pegged to a stipulated multiple (agreed to by both sides) over the nursing-home operation's earnings. What hadn't been agreed upon were the actual numbers. "We couldn't get a satisfactory report from our accountants," Bio-Dynamics admitted at last. The earnings "base," it seems, kept going up, and with it the price. Last month, the deal fell through (the announcement coming from Detroit, with Indianapolis not even formally notified). Other, more alluring siren songs were presumed to be in the air, possibly emanating from Wall Street.

BETWEEN THE SHEETS

That gives some idea of the throbbing pulse, and sweating palms, characteristic of nursing home stocks on (or near) the market today. Flying about in all this feverish activity are certificates of equity (shrunk in actual book value by severe dilution at the outset) which represent quite a wide assortment of interests. The new issues, of course, have in common a reliance on Medicare and Medicaid, to fill existing beds and all the new ones being thrown up. Their high prices, in turn, clearly are pegged not to any history of rising sales and earnings—which is the usual criterion Wall Street employs to determine what's a growth stock but rather to rising expectations. Given capital, the new nursing home companies are expected to build and buy additional facilities as fast as they can, thereby expanding their earnings base in the only way possible.

The facilities which they own, operate, lease or franchise are pretty much alike in physical attributes and appearance, too. What they differ markedly from is the typical general or acute hospital. On the whole, the homes are smaller than hospitals—though the average unit size, regarded as operationally ideal, of 100 to 150 beds is also true of many small-town hospitals—because they dispense with such space-consumers as operating rooms, maternity wards, emergency-treatment sections and, for the most part, extensive diagnostic and laboratory facilities. (Hence their lower costs.)

Beyond that, they seldom look much like hospitals even from the vantage point of a semi-private patient. Except for the movable tray-table and a (usually modified) form of the classic "hospital bed," the impression one gets is that of a comfortably modern motel double room rather than anything institutional. To be sure, older units of the type usually known as "rest homes"—and depicted disparagingly in a recent book called *Where They Go to Die* (which is scandalizing the industry)—almost without exception are not among the real estate holdings of the publicly owned nursing-home companies. Their properties range from a few perhaps 10- or 15-year-old, refurbished multi-story structures, to the typical, sleek, well-landscaped single-story units. Architecturally, they resemble Howard Johnsons or Holiday Inns. On the inside, that theme is carried even further with plush wall-to-wall carpeting, smartly decorated lounges and rooms, comfortable furnishings—and nary a whiff of "hospital odor."

GET WELL QUICK

Such a nursing home, in the words of one of the leading operators—actually, the slogan, coined by Medicenters of America, is meant to apply just to Medicenters—is, indeed, “a nice place to get well.” Convalescence, rather than long-term or permanent confinement, is what most of these units are being built to provide. It’s that concept of “extended care” for patients (of any age) able to leave the intensive care of a general hospital, but not yet ready to go home, around which today’s new nursing home companies have been constructed.

State licensing authorities differentiate among several types of nursing homes: the aforementioned rest homes, with little if any nursing care available, designed for the aged and infirm; the specifically characterized “nursing home,” in which a registered nurse is on duty part-time (replaced at other stations and on other shifts by practical nurses); and the extended-care facility (ECF), which must have a staff of RNs on duty at all times. (Still other types, known as convalescent-care or intermediate-care centers, generally fit somewhere between the latter two main categories; however, they also may qualify as ECF units.) The point is that Medicare coverage can be extended only to a unit properly certified as an ECF. And such a unit, better-equipped and staffed than run-of-the-mill nursing homes, in turn must operate within fairly strict limits—to retain its certification, on the one hand, and to turn a profit on the other.

It’s here that the “fevered fifty” publicly held “nursing-home” companies begin to differ from one another, in their overall approach, their short-range and long-term goals—and in their probable ability to survive and prosper.

BARRON'S, Feb. 24, 1969.

NO TIRED BLOOD

Nursing Home Operators Are Long on Enthusiasm, Short on Experience

This is the second in a series of articles on public ownership in nursing homes. The first installment appeared February 10.

BY J. RICHARD ELLIOTT, JR.

Memphis—Headquartered in this bustling river port city under Chickasaw Bluff is the hearty host to a nation of motorists, Holiday Inns of America. Here too, by no mere coincidence, is Medicenters of America, Inc., the No. 1 builder and operator of ECFs—elaborate, motel-like nursing homes, designated “extended-care facilities.” Upwards of 1,500 Holiday Inns dot the U.S. landscape, or will by year-end; similarly, early in 1970 more than 100 Medicenters will be up or going up. Besides such striking growth, the two companies have more in common. Chairman Kemmons Wilson and President Wallace E. Johnson of Holiday Inns happen to hold down the same two jobs (the titles are merely reversed) at Medicenters of America.

Barely three years ago, this enterprising Memphis pair formed the new firm from the mold that had worked so well before. Accordingly, Medicenters, while not part of Holiday Inns, enjoys the same ready access to money, management, business contracts and construction know-how as the motel chain. Inn-keepers Johnson and Wilson, holding about half-ownership between them, like to call Medicenters “a nice place to get well.” It’s clear that the two promoters, when they launched the nursing-home venture, intended no undue risks either to their own financial wellbeing or, when Medicenters went public in 1966, to that of some 1,000 outside investors.

EMERGENCY TRANSPLANT

That’s why what happened to Medicenters—right here in Memphis—came as such a blow. At the outset, Medicenters decided that the ideal site for its first company-owned facility, its largest ECF in the projected chain (and a model home for the whole industry), was nowhere but Memphis, smack in the heart of a renowned, ultra-modern hospital complex surrounding the University of Tennessee’s School of Medicine. On June 19, 1967, amid a blare of publicity, the sleek and sumptuous 270-bed Medicenter of Memphis threw open its doors. As the prototype, it combined the best in ECF accommodations that money could buy, with a prime location, convenient both to top management and to a sure-fire

market; within a month, according to a local paper, it had "more doctors on its rolls than patients." signifying impeccable credentials and unprecedented professional acceptance.

Just 18 months later, however, magnificent Medcenter of Memphis looked (to all intents) like it was on its last legs. Far from thriving on a high-priced full-occupancy, the unit by last year-end stood virtually empty—its few patients outnumbered not only by affiliated doctors but also by nurses, administrators and even maintenance men. Its condition, to be sure, was the result of a management decision; Medcenter of Memphis hadn't been hurting for business. But the ECF, equipped and staffed for post-hospital, extended-care, convalescent (i.e., fast-turnover) patients, somehow had filled up instead (through an inexplicable administrative snafu) with the long-staying, low-paying, aged and infirm, mainly on welfare. When its discreditable P&L sheets finally caught the eye of the busy brass across town, the Medcenter's administrator was first to go. In his wake went the sorry lot of patients, as quickly as transfers to less exclusive homes could be discreetly effected. Not long ago, an unexpected visitor found the place barren as a barn—awaiting redecoration, reorientation and as the new unit administrator explained, rebirth.

"IT CAN'T HAPPEN HERE"

Medcenter of Memphis undoubtedly has cost its owners a pretty penny, and possibly an ulcer or two as well. At the least, break-even time has been postponed in Medcenters' largest single investment by at least a year. The object lesson, in any case, is as clear as a laboratory specimen. Under supposedly expert management (a fair description of the Holiday Innkeepers), and in the best of circumstances, operating a nursing home for profit is no cinch. Just as in the practice of medicine itself, so many variables exist that the unexpected (if not a foregone conclusion) may be lurking behind the next chart, or under the bed.

Perhaps the most tell-tale signs appear on scattered financial statements. National Health Enterprises, to take a case in point, is a Milwaukee-based operator of 11 "skilled-care" nursing homes (with capacity of nearly 2,000 beds) which debuted publicly last September under the tender loving care of White, Weld & Co. By anyone's thermometer, National Health clearly is in the pink. Steady and profitable growth, coupled with ambitious expansion plans, have earned for the stock a price-earnings multiple which is far from modest, but also far less fever-ridden than many others in the field.

Nevertheless, National Health displays a paradoxical P&L chart. On the one hand are four venerable nursing homes in Wisconsin (the company's cornerstone), all 90%-occupied or better, which on \$4.5 million of patient revenues last year turned a profit (before taxes) of \$1.25 million—a glowing 28% pre-tax margin that's beyond most health-care operators' fondest dreams. But on the other hand are National Health's seven remaining "Golden Age Manors" (1,131 beds) in Texas and Colorado, acquired last year for the relatively high price of \$9,000 per bed, or roughly 47 times pre-tax earnings. These units, currently running between 70% and 90% occupancy, grossed \$3.8 million in 1968 but netted just \$210,000 before taxes a 5.4% margin (down from 7.2% the year before), inadequate (even when added to depreciation) to cover current debt maturities. "We have every hope of improving that performance," says National Health's President, Richard Paliafito. "In fact, the profit potential in Texas and Colorado is our built-in growth factor." Meanwhile, however, National Health, resembles a patient with one healthy arm and leg, but coming down with measles on the other.

RED INK SPOTS

That's not so serious as many other cases. Quite a few firms, for example, went public (or are about to go) without any medical history at all. Thus, Metrocare Enterprises, when it came out last month (promptly soaring well about the offering price) noted in the prospectus that "the company has had no operations to date. . . ." Thereupon, the company took its \$6 million (550,000 shares, having a book value of 15 cents apiece, were sold for \$12 per share) and acquired six nursing homes from insiders; the facilities show an occupancy average well over 95%, while netting, last year, only 1% on gross revenues. Similarly, Autumn Aegis Nursing Centers, currently in SEC registration, admits to "no operations to date." Some, of course, are planned, specifically 11 nursing homes

(plus a construction outfit) to be acquired with the proceeds; last year, the combined group pulled out of the red for the first time since 1964.

Another newcomer to the field is American Medical Affiliates (also in registration), which has been running two Pennsylvania units (218 beds) since last August, and plans to acquire six more elsewhere; candidly, the firm concedes it has "virtually no history of operations and there can be no assurances respecting the scope of such operations or whether they will be profitable." Just possibly, they will not be—at least for awhile. A "pro-forma consolidated statement of operations" covering all eight facilities showed a deficit for fiscal 1968. Best of this breed, though, is Continued Care Facilities (currently building three), which should clear the SEC soon and offer 300,000 shares publicly at \$10. Any price-earnings multiple would be merely a gleam in someone's eye. "Since all the company's proposed nursing homes are in the planning or construction stages," Continued Care's prospectus advises, "no operating personnel have been employed."

SINKING SPELLS

The P&L charts of a number of firms already in the business—hence, based on actual consolidated operations—also can give an observer pause. Professional Nursing Homes of America (200,000 shares at \$10 in registration) "commenced management of its first facilities in December 1966," and "currently manages eight extended-care facilities having in the aggregate 778 beds." It broke into the black (five cents a share) last year, but points out in its prospectus that "for the period from its inception, treated as one accounting period, the company has operated at a loss."

Growing pains are more evident elsewhere. Thus, Care Corp. (a recent Laird, Inc., underwriting)—which went from \$8 to over \$20 bid on its first day over-the-counter—boasts a steady rise in revenues at the seven Midwest centers which it operates; yet in the latest reported quarter, despite virtually full occupancy, earnings sagged 11% to eight cents a share. Even a veritable old-timer like Hillhaven, Inc. (offered at \$29 per share last December via a syndicate headed by Dominick & Dominick), which owns or operates 30 facilities, couldn't make the profit chart look good in time for visiting day on Wall Street. Hillhaven's prospectus cautioned that "for the past five fiscal years the company has had a fluctuating earnings history, including a loss before extraordinary items . . . (in 1966)." In the latest reported five-month period, net sank from 20 cents a share (plus four cents of extraordinary items) a year earlier, to 17 cents.

MARGINAL CASES

Nor are reported profits in nursing homes necessarily all that they seem. Without exception, the publicly held firms include as revenue in their latest financial statements the funds received from Social Security as Medicare payments—these account for anywhere from 5% to 70% of gross income, depending on the concern—in the knowledge that all such payments are subject to official audit, and likely retroactive adjustment. Notes to some financial statements point this out. (The problem will be discussed in another article.)

In addition, other bits and pieces of reported earnings frequently are subject to varying diagnoses. "Extraordinary items" are encountered as often as the common cold: many firms include such nonrecurring gains in earnings, on the theory that a "growth" company which counts on recurring expansion will find nothing extraordinary about such windfalls. Thus, Hy-Lond's enterprises shows net exclusive of such items dropping from 26 cents a share in fiscal 1967 to 13 cents in '68, despite rising revenues. Again, in the first quarter of fiscal '69, revenues rose sharply, to \$1.8 million, but earnings plunged to \$30,000, or seven cents a share, from \$61,000, or 16 cents. Chairman Jack Breittigan complains that "as you expand you earn a lot of investment tax credits, and this is really recurring income which should be added in." Unofficial reports of 18 cents per-share net for Hy-Lond's six months through December, accordingly, reflect this judgment.

NURSING LOSSES

Another favorite is the tax-loss carryforward. Medic-Home Developers, which went public last June and is showing signs of incipient conglomeratititis, reported earnings for the year ended last September 30 of \$235,000, or 36 cents a share (against a loss of \$120,000 in fiscal '67); a footnote reveals that \$111,000, or 17 cents a share, of the "profit" consisted of a tax-loss carryforward.

Medic-Home boasts another distinction. The company is on the verge of merging with deficit-ridden Care Centers, Inc. (Delaware), which appears to have perhaps the poorest operating record of all the industry's "fevered 50." Care Centers went public nearly a year ago at \$6 per share (in a 200,000-share offer underwritten by Stanley Heller & Co.), subsequently doubling in price. At the time, it had four nursing homes open, and six more in final stages of construction—all in Florida—so start-up costs understandably weighed heavily.

In any event, Care Centers went to the market showing a net loss of 29 cents per share for the fiscal year ended the previous October 31; in the subsequent first quarter of fiscal '68 (the latest reported to date), the deficit rose to 22 cents a share, from 15 cents in the year-earlier period. Nonetheless, Medic-Home plans to swap one share of stock for each 2½ shares of Care Centers Class A common. Stockholders approved the deal last month, along with a name change (to "Medic-Home Enterprises"), reflecting, says Samuel H. Klurman, president of the New York firm, "the company's expanding activities in the health care fields (and) a variety of related fields."

As all the foregoing would seem to hint, "nobody can lose money in this business" except quite a few. There are, indeed, a host of factors affecting the profitable development and operation of nursing homes, and problems already have arisen to plague firms in the pink as well as in the red. Of all these, probably the key component is management inexperience. Administration of a health-care facility, or a string of such facilities, is not as complex as the running of a full-scale hospital; nevertheless, it's closer to that than almost anything else in the business world. Today's nursing homes may be compared frequently to luxury motels, but as Medi-centers discovered, the comparisons are superficial. Motel guests, after all, seldom stay longer than a night or two, demand a minimum of care and feeding (and never on a 24-hour basis), and find few if any federal or state agents standing protectively between themselves and their hosts. Hardly least, the maintenance of professional standards, in the medical sense, imposes a whole extra dimension upon the managerial function.

Hence, it's worth noting that the new (and newly reorganized) nursing home companies are directed by corporate officers and unit administrators whose respective backgrounds cover a broad gamut. Several top executives, for example, claim careers in unrelated real estate development, syndication or promotion. Outright scandal, incidentally, so far has touched the industry but once. An offering called Mediatries, involving a proposed 2.5 million shares and several health-care facilities, was barred last May by the New York State Attorney General, on grounds of the promoter's "allegedly fraudulent dealings in at least six previous realty securities offerings over the past 10 years." The offering was withdrawn.

Real estate promoters needn't be suspected of fraud, however, to be less than expert in the ways of nursing care. Edwards Industries, to illustrate, is the leading land developer and home builder in Portland, Ore., specializing in construction of condominiums and "planned communities"; a few years ago, it decided to build a nursing home, then another; three are now open and a fourth is going up, with Edwards owning and operating them all. But management's background in running a business, aside from general contracting, has been confined to a lumber planning mill, several contract glass shops and, until recently, a Rambler auto agency (sold last year at a loss).

Four Seasons Nursing Centers, to take a different case, is headed up by a three-man team of officers and principal stockholders. (In last November's second public offering, the company sold 100,000 new shares for \$5.5 million while insiders unloaded 497,800 for \$35 million; the management trio reduced their equity interest from 53% to a combined 31%). Two of the three are former housing developers (42-year-old Chairman and President Jack Clark having launched his career as a salesman, first of golf carts, then of gypsum products); the third man, Vice President Tom Gray, previously operated Gray's Nursing Home in Henrietta, Texas, which he founded after a five-year stint as proprietor of a Henrietta beanery called the St. Elmo Coffee Shop. Mr. Gray, naturally, is Four Seasons' operations man.

STATEHOUSES TO WAREHOUSES

Other firms boast unusual business backgrounds, too. The five-unit, all-Pennsylvania, Intermediate Nursing Centers (listed on the National Stock Exchange) is a case in point. Intermediate—which announced last month that it's branching

out into electrical supplies and trucking—specializes in highly skilled extended-care services, and is seeking to offer these services to any Pennsylvania hospitals planning to add ECF units of their own. The company is controlled by Chairman and President George Leader, who served as an executive with a mortgage company, and then with an aluminum smelter, after completing his tenure as Governor of the Commonwealth in 1959; Governor Leader's wife, Mary Jane, is Administratrix of one of the Leader Nursing Homes; the company treasurer is a former bank examiner for the Keystone State.

Aforementioned Care Centers, for its part, is headed up by President Hamlin Briggs, owner of a general wholesale house in High Point, N.C., until last year, when he went down to Florida to become a full-time operator of the nursing-home business; his right-hand man (now also devoting full time to Care Centers) is the former administrator of Florida's State Nursing Home Licensure and Construction Program. Meanwhile, their new partner, Medic-Home's Mr. Klurman, was a "private investigator" before going into nursing homes.

Elsewhere in the Sunshine State, Sossin System (which went public this month) is run by Michael Sossin, veteran operator of "retirement residences" (of which the company has two) but new to nursing homes; he has been joined by some of his relatives. (Wall Street wags were speculating that the firm might be renamed Four Sossins.) Of these, son Marvin formerly sold industrial fasteners, while brother David is a distributor of auto parts. Still another new nursing-home operator, Electro-Care, changed its name (not its management) last year, from TraileRoyal Park, Inc. Having abandoned the mobile-home business (at a sizable loss), the firm embarked upon its "Renaissance," according to President Marcel Gauthier—by launching development of a "new, low-cost centralized electronic hospital patient monitoring system" and, as a second line, the leased operation of two California ECF hospitals.

DOCTORS AND LAWYERS

To be sure, a number of managements stand out as exceptions. California Health Care, for one, is deep in relevant knowhow at the helm; its top three officers all have had careers in health-care with development and administration going back a decade or more. Continued Care Facilities, for another, is in the hands of a consortium of business-oriented doctors, lawyers and nurses, while Golden State Health Centers is equally well staffed. American Institutional Developers President E. Charles Conway, a consultant and administrator in the health-care field since 1951, has a top real estate legal-eagle as chief aide. Beverly Enterprises is run by a carefully selected management team which combines experience in hospital administration, contracting and corporate development; it was organized and has been headed up since 1963 by a CPA who previously specialized in this field with Arthur Young & Co. and his own accounting firm.

Other industry leaders boast management groups with impressive business credentials, too—but perhaps better-suited to some other line of work. Medicenters, as noted, is run part-time by two acknowledged experts in the field of mass construction, franchising and institutional catering—motel variety, rather than medical—while the company's full-time manager, Vice President John DeCell, is a former U.S. Air Force hospital administrator drafted three years ago by the Holiday Inns people from his civilian job at a mortgage company. Extencicare, one of the industry's three biggest concerns, is managed by a co-founding quartet of crackerjack young lawyers and accountants, not one of whom had been near a nursing home or hospital (except as a patient) until two or three years ago.

Then, too, there's the new and ambitious Geriatric & Medical Centers, headed by a prominent Pennsylvania CPA, which claims useful experience in its Vice President and Administrator (an ex-Army Nurse) and variety, at least in its Executive Vice President-Secretary (and co-founder), who formerly ran Girard Cold Storage Co., a warehousing firm. Not to be overlooked, finally, is the curious management mix at Monterey Nursing Inns, a chain of seven facilities in Ohio and Minnesota. The latter state's operations are run by their veteran administrator and former owner; the remaining units, by his counterpart in the Buckeye State. Overall, though, Monterey is the business of Board Chairman Irving Abramowitz, a Ph.D. and full-time professor at Ohio State University (where he can be reached during business hours), and of President Carl Mellman, a practicing attorney who, at last encounter, was managing corporate affairs from the office of his law firm.

Clearly, top management in the nursing home business, taken as a whole, is a motley group. The same is true at the day-to-day, unit-by-unit, working level. Second-echelon expertise, such as that which Monterey Nursing Inns happily can rely upon, apparently is a commodity almost as scarce as the Rh-negative factor.

Statistics are not available, but the plaint of Extendicare's Mr. Cherry, noted at the outset, echoes throughout the trade. Demands for experienced administrators far exceeds the supply; to make matters worse for the nursing homes, general hospitals usually attract the cream. In consequence, nursing-home companies, from the smallest to the biggest—ironically, industry leaders engaged in the greatest expansion (hence, the most sought-after "growth stocks") are the ones most severely affected—must hire and train recruits wherever they can be found.

DEADLY SERIOUS

On-the-job training is a costly, but deadly serious, activity. American Institutional Developers claims to put every rookie through a one-year course of instruction. "Then we equip him with our nurse's procedure manual, our book on dietary procedures and a number of other policy guides," says Mr. Conway, "and send him out to the facility three months before it's ready to open. He gets to know his business backwards and forwards by the time the first patient arrives."

Extendicare practices a similar technique. "Each of our administrators and assistant administrators is supplied with a complete set of looseleaf volumes which describe all of our systems, policies, procedures and forms," Mr. Cherry told a trade magazine, *Professional Nursing Home*, not long ago. But he adds: "We use looseleaf material because our policies and procedures are constantly evolving as our experience grows."

Most of the others do much the same. Medicenters and Four Seasons run each newly hired unit manager through a period of instruction ranging from three to six months, or longer, and try (once the man is given his post) to keep him abreast of changing procedures. "Like anywhere else," a Medicenters man said recently, "you learn this business from your mistakes, and the top management has to learn it the same way." Another company official remarks wryly, "You might say it was like the blind leading the blind around here for a while."

Whether such headaches eventually can be cured remains to be seen. Industry leaders, of course, are confident. "One of our ablest administrators," Four Seasons President Jack Clark likes to say, "is a former bakery foreman." And at Medicenters, in Memphis, a spokesman recalls that "the best one I've run into used to operate a filling station." Nevertheless, some of the evidence to date leaves room for doubt. From pumping gas or selling auto parts to administering a 100-bed extensive-care facility—or managing a string of dozens of them—seems, at least to some observers, a long stretch indeed.

The recent trouble in Memphis, and in quite a few other places, makes plain that turning a profit in nursing homes is not quite as easy as falling out of bed. A number of peculiar factors—and some by no means mysterious—go into the plotting of those profit-and-loss charts.

BARRON'S, March 3, 1969

LONG BED REST?

Some Areas Have More Nursing Homes Than They Need

This is the third in a series of articles on public ownership in nursing homes. Initially slated to run in three parts, the report has been expanded to four, in order to cover additional developments within reasonable limits of space. Articles I and II, on the promise and performance of leading companies, appeared in Barron's, February 10 ("Unhealthy Growth?") and February 24 ("No Tired Blood"). The fourth installment will conclude with an examination of the industry's outlook.

BY J. RICHARD ELLIOTT, JR.

MILWAUKEE—The family of Joseph Paliافتو doesn't believe in doing things by halves. Mr. Paliافتو, who opened his first nursing home here in 1953, now is chairman of National Health Enterprises, Inc., which owns and operates a chain of such facilities, stretching to Arizona, Texas and Colorado. At the moment, 18

units (housing well over 3,000 beds) are in business or under construction. And Mr. Paliافتo's three sons, who grew up in the business, are running it from the firm's two executive suites—Eastern division headquarters here, Western division base in Phoenix. The clan cut the public in last fall with a 405,000-share offering, but retains 60% of the stock of National Health, which at current over-the-counter levels is worth around \$9 million.

All that would be enough for most families, but for the Paliافتos it's only a beginning. "It is conservatively estimated that more than 500,000 nursing home beds will be required in the next three years," eldest son, Richard, the president, told a local meeting of security analysts last month. "We consider it both a responsibility and an opportunity to help meet this need." Accordingly, National Health, with as much experience in nursing homes as anyone else—and far more than most—is staking out "a not unreasonable 10%" of what it regards as the potential market. The company has set for itself a three-to-five year goal of 50,000 beds—specifically, as President Paliافتo told a reporter the other day, 480 homes (to be built or acquired) with an average 104 beds apiece. National Health, in short, plans to expand some sixteenfold by sometime in the early Seventies. "This business will have its General Motors, Ford and Chrysler," the younger Paliافتo shrugs. "Better us than somebody else."

THE ECF EPIDEMIC

Nobody else has set his sights quite so high as yet—at least, not in public—but National Health is far from unique in its enthusiasm. For nobody in the nursing home business (publicly held or planning to be) has any thoughts of peacefully retiring on present assets: Since Medicare and Medicaid changed the rules two years ago, the name of this game is expansion. Whether the demand for extended-care facilities (ECFs) and other types of convalescent homes is visualized as a half-million new beds by 1972—or as some number considerably less staggering—the biggest, best-promoted and most ambitious concerns in this suddenly go-go-growth industry all are scheming to add new units by the scores and hundreds, literally as fast as the money can be found. "They see ECF beds in their sleep," a trade observer noted recently, "the way other people count sheep."

Such sweet dreams, however, may be followed by some bitter mornings after. One headache, of course, is the record high cost of money today. For most firms, to be sure, equity capital has come cheap (owing to those high multiple over both earnings and book value), but there's a limit to how much of his business anyone wants to give up. Construction loans and funded debt remain necessary burdens, which means increasingly sizable fixed charges. (The SEC now requires companies to list a schedule of maturities in every prospectus.) The big expanding firms, nonetheless, are undaunted. Medicenters of America, with plans for a total 13,000-bed capacity on the ground or under construction by this time next year, has gone to the stock market twice in three years; though it has relatively easy access to construction funds, the firm has taken up around \$10 million in long-term debt (at last report) besides.

OFFERING THE KICKER

Hy-Lond Enterprises and Extendicare, meanwhile, have decided to go the convertible-debt route. (The former's offering, scheduled for May, has not been made public yet.) Extendicare, which is on the record with plans to more than double the present chain of 21 EC facilities (nearly 3,000 beds), operating or under construction, by another 27 health-care centers within a year or so, has boosted its long-term debt from \$3 million to some \$17 million in less than a year. In addition, the firm recently filed for registration a unit-issue of 140,000 shares of common plus \$7 million worth of convertible debentures. Beverly Enterprises, for its part, will jump operations from last year-end's 2,500 beds to around 6,000 by December. Roy Christensen, president, told a group of New York analysts recently that "several insurance companies" had been talking in terms of a \$15 million long-term financing, presumably including an equity kicker of some kind.

American Institutional Developers is no piker on this score. The company—incidentally, with only about 200,000 shares of stock in public hands—is in process of adding to its 11 existing facilities (over 1,500 beds) more than a score of new units (with at least 3,000 more beds) before the year is out. It recently negotiated a \$10 million long-term first-mortgage commitment with the

CNA Group (Continental Assurance). "When we go through the \$10 million," Mr. Conway reports, "I daresay we'll have another \$10 million waiting for us after that." The chances are good, surely, since as part of the package A.I.D. sold Continental \$3 million of convertible debentures.

OUT OF SEASONS

Such expensive but more-or-less routine examples pale before the most imaginative financing scheme to date. Certainly the most intricate, it was dreamed up by Four Seasons Nursing Centers. At last count, the Oklahoma firm had 14 units in operation and another 20 in construction or under development (total overall capacity: 4,200 beds), not to mention a whopping three-year program involving some 20,000 beds all told. Until now, Four Seasons had been enlisting local doctors and other investors at each new site, to provide the capital as 50% to 70% partners in individual units; Four Seasons itself meanwhile has been pocketing the construction profits. The new financing plan is a sophisticated and far more systematic extension of the old. What's more, it promises to raise \$30 million in one fell swoop.

Last week, then, came a public offering (underwritten by Walston & Co.) of 545,000 shares of common stock, at \$11 per share, in a new outfit: Four Seasons Equity Corp. Ostensibly independent of the Amex-listed mother firm, it will own 70% (Four Seasons Nursing, the other 30%) of a third company, called FSN Corp., which in turn will be "owner" of all the new nursing homes Four Seasons will build (and manage, for a 7% of gross revenues fee). The point is that "10 financial institutions and a private investor" have agreed to provide (along with Four Seasons' three original promoters and four newcomers, who are "promoters" of the Equity Corp.) a total of \$2 million in equity capital and \$22.5 million in long-term financing to the corporate offshoots. The kickers, as well as the carrying charges, won't burden the original company at all.

At any rate, that's the plan. Insiders have subscribed in all to 40,000 shares of Four Seasons Equity (at \$11), with warrants for 40,000 more, and another 30,000 shares of a nonvoting issue; in addition, they'll take \$3 million of unsecured subordinated notes on FSN Corp., Four Seasons Equity's 70%-held subsidiary. The 11 well-heeled outsiders will purchase 135,000 shares of the new common (also getting 195,000 warrants), plus \$714,000 of 6½% junior subordinated convertible bonds. Atop that, moreover, the latter will buy \$19.5 million of first mortgage notes on FSN; which will bear interest at 7½%—when FSN's properties begin to yield it. The public, finally, is to put up roughly \$6 million for the remaining stock of Four Seasons Equity Corp. (Last Friday, the first day of trading over-the-counter, the new issued tripled in price.)

These new shareholders, of course, will have no call on Four Seasons Nursing Centers' corporate income—the construction profits, that off-the-top 7% fee and any future dividends on its 30% equity in FSN—but they will share in the 70% chunk which their company owns of what's left-over in FSN. As for the old stockholders in Four Seasons Nursing Centers Inc., they can look forward to a construction bonanza with none of the debt charges—as long as there are nursing homes waiting to be built—but also at the price of most of the equity in the latter. Some distant day, presumably, the listed company will settle down to a nice steady income from its fees and perhaps even from its 30% holding. That hinges on whether and when the nursing homes are operating at a profit. Last year, it might be noted, the only two units in which Four Seasons Nursing Centers holds a majority ownership managed to clear from operations (before any corporate expenses) about three cents each per share of Four Seasons stock. That works out to 3/100ths of a penny per bed. Multiplied by 20,000? The mind boggles.

"LITTLE UTILITIES"

So much for the cost of money. High though it may be, one way or another, nursing home companies (like any other) have been going public essentially to raise such growth capital on the best terms possible. Hence, if that were all they had to worry about, they'd be well on the way to carefree health—for the basic economics of the nursing home business, according to reputable authorities on every hand, would appear to provide a kind of magic potion that ensures prosperity. One well-known investment banker, quoted in a leading business journal, compares nursing homes to "little utilities." Each, the magazine reports, has "a monopoly in its locality."

Life, however, is never quite that trouble-free, and the nursing home business, on closer examination, is no exception. As it happens, the all but mindless expansion by the industry seems virtually an invitation to pain, self-inflicted. No one can say with certainty (despite expressions to the contrary) exactly how many extended-care beds may have been needed to fill demand on a nationwide basis; such statistics simply are not available. On a local basis, however, some careful calculations are possible in any given market, and a number have been made.

Typical of those available at present is a study released two years ago—taking the potential impact of Medicare into account—on “Nursing Home Needs, 1966–1975, in the Philadelphia-South Jersey Metropolitan Area.” It was prepared by the Hospital Survey Committee (a non-profit corporation), which is chaired by the president of Smith Kline & French and boasts a board of directors that reads like a Who’s Who of finance, medicine and civic affairs in the Philadelphia area. Its conclusions are even more fascinating for being slightly out-of-date.

“By the end of 1966,” the committee projected, “11,758 nursing home beds will be available, representing an expansion of 20% in the last 18 months. Present plans call for an additional 4,414 beds to start construction in 1966. In the period 1967 to 1970, there were reported proposals for facilities containing an additional 5,000 beds. The resulting total . . . would more than double the number of beds available for service as of January 1, 1966. Currently, 100 additional nursing home beds open in this metropolitan area every three weeks.” (Over the period since the report was released, it should be noted, each of these figures has increased.)

The Philadelphia study group minced no words in presenting a Plan of Action based on these findings.

“We estimate that no more than 3,048 additional nursing home beds are needed in the next decade—8,000 less than the number proposed at the present time. Uncoordinated construction in the nursing home field by inexperienced parties can have no other effect than the flooding of this area with unneeded nursing home facilities and beds. This will adversely affect the cost of nursing-home care, it will increase the presently acute shortage of professional and technical personnel in the health field, and could eventually result in a further deterioration of nursing home care.”

In stating its case, the committee concluded: “Construction of nursing home facilities should be based upon community need.” Yet it discovered that its own community, prior to the expansion program outlined above, actually suffered a glut of beds. “The occupancy rate for all nursing homes in this metropolitan area was 86.8% in 1965, in contrast to a minimum of 90% occupancy deemed desirable for this type of facility by experts in the field.” Medicare, it seems, having changed the Philadelphia glut to scarcity, soon led to a further—and far greater—excess of capacity.

UNHEALTHY GROWTH?

If it can happen in the City of Brotherly Love, it can happen anywhere. The evidence, indeed, suggests that while much of the industry’s current growth undoubtedly is well-founded, many a headache may be in store for builders and acquisition-minded alike. That’s true, moreover, despite the fact that every leading firm undertakes extensive research—feasibility studies for new areas, audits and the like for existing properties—in order to get a good look at a given market situation before making the leap. So much leaping happens to be going on, however, that some inspections apparently are cursory at best, and deals are prompted less by caution than by impatient, aggressive acquisitiveness. In nursing homes today, it seems, nearly everybody wants to be first—and biggest—on the block.

There are exceptions to be sure. Sossin Systems, for one example, has just two units in Miami and claims no such ambitions. “You have to plan for growth in this business,” a man close to the company admitted recently, “and the only way to grow is by adding beds. After all, one nursing home by itself, fully occupied, is worth no more than 10 times earnings.” Nevertheless, Sossin’s forward planning is conservative by industry standards. “They looked over an established home in Florida,” according to this source, “decided it would be fully occupied for at least 10 years, offered no potential for further growth, and ruled it out.” Nor is Sossin likely to search beyond its own back yard. “They know they’d be foolish to go out, say, to Butte, Mont., and pick up a unit or build one.”

he adds. "Their strength is in the depth of their knowledge of the Miami area market. They'd have to buy that experience anywhere else, and that's like buying a pig in a poke."

THE WHAT-WHERE FACTOR

Most firms, however, are doing exactly that. Generally, the publicly owned concerns have been expanding via new construction rather than acquisitions, in order to get just what they want, where they want it—at the cost of time lost to planning, development, building and start-up operations. None will pass up what they regard as a good opportunity in an existing plant, though. National Health, for example, last fall acquired its seven Western units for the equivalent of \$9.8 million (including debt assumption), or roughly \$9,000 per bed, even though its own construction outlays average \$7,500 per bed, "because it would have cost as much," Mr. Paliafito says, "to build, equip and establish them operationally in those markets."

Similarly, Beverly Enterprises keeps an open mind, having added facilities to its expanding California-based chain through acquisitions as well as construction, at around \$8,000 per bed either way. Extencicare, planning to build, "something like six to 10 new units a year," won't hesitate to shell out \$8,000 per bed for existing units, such as the five (in Arkansas and Tennessee) it picked up late last year, or even \$8,750 per bed as it did for 14 units in San Francisco. And fast-growing United Convalescent Hospitals has been both buying and building up and down the West Coast, and as far East as Florida, at slightly lower average costs.

Typically, the leading firms prefer to design their own units from scratch. American Institutional Developers, while looking over dozens of possible acquisition deals every month—it passed up the proffered takeover of a well-located multi-story ECF under construction in New Jersey, for instance, after determining that the private investors were paying over \$10,000 per bed to build it—keeps several draftsmen busy working up blueprints for its own units. Thanks to central purchasing of 60% of the materials and equipment, Mr. Conway claims A.I.D. holds total costs (excluding real estate) to an average of \$6,400 per bed. A.I.D. assembles the real estate first, then designs a building to fit it.

GOING UP?

Extencicare, for its part, maintains a file of ready-to-use designs for plots of every size and shape. According to an executive of the Louisville firm, a typical floor plan calls for 124 beds in a cross-shaped structure; "we prefer a one-story building," he adds, "to spare the inconvenience and cost of elevators." Medicenters also builds from set designs which in appearance are not unlike those for Holiday Inns motels—but its preference is for multi-story construction. "For the convenience of doctors and our personnel, an ECF must be as near as possible to the hospital with which it's affiliated," an aide explains. "That kind of land isn't cheap, so the economics generally point to vertical rather than horizontal space."

Indeed, one revolutionary space-saver concept which the Memphis company has come up with, and now is actively promoting, is the "Medicenter-Auto-center." On a leased portion of a general hospital's parking lot (typically 35,000 square feet), Medicenters will construct a combination multi-story parking garage and extended-care facility, with the latter—in the firm's standard L-shaped design—perched atop the structure. It can be connected to the main hospital by tunnel or elevated walkway.

Four Seasons is the firm which has pushed the single-blueprint concept furthest. The Oklahoma concern builds no type other than its 100-bed, X-shaped model—one wing usually set aside for ECF patients, the other three devoted to traditional nursing home care. Where the market permits, it alters the plan only by doubling it, placing an identical second story on top of the ground floor. Because of this ultra-simplified engineering and architectural operation, the mass-volume purchasing it permits and the largely trouble-free period of actual construction ("the same people build the same building over and over again," points out Vice President Tom Gray), Four Seasons manages to get by with the industry's lowest costs: some \$6,000 per bed.

At the same time, however, the rigid requirements of the Four Seasons design can cause a few headaches in real estate acquisition. The X-structure needs

a minimum lot of 90,000 square feet—300 x 300 (325-ft. depth, to handle parking, if the building is two-story)—no easy parcel to obtain in most downtown areas near hospitals. "So we don't go that route," says Mr. Gray. "We'd rather build our homes out in the country, or at least in the suburbs, where the doctors live."

NATURE'S CALL

Deciding what to build, of course, is the least of a nursing home operator's expansion headaches; where to build it, obviously, is the key. In this regard, site location within the selected market has become more than just a matter of taste (or real estate prices). Four Seasons, as noted, likes to put a unit out where not only doctors have their residences but the living is easy for patients as well. "Looking at lovely scenery through your bedroom window and being able to stroll around landscaped grounds in the country air can do wonders for the recuperating patient," Mr. Gray believes. (The Four Seasons Nursing Center in home-town Oklahoma City, ironically, looks out on an auto junkyard.)

But Extendicare, like many another firm, prefers to compromise between cost and convenience by usually building somewhere between the hospital and "where the doctors live," the precise site depending on local realty market opportunities. American Institutional's Mr. Conway, however, like Medicenters, feels competitive (or at least potentially competitive) pressure forces the choice of a site as near the hospital as possible. "A doctor isn't going to transfer his convalescing patients out of the hospital and down the street a mile or two, if he has to look in on them once or twice a day," insists the Philadelphian, a long-time consultant in this field. "You've got to be right there where the action is, if you expect to get your share of it."

KNOWING THE TERRITORY

Beyond such local considerations, finally, is the major problem of site selection by geographical territories. The aforementioned feasibility studies, which attempt to estimate market potential based on available state and local hospital records as well as population factors, generally apply standard rules-of-thumb. A new facility intended to specialize in extended-care (with Medicare approval) must first, of course, gain binding affiliation with a licensed hospital—and hope that a fair-sized chunk of that institution's case load will wind up in the new unit's beds.

More vital for the facility's long-term viability, however, is the area's population mix. Within a radius of 15 to 20 miles (and, to be practical, a far shorter one in suburban or urban locales)—the maximum distance relatives and friends can be expected to travel on visits—roughly five of every 1,000 persons over 65 are assumed to represent patients for a nursing home. That means a new 100-bed facility must be able to count 20,000 graying heads for which nursing home pillows are not presently available in the chosen market.

Clearly, some knowledge of what the competition is up to in the market becomes essential. Not only may homes already on the scene be planning expansion of their own, but general and acute hospitals themselves increasingly are adding ECF or convalescent-care annexes (at competitive rates); moreover, every other nationally ambitious nursing home company (particularly the publicly held) can be assumed to be checking out the territory, too, and may have gotten there first. (The basic cause of the trouble Medicenters of Memphis encountered, as recalled last week, was that 450 new beds suddenly were put in place by hospitals in the area, playing hob with the calculations and forcing the new ECF to fill up with other types of nursing home patients.)

IN CLUSTERS

In addition, to ease operating headaches, the company needs to think about throwing up not merely one but at least three units in the general market area. Otherwise, experienced operators say, efficient administration (including day-to-day supervisory controls) may be jeopardized. "We won't expand into any but so-called cluster operations," National Health's Mr. Paliavito states, "That means three to five homes under a central manager and within his easy access." Most of the big-money expansion firms agree; Four Seasons, indeed, now appraises new markets only in terms of such multiple possibilities.

A number of others, however, are scattering their chips—on the theory that unit efficiency can be compromised at least temporarily, for the sake of gaining

a beachhead in new territory. Thus, Heritage Nursing Centers (now in registration), while soundly based in Minnesota, has stuck lonely units in places as remote as Michigan, Arizona and Florida, and has plans for another in Ohio. Even highly regarded United Convalescent, with profitable "clusters" in California and Florida, has been planting solitary offshoots in Kansas, Utah, Missouri and Texas. And Unicare Health Services, like National Health a Milwaukee-based operation, also has jumped into Texas with a single unit.

In any case, once the new nursing home opens its doors for business, the chips are on the line: all the projections of market potential must be borne out by gradual, but steady, increments of occupancy, until some 65%-75% of the beds—generally the breakeven point—have been filled. Allotted time: 18 months. After that, 90% of capacity should be attained within another year or two; if not, the headaches will begin to set in. (Absolute 100% occupancy, though often bandied about in the business, actually is an impossibility; up to 5% of the total beds must be kept open to accommodate unpredictable of the case load—men and women in separate rooms, for example, and ECF capacity available for Medicare transfers at all times.

GETTING THE BUSINESS

Getting the business, industry experts all seem to agree, is no problem. "It's not like building a hotel in the Virgin Islands," one sage analyst was quoted recently. "You don't have to worry about filling it up." The aforementioned Philadelphia story, however, belies such unqualified optimism. Indeed, rumors persist that a number of other major urban markets are close to nursing home saturation too. "No more big cities for us," states Mr. Paliapito of National Health, whose highly profitable Milwaukee centers one day may feel the pinch of some aggressive current expansion by competitors. A.I.D. President Conway, as noted at the outset, sees the possibility of head-to-head competition beginning to emerge in at least one of his company's-staked-out territories.

To be sure, no publicly held nursing homes seem to be in any serious trouble as yet. "But a number of new ones built by private investor groups have foundered," according to Tom Gray of Four Seasons. The closest call, as it happens, appears to have come at one of Four Seasons' own early ventures—a unit in Kansas which, Mr. Gray recalls, was built on the strength of a feasibility study not terribly reassuring. "It took forever just to fill up about 60% of the beds," he said recently, "and that included every last possible patient within a radius of 15 miles or more. The whole thing was much too close for comfort." Four Seasons since has bailed out of that one (at a profit), and none of the rest in the big chain appear in any danger.

Nevertheless, some other publicly held facilities have begun to reveal distressing symptoms of oversupply. Professional Nursing Homes of America (which went public last week) operates eight centers in five states, of which two show declining occupancy ratios. A unit in Houston, opened one year ago, at last report was down to 62% occupancy from 79% six months earlier. Another, in Salina, Kan. (open since 1966), had dropped to 72% from 85%—even though it holds only 38 beds.

American Medical Affiliates, expecting its offer of 350,000 shares to go public soon, also is having problems. Of the eight convalescent homes which the firm has (or has contracted to take over, after the offering), three show declines in licensed-bed occupancy. One, in Bridgeton, N.J., was off slightly to 88.1% at last report, from a peak of 91.8%. A second, in Greenbelt, Md. had fallen to 75.5%. And the third, in Winter Haven, Fla.—which, by the way, opened for business back in 1964—had slipped from a 1966 high of 85.3% to 61.9%. (Only one of the three actually ran in the red last year, on a pre-tax basis.)

Still another such case in point, finally, is Hillhaven. This Tacoma, Wash.-based operator of 30 nursing homes (stretching across the country) went public last December. "Due to the age of many of the company's facilities," the prospectus cautioned, "obsolescence may be a factor requiring replacement or improvement of certain present facilities . . ." Of the 30—most of which have been operating for at least five years (the oldest was opened in 1956)—fully 18 were below 90% in occupancy at last report, and seven of those were at 80% or less. Moreover, a number showed sharp declines from the levels of a year earlier.

"The overall combined occupancy for all the company's facilities for the five-month period ended August 31, 1968, was 81.72%," Hillhaven noted when it sold its stock, "as compared to an occupancy rate of 84.27% for the comparable period

in 1967." Through the months of September and October, moreover, the rate continued to slip—to a combined 79.2%. Explained the firm: the slippage "is due in part to the general trend toward more rapid patient turnover resulting from the shorter stay of convalescing patients (covered under the Medicare program or on private status) transferred from acute hospitals . . ."

The industry's expansion orgy, in short, is beginning to cause some heads to throb. Of course, Medicare (with Medicaid) is supposed to fill the beds, encourage the building of hundreds of thousands more—and pay all the bills. That, at least, was the original prescription. The record, however—as will be further reported here—suggests that Uncle Sam's shot-in-the-arm is proving to be no panacea for nursing homes.

BARRON'S, March 17, 1969.

WARDS OF THE STATE?

Healthy Growth in Nursing Homes Calls for Intensive Care

This is the fourth and final article of a series on public ownership of nursing homes. Earlier installments appeared in the issues of February 10, February 24 and March 3.

BY J. RICHARD ELLIOTT, JR.

BALTIMORE—During the latter half of 1966, the Social Security Administration—so sprawling a branch of the federal bureaucracy that it had been transplanted, long before, to the desolate outskirts of this city, 30 miles from Washington—was in the throes of extraordinary growth, the likes of which even Parkinson's Law could not have foreseen. The reason was Medicare. Just two months after President Johnson's Health Insurance for the Aged Act took effect, on July 1 (as Title 18 of the amended Social Security Act), Medicare patient No. 1,000,000 already was being processed into a U.S. hospital, and nearly 20 million additional senior citizens were, in effect, awaiting admission. On January 1, 1967, moreover, the so-called extended-care provisions of Title 18 were slated to become effective, meaning that another vast quantity of tape (both medical and red) would begin unwinding as Medicare gained access to the nation's nursing homes.

NOT FOR EVERYONE

Commissioner Robert M. Ball and his men in white were ready, however, for anything. "With our eye on the deadline, we and the state agencies are moving ahead rapidly to certify eligible extended-care facilities," he told a Chicago convention of the American Hospital Association late that summer. "Of course, a sizable proportion of the homes . . . will not meet the quality standards of the program (which) is designed, not for the custodial cases often cared for in the nursing homes, but for the recently hospitalized individual who continues to need full-time skilled nursing home care for a relatively short duration."

By November, when Mr. Ball trekked out to Fort Worth to brief the Texas Nursing Home Association (and thereby the whole trade) on how the new program would work—"It is a pleasure after all these months to be able to tell you exactly what the reimbursement formula will be under Medicare"—he also was able to make an essential formulation of his earlier, and rather more fundamental, point. "I suppose," said the commissioner, "that as a result of the qualifying conditions and the relatively short duration of the benefit, Medicare will not be paying for more than a fourth of the skilled nursing home beds in the country at any one time."

UNDER THE COVERS

All this is worth recalling today, because, for once, a federal forecaster apparently has turned out to be infallible. Despite the go-slow signs extended-care benefits under Medicare were being hailed then, and are being hailed now, as a shot in the arm for the nearly 20,000 nursing homes in operation or under construction—making up some 750,000 to 900,000 beds—and, indeed, as the seed of life for thousands yet unborn. At latest official count, however, no more than 4,850 homes have qualified, with a total ECF capacity of around 335,000 beds: the latter, in turn, are occupied by Medicare patients only part of the time. (According

to an SSA spokesman, indeed, over 240 once-certified nursing homes, with nearly 12,000 beds, voluntarily have pulled out of the program.) In short, while Medicare clearly has supplied the industry with some fresh linen, it scarcely has furnished blanket coverage.

What's more, even for those facilities on the federal payroll, Uncle Sam's billion-dollar insurance policy appears to be something less than a security blanket. For one thing, that magic formula proclaimed by Commissioner Ball two-and-a-half years ago is still far from precise in its application. Payments are, of course, being made to extended-care facilities—a recent tally indicated that Medicare reimbursements (exclusive of hospital and doctor claims) are running at a monthly rate approaching \$25 million—but are subject to audit and possible rebate. Cost items ranging from depreciation to franchise expenses are under scrutiny. Yet reserves against possible refunds to the government are scanty or non-existent.

HELP OR HEADACHE?

It's safe to say that administrative uncertainties leave many a nursing home P&L sheet up in the air. Other aspects of government support make Medicare a wobbly crutch as well. Inevitable red tape, for example, has snarled the machinery, delaying reimbursements and causing other snafus. The whole procedure—again, perhaps inevitably—has brought private nursing homes to the brink of that dubious status accorded public institutions: ECF, if not yet a utility, is the newest federally regulated industry.

In many respects, ECF operators already do far more paperwork for Washington (not to mention state and local agencies) than they do for themselves. Typically, one large nursing-home chain reports that while just 25% of its bed capacity (providing a mere 15% of total revenues) has been certified for Medicare, it is being permitted to charge 40% of overall administrative overhead to Uncle Sam. Despite its high costs, however, Medicare pays less per bed in an established, first-class facility than the private market.

Finally, Medicare's sister subsidy Medicaid (specifically, Title 19 of the Social Security Act)—which provides matching federal funds to states with a qualifying plan of medical assistance for the indigent (and "medically needy")—leaves, in most of the 44 states having adopted it, even more to be desired. Like Medicare, Medicaid reimburses nursing homes on essentially a cost-plus basis, but the rates often are so piddling as to be unprofitable. Since long-staying welfare patients don't run up "extended care" costs, the picking here start out slim; moreover, unlike Medicare, a maximum daily rate is fixed. Nevertheless, both programs have swollen in total cost far beyond original budgetary estimates, drawing fire—including threats of cutbacks—from critics in state houses and on Capitol Hill alike.

ARMS OF THE LAW.

Rather than a shot in the arm for nursing homes, then, Medicare could prove to be a shot in the head; Medicaid, in turn, offers scant relief. Congress, however, never intended either measure to provide a bonanza for private industry; the history of evolving socialized medicine in America has had as its aim the construction and financing of public (or at least non-profit) institutional capacity. Both Titles 18 and 19 of the 1965 legislation, while taking Uncle further into the medical business in two giant strides, trace their political genesis to the earliest days of the New Deal.

The first tentative steps were taken during the Depression. In 1933-35, the Federal Emergency Relief Administration provided funds to the states for medical expenses of the indigent unemployed. The Social Security Act of 1935, among other things then permanently institutionalized this "categorical" system of public health assistance. And subsequent amendments progressively have broadened and boosted the coverage: in 1950, the principle of "direct vendor payments" (to doctors and hospitals, rather than to patients) became law; in 1956, that of federal "matching grants" to the states.

Under the Kerr-Mills bill passed by Congress in 1960, Washington adopted the idea of public responsibility for the aged. Kerr-Mills provided a maximum \$15 monthly payment per patient to the states, for patients (whether indigent or not) of 65 and older. It also authorized the reimbursement of from 50% to 80% of the costs run up by any state establishing a program of bill-paying for all aged persons categorized as "medically needy." When Kerr-Mills turned out

to be lopsided in practice—state eligibility tests were unequally restrictive and “rich” states were getting more than “poor” ones—the drums began to beat along the Potomac for Medicare and Medicaid.

IT'S STILL WHERE YOU ARE

In brief, here is what's now on the books. Medicaid—Title 19, which actually was first to become effective, on January 1, 1966—liberalizes Kerr-Mills and its precedents by parceling out more cash to the states on a to-each-according-to-its-needs basis and by standardizing the eligibility tests which determine who's indigent or medically needy. Thus, federal matching funds now run from 50% to 83%, varying inversely according to a state's per capita income; the ceiling above which no patient is regarded as needy is 133% of the existing state welfare level (as set by the Aid to Families with Dependent Children, or AFDC, program).

Of the 50 states, 44 will have an approved Medicaid plan in effect by mid-1969. The six laggards, put off by both economic considerations and the severe civil-rights provisions of the new law, are Alabama, Arkansas, Florida, Indiana, Mississippi and North Carolina; pressures to get something enacted before Medicaid's cut-off date of January 1, 1970, are building in all these capitals, particularly Tallahassee and Little Rock. Even without them, however, Medicaid's costs have gone nowhere but up. Against the \$1.36 billion total of federally assisted medical vendor payments in 1965, the last pre-Medicaid year, the total reached \$2.77 billion in 1967, of which \$2.47 billion was Medicaid (and \$1.22 billion Uncle Sam's share of it). Estimates for fiscal 1968 are \$3.56 billion, and for '69, \$4.38 billion, of which Washington will have paid half—or twice as much as the whole scheme cost both federal and state governments just three years ago.

NOT THE HALF OF IT

Meanwhile, Title 18, which already is costing the U.S. something over \$5 billion a year—the nursing home industry's slice of that melon currently runs to about 5%—sets the cost-reimbursement standards on which both programs are based. The Medicare formula provides a 1½% premium over “reasonable costs” (both operating and overhead, including accelerated depreciation, but excluding interest)—with, as yet, no prescribed limit such as the per-diem maximum required under Medicaid; hence, in theory, a new nursing home fully staffed but with a single patient can charge everything off to Medicare even if the resulting “patient rate” is astronomical. (In practice, Blue Cross, which serves as administrator for the program, says no-no to fantasies as far-fetched as that.)

In addition, Medicare authorizes a return on equity of 7½% at present (the return is variable administratively), but this is based on net equity; hence, a year-old facility identical to a brand-new one will draw less, owing to depreciation. Finally, the Medicare provision covers a patient only if he is admitted to the home within two weeks of being discharged from a hospital (where he must have been a patient for at least three days); the coverage runs to a maximum of 100 days for each “spell” of illness, with Medicare paying the full tab for the first 20 and the patient picking up the first \$5.50 per day over the remaining 80. (Medicaid imposes no time limits.) To qualify at all, of course, a nursing home must be certified by Social Security as an Extended Care Facility, meeting stipulated requirements governing staff (registered nurses, on a fixed per-patient formula, around the clock), dietary procedures and equipment.

So much for the laws. What kind of support are they providing for the industry? Let's look at Medicaid first. As indicated, the federal-state plans vary from one state to the next. According to the American Nursing Home Association, the lowest average public assistance payments (as of January 1, 1968) were made under Florida's non-Medicaid program: \$95.17 per patient per month, or barely \$3.25 a day. (The Sunshine State's maximum monthly rate is \$100.) Highest, on a statewide basis, is Hawaii, with an average of \$461.70 per month (and, uniquely, no stated maximum). New York State, however, divides itself into regions, and while the maximum in the western counties runs to \$387 per month, the top payment in New York City ranges up to a whopping \$1,337 monthly.

Other states, like California and Wisconsin, are liberal, too. Thus, in the first-named, companies such as Beverly Enterprises, California Health Centers and

California Medical Centers happily opt for a relatively high proportion of welfare clients. The so-called Medi-Cal plan (which permits costs to be based on a 10% vacancy rate) has a top per diem rate of \$14, within a few dollars of the private rates charged (for semi-private accommodations) by facilities equipped to qualify for the maximum. Similarly, in Wisconsin, where Medicaid payments on "first-class" nursing home beds virtually equal the prevailing private rates at \$16.50 a day, such companies as National Health Enterprises willingly fill up available space with publicly assisted patients. Unicare Health Services, another Milwaukee-based chain, claims nearly full occupancy from this source of revenues alone.

PUBLIC HEALTH . . . OR PRIVATE?

[In percent]

Company	Source of patient revenues medicaid or—		
	Medicare	Other welfare	Private
American Inst. Developers.....	35	-----	65
American Med. Affiliates.....	39	-----	61
Autumn Aegis Nurs. Ctrs.....	15	35	50
Beverly Enterprises ¹	15	50	35
California Health Care ¹	11	69	20
California Medical Ctrs. ¹	7	67	26
Care Centers.....	14	54	32
Care Corporation.....	10	35	55
Continental Care Centers.....	3	47	50
Convulariums of America ¹	17	30	53
Convalescent Care Centers.....	16	28	56
Convalescent Nursing Ctrs.....	5	75	20
Extendicare ¹	23	48	29
Four Seasons Nurs. Ctrs.....	25	35	40
Geriatric & Medical Ctrs.....	63	-----	37
Golden State Health Ctrs. ¹	15	70	15
Heritage Nursing Centers.....	11	57	32
Hillhaven, Inc.....	32	13	55
Huntington Health Svcs. ¹	37	15	48
Intermediate Nurs. Ctrs.....	35	-----	65
Medicenters of America.....	75	-----	25
Medic-Home.....	33	30	37
Metrocare Enterprises ¹	12	48	40
Monterey Nursing Inns.....	12	49	39
Natl. Health Enterprises.....	20	33	47
Professional Nurs. Homes.....	32	-----	68
Sossin System.....	70	-----	30
Unicare Health Services.....	5	90	5
United Convalescent Hosps.....	50	-----	50

¹ Heavy concentration of California facilities, eligible for "Medi-Cal" program.

Elsewhere, though, Medicaid is something else again. "Twenty-five states," ANHA noted in a recent report, "still averaged \$200 or less per month in 1968. . . ." That's less than \$7 a day, and well below the going rate for semi-private accommodations in good nursing homes anywhere in the country. Accordingly, any multi-facility company may find itself doing business in a variety of geographically (and otherwise) related markets, where costs are roughly similar but Medicaid payments vary widely.

Four Seasons Nursing is a case in point. In Texas, the average monthly payment comes to \$246, or \$8.20 a day. (Four Seasons' Vice President Tom Gray says the maximum rates, for which his units qualify, are \$10-\$11 daily, compared with the local Medicare standard of \$14 a day, which in turn is near the company's private rates.) In nearby Colorado (average: \$181 monthly) and home-state Oklahoma (average: \$212 monthly), however, the top Medicaid rates are \$251 a month, or just \$8.30 per diem.

What's more, increases in the payment level—often formulated on a seat-of-the-pants basis—come hard out thataway. Thus, Oklahoma has one in the legislative hopper, to boost the basic rate of \$200 (for "Type I Nursing Homes") to \$240. One state representative, however, asked the state welfare director to justify such a move. "No particular cost analysis were (sic) made prior to establishing the \$200 rate," answered the bureaucrat. "We have made no audits of the nursing home cost." Shot back the legislator: "Then the question arises as to whether the proposed increase . . . is adequate, excessive or insufficient. In fact, with

no cost analysis, or audits, there is a question of whether the present (\$200) rate is equitable."

STEPPING ON TOES

Not least significant is state house pressure to hold the line—even where Medicaid payments seem somewhat out of line and, in several cases, actually to cut back. Thus, California's Medi-Cal plan lately has been under investigation, over charges of misuse of funds. The best example is provided by the Empire State. As restless natives know only too well, New York happens to be the best provider in the welfare business: publicly assisted medical vendor payments rose from 1965's then-record \$220 million, with the advent of Medicaid, to a whopping \$707 million in 1967—28% of the total for the whole country—and last year, by best estimates, the figure doubled again (surpassing total payments of this kind for all 50 states in the final pre-Medicaid year). New York's part of the bill came to \$435 million in 1967, and shot up near \$1 billion in 1968.

Under a Medicaid option, states can include local governments in the cost-sharing if they choose, and New York has adopted such a program. Hence, City Hall as well as Albany now is showing signs of alarm. New York City, which contributes 25% of its own huge Medicaid tab, recently decided to cut professional fees paid by the plan an average 3.6%. The city's Medicaid director, in a speech just last week ostensibly warning the industry against "fiscal myopia," charged that one New York nursing home had been forwarding podiatrist bills to the city of "several thousand dollars a month," merely for "clipping toenails."

ROCKY'S RX

Governor Nelson Rockefeller, of all people, evidently wants to tighten the pursestrings on Medicaid as much as anyone. The welfare-minded chief executive has proposed a slash in state expenditures of no less than 20%. Such a cut, warns New York City's Social Services Commissioner, "may discourage physicians in particular from participating in the program." But a detailed, 120-page report released recently by the federal Advisory Committee on Intergovernmental Relations suggested that padding by physicians has had much to do with the rise in Medicaid's cost. In any event, the commission recommended no overall cutback in federal-state payments, but a redistribution of revenue sources instead; a requirement that patients contribute to Medicaid, a campaign to induce private insurance into assuming a part of the burden and a proposal that the federal government take a larger proportionate share.

The same panel, however, also called for a new kind of reimbursement system for hospitals and nursing homes, one that would be "contingent on their operating under an acceptable standard of management efficiency." That, it seems, could cut the bill nearly as much as Rockefeller's budgetary reduction—and would put the squeeze on health care facilities even more. Whether New York succeeds in reversing the rising trend, or the ACIR report convinces program administrators to tighten standards, remains to be seen. But taxpayers across the country, if not nursing home operators, are taking heart.

If Medicaid subsidies to nursing homes are at least potentially cuttable, like any other item in a swollen government budget, no one in his right mind expects the axe ever to fall on Medicare. In theory at least, Title 18 is no ordinary budget item: after the usual Social Security pattern, it's financed by trust funds. In reality, of course, Medicare has nowhere to go but up, and Uncle Sam no recourse but to foot most of the bill. That would seem to make it an irresistible attraction for nursing homes, yet the program clearly is no bed of roses. Fewer than one home in every four, as noted, has sought and received certification. High-income areas indicate even a lower degree of industry acceptance: in exurban Monmouth County, N.J., for example, just two of more than 30 nursing homes have signed up for the program in the almost three years of its existence.

Then, too, there's that record of nearly 250 homes voluntarily withdrawing from Medicare. "In several cases," an official of SSA explains, "their professional staffs, particularly state-licensed practical nurses (LPNs), didn't meet our specifications, but the homes refused to replace them." More frequent reasons, the official adds, were too strict requirements for medical facilities, too much red tape and too few rewards. "They thought Medicare payments just weren't high enough for all the trouble."

In that connection, the Florida Hospital Association reported not long ago on the first of Dade County's nursing homes to drop out of the program. (Because Sunshine State welfare payments are so low, Medicare would seem to offer reasonable protection against vacancies.) Warning that "somebody may lose his shirt" if current expansion of capacity in the state continues, the administrator of the Venetian Nursing & Convalescent Home told a reporter why his facility has stopped admitting Medicare patients. More and more such patients had been using up their allotted 100-day periods, and then had become welfare patients, suddenly chopping two-thirds or more from the home's per-bed revenue.

The Health Planning Council of Jacksonville, Fla., meanwhile, has issued the results of a survey of Medicare experience in the ECF units of Duval County. "Considering the number of certified beds available in the county, the number of patients discharged and the average length of stay," the council reports, "it appears that there is at present a considerable surplus of Medicare certified ECF beds in Duval County." Ironically, the report noted that just two of the seven ECF homes studied were non-profit, yet these "devoted a smaller proportion of their beds to Medicare patients, compared to the proprietary nursing homes."

SLOW AND EASY?

Most of the profit-oriented ECFs—which includes virtually all of the publicly held nursing home chains—are, indeed, counting heavily on Medicare, but at uncertain costs in time and trouble. Administrative delays in settling accounts is a widely heard complaint. Care Corp., which operates seven ECF centers in the Middle West, derives lower average revenues per bed from Medicare than from private patients, owing in part to lagging payments. Geriatric & Medical Centers, with two units keyed particularly to skilled care for the elderly, is heavily dependent on Medicare, yet finds reimbursement procedures slow and taxing. "Audits are running at least a year behind," says David A. Jones, president of Extendicare, a 4,000-bed chain fully certified for ECF.

At the same time, some nursing homes plainly are cashing in extravagantly at Medicare's expense. "Our revenues average about \$19 per bed per day for semi-private accommodations," explains California's Beverly Enterprises President Roy Christensen. "Outside of the extra services Medicare as well as private patients want and pay for themselves, our payments on Medicare run from \$13.50 to \$18. Yet in our very market, competitive facilities are getting away with as much as \$40 a day from Medicare." (In its first full year with Title 18, Beverly reports that 17% of patient-days were accounted for by Medicare, but only 12.7% of total revenues.)

David Harans, vice president of Baltimore-based Convalescent Care Centers, makes the same point. "Presently, the Medicare reimbursement formula is strictly on a cost-plus basis," he notes. "The more you spend, the more you make. This fosters waste, incompetency and inefficiency. Within a given area, the charges . . . can vary by as much as 50% or more. It is hard to believe that the government will long continue to abet and foster these conditions."

Indeed, Congressional action seems certain. Possibly in the current session, the Act may be amended to modify—perhaps even to replace with a sliding scale, geographically based—the cost-plus formula. The aim would be not to kill Medicare, of course, but finally to clamp a legislated lid on rates.

Government officials are not unaware of such contradictions, but tend to blame the industry's excesses on a reaction to the publicity attending Medicare and the explosive growth of ECFs. "We're very concerned about the prevalence of the idea that here's the place to make an easy buck," an SSA official remarked recently. "The cost-reimbursement formula is one thing. But some operators seem to feel that the government not only will reimburse costs but also keep boosting the cost-plus basis to assure them a profit. They think that the 1½% formula will go up to 2% if necessary, and then higher and higher. Nobody around here has any such thing in mind."

Actually, Medicare administrators are beginning cautiously to move in the other direction—toward some form of incentive system which would reward efficient hospital and nursing home management and penalize the inefficient. "I think the cost-plus 1½% concept ought to be replaced," Four Seasons President Jack Clark, for one, agrees, "by incentive-based reimbursement." Congress specifically authorized experiments along this line in its 1967 amendments to the Social Security

Act, and the first test program is about to be launched in the Connecticut-New York City market area.

Several hundred thousand of the total 19 million Medicare patients will be involved. Participating institutions and physicians have set target costs for a number of routine and controllable services (food, laundry, pharmacy, etc.). If the targets are overshot, the offending facility will be penalized by the loss of its 1½% premium payment. But if costs are held below targeted levels, the savings will be shared, on roughly a 50-50 basis, between government and the contracting institution. "The whole theory," according to SSA Deputy Commissioner Arthur Hess, "is if you want to profit, you've got to be willing to suffer the cost."

SUFFERING AUDITS

Meanwhile, Medicare men now appear to be moving along a broad front in an effort to cut reimbursements directly. Reacting to obvious distortions in the meaning of "reasonable costs," on which claims have been paid with few questions asked, SSA auditors are poring over the books of ECF operators, large and small alike. "We're told the government may want to review every extended-care patient to date, to determine whether they really should have qualified for Medicare in the first place," Extencicare's Mr. Jones noted recently. "Conceivably, some patients would be ruled out, and the ECF facility forced to make retroactive refunds to Uncle Sam while trying to collect from them." Says National Health Enterprises President Richard Paliatito: "We frankly don't know what our reimbursements will amount to after the audits."

Indeed, despite the exactitude with which SSA Commissioner Ball spelled out the reimbursement formula in Texas over two years ago, questions of interpretation and administration abound in Medicare. A fundamental one for many investors concerns the program's concept of profit. Thus, "costs-plus" is widely taken to mean that the "plus" factor—the 1½% premium—represents an earned markup, as in conventional government contracts. Not so. "There is no 'profit' of 1½% of costs," says Thomas M. Tierney, SSA's Director of Health Insurance, "The 1½% is an allowance to take account of costs that are not precisely measurable or specifically recognized in the reimbursement formula." It is, in other words, an allowance to cover contingencies which may or may not be determined to have existed when placed under the scrutiny (and hindsight) of an auditor a year or two later.

PROFIT MOTIVE?

Medicare's stipulated profit is, instead, confined to the approximately 7½% return provided on net invested capital. Here, however, a marked degree of uncertainty plagues the industry. For one thing, only that part of equity deemed applicable to a nursing home's Medicare business may be used. For another, equity is regarded as the net depreciated cost (although an older, fully-depreciated unit is allowed to take a further write-off factor for cost purposes, it provides no basis for the 7½% return); hence, if accelerated depreciation is taken to boost reimbursable costs, the equity and its return are at the same time reduced. To maximize the latter, most publicly held companies are employing a straight-line, 40-year write-off; as it happens, though, most of the same companies claim that the useful (or at least competitive) life of a modern ECF nursing home may not be more than 20 years.

In any case, the provisions bearing on assessment of equity are open to wide-ranging interpretation, too. "The return on equity capital," Mr. Tierney says, "will depend on a number of factors, including, for example, the method that is used to figure the allowance for depreciation." Nevertheless, the major ECF companies appear to be hoping for the best. Four Seasons Nursing, which blocks off one-fourth of each facility's capacity for Medicare patients, and uses a 40-year depreciation schedule, reports in its latest prospectus that its claims are based on a return on equity of approximately 8¼%. "The determination of such Medicare payments is largely discretionary with Medicare authorities under developing administrative concepts," it hastens to add. Extencicare, likewise with about a quarter of its patient-load on Medicare, says in its current prospectus that "the presently indicated annualized return . . . on the net equity" is up to 8.4%. "Such payments are subject to examination," the prospectus then notes.

AFTER THE INTERIM

The fact is that SSA regards all payments made to date as "interim," subject to "adjustments when the audited cost reports and final statements are analyzed." According to Mr. Tierney, "There have been very few audited cost reports submitted to date, and virtually no final statements." Reimbursement of "reasonable costs" and a number of other tentative policies all are "subject to a great deal of further scrutiny and negotiation." The American Nursing Home Association is frankly concerned that a number of ECF reimbursements sooner or later will be audited downward.

Some of the anxieties appear well founded. Thus, apropos of David Jones' comment, Bureau Director Tierney has bridled at implications that "every Medicare patient admitted to an institution that provides skilled nursing services will be eligible for extended care benefits." Says he: "This is by no means the case." With regard to the operating procedure adopted by Four Seasons Nursing, and now imitated by many another concern, Mr. Tierney has scorned inferences "that an institution may select any number of beds which it feels will provide the greatest economic advantage and get that unit certified as a 'distinct part' of an institution to avoid spreading operating costs over the entire patient load." According to the director: "This is not in keeping with the intent of the law or the regulations."

Finally, Mr. Tierney has referred to implications that "any franchise fees or costs, even though computed on the basis of a percentage of gross revenue, are fully covered." The leading franchiser of nursing homes, of course, is Medicenters of America (the Holiday Inns offshoot), and other new firms are following its lead. Coverage of "any franchise fee," however, is "contrary to our position," Mr. Tierney states.

Indeed, a proposed rule change is under consideration which would apply a scalpel, if not the axe, to just such fees. Eliminated from Medicare's category of reasonable costs would be that part of licensing payments "not directly related to patient services." When originally put forward last year, the suggestion elicited a quick reaction from Medicenters' Executive Vice President John A. DeCell. It would apply, if at all, Mr. DeCell said, only to one non-recurring fee charged to Medicenter franchisees and used partly for advertising and promotion. The Social Security Administration, he added, would not "try to pull the rug from under the industry now."

Medicenters is not, of course, the industry—merely a fast-growing (and influential) part of it—but franchised facilities are an even faster-growing part of Medicenters. At present, 15 of the firm's 27 operating units, with 1,600 of the total 3,870 beds, are licensed; by this time next year, no fewer than 60 of a projected 85 facilities (open or under construction), accounting for two-thirds of a total 12,000 beds, are slated to be franchised operations.

Medicenters charges an initial investment of \$5,000 or \$100 per bed (whichever is greater) for a 20-year license to use the name and operating know-how; the franchisee also puts up \$1,500 for a feasibility study and contracts with Medicenters to build the facility (at costs ranging up to \$7,500 per bed). Finally, a "royalty fee" of 3% of gross revenue from room, board and nursing services, plus 1% of gross revenue from ancillary services, is paid monthly to Medicenters "for benefits of affiliation and national publicity."

WHOSE BURDEN?

It's only that first, \$100 per bed fee which Medicenters thinks ought to be affected by any new Medicare limitation. Clearly, however, it's the latter monthly stipend that concerns Social Security; the question is how much of it is directly related to providing ECF services for the patient. At the outset, any new franchised operation needs help from the knowing franchiser. Some time later, presumably, the operator can manage pretty much on his own. Should a patient (or, by extension, Medicare) be required to pay that extra 4% for the privilege of having been admitted to a Medicenter?

The company feels its professional reputation is worth it. Others are less sure. Says Burtell Cutler, president of the New York State Nursing Home Association: "I find it difficult to disagree with the government's position. I think the burden of establishing that a continuing franchise fee payment to an absentee participant is, in fact, related to patient care, should be upon the party trying to justify such a payment."

The "government's position," as it happens, is still undetermined—as it is on most other regulatory matters—but some other chain operations have been or may be affected, too. Though never in Medicenters' league as a franchiser, Extencare launched an identical program last year, sold a franchise, then allowed the plan to languish. Mediatrics, the New York operator which finally went public this month (after having been in SEC registration since 1967), now plans to offer franchising patterned after Medicenters' program—\$100 per bed, plus the 3%-1% royalty—but has granted no licenses to date.

(Mediatrics, which operates five nursing homes, has had all its plans in the deep freeze while awaiting its chance to go public. The firm's original promoter, Philip P. Zipes, was enjoined by New York's Attorney General last May from "engaging in any capacity in the securities business in New York State . . . (and) from acting as chairman of the board or in any other capacity for Mediatrics. . . ." He thereupon resigned as chairman and director, and sold his Mediatrics stock to his sons, who in turn placed it, together with stock of their own, in a two-year voting trust; one son resigned as president, but remains as "director of operations"; the other, elected a vice-president, remains on the board. Trustees of the Zipes family stock, representing 49% of the outstanding shares, are I. David Swawite, the new president, and two other directors.)

PREVENTIVE MEDICINE?

Medicare and Medicaid, then, have given a billion-dollar hypo to the U.S. health market, and a new sense of security to millions of senior citizens, but for nursing homes—despite the hallucinatory effect on Wall Street—the programs look like something of a mixed bag. Of course, the industry's hooked; those dreams of growth and glory would be impossible without Uncle Sam's sugar. What tomorrow may bring is far from clear, yet no one seems unduly worried.

"A substantial portion of the company's revenue was derived from funds provided on behalf of patients under federal, state and local medical assistance programs," points out Beverly Enterprises, in a fairly typical financial-statement note. "(Such) funds," the company goes on to explain, "are subject to audit. . . . Such audits could result in retroactive adjustments of revenue from these programs. . . ." The current prospectus of Extencare adds this comment: "It should be recognized that determination of Medicare payments is largely governed by administrative concepts now developing within the statutory framework and, to that extent, is subject to the discretion of those administering the Medicare program."

And so it goes throughout the literature and ledgers of virtually all the "fevered fifty." What's missing is any protection, beyond verbal assurances, against the possible impact of unfavorable "adjustments." Specifically, as noted earlier, government payments are flowing through the P&L sheets, yet contingency reserves have not been set aside. An indication of the industry's rationale can be found in a recent report issued by the NYSE member firm of Coleman & Co. As part of its warmly enthusiastic recommendation of Medicenters, under the ironical heading "Reserve for Medicare," the following appears in full:

"The company's fiscal 1968 report is based on the departmental method of allocating costs between Medicare and non-Medicare patients. This method is outlined in the Medicare law as being acceptable for cost finding, and suggests that no serious discrepancies will be found when its books are audited for Medicare." There is, in short, no "reserve."

Such affected immunity is epidemic. With rare exceptions, the providers of intensive care don't care to provide much of it on their balance sheets. However, it's not an impossible technique. An exception well worth noting is American Medical Enterprises, the Los Angeles-based operator of hospitals with revenues last year of \$19.8 million (nearly 30% from Medicare). "We do not expect these difficulties to affect (our) operations," President Uranus J. Appel advised shareholders not long ago. "We have been guided from the beginning, long before the advent of Medicare, by establishing conservative accounting guidelines. Today we have reserves of more than \$2 million against contingencies which may arise out of these programs."

Exceptional, too, is the significant fact that American Medical, alone of the "fevered fifty," has put off plans to expand into the ECF business, even though its operations are so closely comparable. "It's a matter of timing," Mr. Appel says. "Some time in the near future, we expect the problems of this new industry

to be solved, and profit formulas to be defined." Needless to add, those who have proceeded him pell-mell into the fray give short shift to this cautious approach.

OUTSIDE THE HOMES

The lack of reserves would seem to leave any nursing home naked as a jay-bird. In lieu of conventional fiscal safeguards, however, there is one interesting and not unrelated development in the industry: corporate diversification. More and more, of late, the publicly held nursing home operators have been setting up some new shelters—away from home. Whatever individual motives may be, the effect of these moves has been to create for some firms a source of revenues and profits outside the actual nitty-gritty operation of convalescent or extended-care centers. Considering the real and potential headaches in nursing homes—and the still sky-high multiples on most nursing-home stocks, suitable for swapping—such a trend could be a tacit admission that the time has come to reach for the bromide.

Whether or not it turns out to be just what the doctor ordered is something else. "This diversification move will substantially add muscle to our existing program of developing and acquiring nursing care centers," announced former Pennsylvania Governor George M. Leader a few weeks ago. Governor Leader, of course, now chief executive of Intermediate Nursing Centers. What did they "muscle" into? Five private companies engaged in the electrical-supply and over-the-road specialty-carrier businesses, that's what.

For an "undisclosed amount" of stock, Intermediate's new acquisitions "will add \$14 million to revenues of the parent company and at the same time contribute to higher dollar earnings of the total entity." (Last year, the nursing centers grossed \$1.3 million and netted \$21,689, or 13 cents a share.) Before it gulped its conglomerate pill and instantly grew tenfold, Intermediate's share were trading at 100 times '68 earnings; last week they were down a half-point to 12½.

So far, most such treatments have not been that far out. In fact, a number of odd bottles in the industry's medicine chest might well be labeled "vertical integration." Thus, several nursing home operators are moving into so-called acute hospitals. Besides being a profitable business in its own right—medical-surgical only, acute hospitals dispense with such general-hospital activities as obstetrics and the costly maternity ward—such facilities also may serve the secondary purpose of supplying recuperating patients for the ECF or convalescent home. Among those gaining admission are Beverly Enterprises, American Institutional Developers and National Health Enterprises.

The last-named, in fact, made a big move last week. National Health announced it had agreed to acquire, for stock worth (at market) some \$45 million, Pacific Coast Medical Enterprises, a California outfit boasting not only three acute hospitals, but also six convalescent facilities, a physical-therapy service, a medical collection agency, a financial-counseling concern (catering to doctors) and a pharmaceutical supply house. Other nursing home operators have similar (if more modest) ambitions to become what some analysts are beginning to call "full-service health-care companies."

Thus, Unicare Health Services has a couple of orphanages, as well as several facilities for the mentally retarded; American Institutional Developers, American Medical Affiliates and Golden State Health all have day-care centers, while A.I.D., California Medical and Huntington operate institutions for the treatment of either psychiatric or alcoholic patients; and Palms of Pasadena, Sossin System, Huntington and Medic-Home Enterprises maintain modern "retirement residences" (which differ, these days, from traditional "old folks' homes" the way resort hotels do from tourist cabins), Medic-Home (as its name may imply) has made a specialty of creating self-care retirement developments, which combine apartments for the elderly with nearby convalescent centers and other handy health services.

Many of these "diversification" activities, of course, don't take the nursing home operator very far away from home; specifically, most such facilities share some of the same problems and are equally dependent on Medicare, Medicaid or other welfare programs. However, they do add new (and in most cases strong) markets. A bit further away is the pharmaceutical and medical-supply field, which, as National Health's current acquisition indicates in part, is one of the more logical, and popular, among the industry's diversifying firms. Unicare, for example, has acquired four Milwaukee pharmacies and a company which

has franchised 15 others in two states; President Joseph J. Zilber says the latter has plans for 100 franchisees in the next two years.

Three of the major firms, moreover, have made the drug scene with even bigger deals. Beverly Enterprises last year acquired Charlotte, N.C.-based Scott Drug Co., largest wholesale distributor in the Southeast (with sales of \$6.6 million, earnings of \$165,000) for 72,720 (pre-split) shares; it followed up with three additional acquisitions, adding eight retail pharmacies in California. Medicenters, for its part, picked up Jax Drugs, Inc., of Jacksonville, Fla., a distributor with operating results almost identical to Scott's; Medicenters created a new Paramedical Supply division around Jax, and on a pooling-of-interests basis was able to upgrade its previously reported fiscal 1968 earnings, thanks to Jax, from 13 cents a share to 21 cents. Finally, United Convalescent Hospitals has acquired Rieger Pharmacies, which operates some 45 discount drug outlets, in Gibson Department Stores, throughout 11 Southern states; Rieger, also a supplier of branded products, is a highly profitable \$10-million-a-year business.

Such moves, it's clear, can bring economies to the nursing home operation—top-rated ECF units not only are volume purchasers of certain drugs and medical supplies, but also feature their own in-house pharmacies—yet their purpose here, just as patently, is to give an immediate and powerful hypo to what might otherwise be (or become) relatively anemic earnings. In that respect, an even more vital contribution is available (and even more logically so) from a source several expanding ECF operators have been quick to tap: the construction business. Autumn Aegis Nursing Centers and Convulariums of America are among the industry newcomers going this route; the way has been shown, however, by the two giants, Four Seasons and Medicenters.

BUILDING BOOMS

To be sure, construction—even of medical facilities in this day and age—is no sure road to profits. The handiest illustration of that fact is a firm called American Medical Building Guild, which went public recently at \$10 a share and promptly dipped a couple of points lower. AMBG's operations consist wholly of "planning, designing and building" medical office buildings, clinics and (according to plans outlined in the prospectus) nursing homes. Unhappily, as the prospectus also points out, "since the company started in business in 1965 it has continuously operated at a loss."

That hasn't been the case with Four Seasons Nursing, which (as noted earlier) now has spun off most of the equity in its rapidly expanding chain, leaving management fees and gross profits from construction as its predominant source of income; the latter already accounted for the vast bulk, amounting from \$2.2 million in 1967 to \$6.5 million last year. As for mighty Medicenters, its Holiday Innkeeping tradition has well served the P&L to date. Construction and building-materials income accounted for 65% of revenues last fiscal year; this year (ending March 31), construction volume was expected to rise to \$500,000, while sales of materials and supplies, according to a company spokesman, may have nearly doubled to \$4 million—around half of total company revenues, yielding on even greater proportion of net.

All well and good, as long as there are nursing homes to build. And particularly while awaiting those promised returns from the completed, occupied and Medicare-subsidized facilities themselves. "If all goes well, it takes three years to get where you're making money in a nursing home," says Medic-Home's enterprising chief, Samuel A. Klurman. "Meantime, the public is looking for earnings."

BEYOND THE PALE

Mr. Klurman, a private investor before helping to organize his growth-minded company nearly five years ago, is an unusually candid man. He likes to tell, for example, about a 160-bed Medic-Home in Virginia Beach in which he discovered that the Medicare case load (33% of the patients) was accounting for 42% of the cost. "The only way we could get a higher reimbursement," he says, "was to drop the certification on some beds. Now 60 are certified for Medicare and 100 are not, so we've concentrated our costs." He hopes that Medicare's policy-makers, and auditors, agree.

But more to the point is Sam Klurman's explanation of what probably ranks as the nursing home industry's farthest-out "diversification move" to date. Earlier this month, for some 43,500 shares of stock, Medic-Home acquired

Freezie Corp. of Atlanta, Ga. Freezie earned \$165,000 last year, on sales of \$2.2 million (and its former owners can double their Medic-Home stock if they double net over the next five years). Freezie makes and sells the machines which turn out a popular kiddie concoction called, more or less, generically, frozen slush. The business of course, has nothing to do with nursing homes; but Freezie's slush funds have everything to do with Medic-Home. "We need those earnings now," confesses Mr. Klurman. "We're in the process of creating convalescent-care beds that will earn us 15% on revenues. When that day comes, we spin off Freezie."

Essentially, that's what the nursing home business today is all about: tomorrow. "The future," Unicare Health's President Joseph Zilber told a group of analysts the other day, "is limitless." So Wall Street and much of the industry seem to believe, and nursing home operators are heading for it at a feverish pace. But the business, for all that bright promise, is plagued with severe growing pains all its own—not least, an utter dependence on public welfare. Only those firms, it seems clear, which apply the most intensive care to their own current operations, can look forward to a happy and healthy old age.

Appendix 2.

ADDITIONAL INFORMATION* SUBMITTED BY DR. R. N. BUTLER

"It is difficult to estimate how many thousands of older Americans are forced to live out their lives under conditions that are even inferior to the worst of the nursing homes. There could be as many as a quarter of a million persons sequestered in these *non-care* facilities. Some are there because they have been systematically denied admission to our mental hospitals, or transferred out of them. Some are there because they have no financial resources or living relatives, indeed, are without any kind of personal or social support.

"I wish to submit for the record an extensive statement prepared by the D.C. Advisory Committee on Aging (Exhibit A) and a personal statement (Exhibit B) by its Chairman expressing grave concerns over the practice of indiscriminate transfer of patients by a federal institution, St. Elizabeths, into questionable facilities.

"The local situation—in the nation's capital—is important as an example of a national problem.

"I believe patients who have been transferred to unregulated and substandard facilities should be returned to the hospitals from which they have been sent. I urged that patients be returned to St. Elizabeths where at least there is protection against fire, 24-hour medical and nursing coverage, adequate nutrition and some activities. Alternative care facilities in the District would have to be substantially upgraded and new kinds of facilities built.

"Finally, I wish to submit an editorial published in the Winter Issue of *The Gerontologist*, (Exhibit C) an official publication of the Gerontological Society, the national organization for professional gerontologists.

"This is: Immediate and long-range dangers to transfer of elderly patients from state hospitals to community facilities." *The Gerontologist*. 10 :259-60, 1970."

Sincerely yours,

ROBERT N. BUTLER, M.D.,
Chairman, D.C. Advisory Committee on Aging.

EXHIBIT A—STATEMENT OF D.C. ADVISORY COMMITTEE ON AGING

June 5, 1970

The D.C. Advisory Committee on Aging is gravely concerned over the extensive transfer of elderly St. Elizabeths patients to foster homes that is proceeding at present. It fears that fiscal considerations have once again taken precedence over social and medical ones.

Senile and arteriosclerotic brain diseases are mental disorders contrary to the apparent attitude of St. Elizabeths Hospital. Those suffering them require and deserve high quality comprehensive medical, psychiatric, and social evaluation, care, and treatment. Foster care homes do not provide such services.

Indeed, foster care and other care facilities (nursing and personal care homes) in the District do not usually provide social, restorative, and medical services nor activities programs.

St. Elizabeths quickly eliminates its patients from the hospital rolls. Patients are, therefore, lost to any supervision or follow-up.

The D.C. Advisory Committee calls for the establishment of a special Blue Ribbon Committee to investigate the mental health problem of the elderly in the District and to offer a body of constructive proposals for the comprehensive evaluation, care, and treatment of old people in the District who seek or need counseling, and who are suffering emotional and mental disorders. Such a comprehensive program must range from home care to mental hospital care to foster care.

* See Dr. Butler's testimony, p. 908

BACKGROUND OF PROBLEM

Given modern knowledge, adequate manpower and resources could help keep many older people at home. This would be personally desirable for many old people and less expensive to society.

The role of the mental hospital remains important and the modern community mental health centers have not demonstrated as yet that the mental hospital is unnecessary. There is a special need for brief hospitalizations for evaluation and treatment. It is most difficult to arrange for such hospitalizations in the District as was demonstrated in the HEW-funded Protective Services Program.

The District also sorely needs psychiatric outreach programs (virtually non-existent) and expanded home care.

Foster care, nursing home and personal care homes have a place as well. But there is considerable controversy. In the District we lack necessary standards for admission, continuing evaluation, and programs of care.

The D.C. Advisory Committee recognizes the need for a range of facilities and services in the community. The Lake versus Cameron decision of the U.S. Court of Appeals (Judge Bazelon presiding) concerned the provision by the community of alternatives for the care of the elderly. But the Committee realizes that such a range—and therefore *choice*—by patients, families, doctors, social workers—does not presently exist in the District.

The Committee wants to know how many of the elderly and/or chronically mentally-ill have been transferred from St. Elizabeths. (There are seeming conflicts between the reports in the press and correspondence from Dr. Sherman Kieffer to the Chairman of the Committee.) How were the decisions made? Precisely what kind of evaluation was undertaken? What tests? Were there psychiatric evaluations? How long were they? What medical examinations?

The Committee wants to see a study done of those who have been transferred. How long do transferred (and/or discharged) St. Elizabeths patients remain on the hospital rolls? How long are they followed? What kind of supervision? Who does it? What is the staffing and the individual case load of a social worker with the St. Elizabeths Foster Care Department?

What are the morbidity and mortality rates for transferred patients? A variety of scientific papers dating at least as far back as 1945 demonstrate what is now commonly referred to as "transfer mortality."

The Committee not only wants to know the conditions and arrangements at St. Elizabeths wherein the decisions are made regarding transfer. The Committee wants also to know about the foster homes themselves and other facilities where elderly patients are being sent:

What are their names and addresses?

What kind of supervision exists?

What is the training of those who operate these homes?

What are the details of the financial arrangements?

What is the money used for?

What is the character of the staff?

What is the staff/patient ratio?

What nursing services are available?

What social services?

What kinds of activities programs?

What restorative services are available?

What medical coverage exists?

What about food and medical diets, fire and safety, etc.?

The Committee wishes to work toward the creation of standards for licensing of these homes and for the provision of proper enforcement of these standards. It has been encouraged to do so by the office of Philip Rutledge, Human Resources. At present, to cite one example, the foster care homes are not really supervised by the District—for all intents and purposes. The Committee desires to see the regulation of the various care facilities in the District under one department—the Human Resources—rather than distributed among various agencies.

Several—but fortunately not many—other states started to transfer elderly and/or chronically-ill patients out of the state hospitals into nursing, personal care or foster care homes. Some have begun to backtrack (for instance, Personal Communication, State of Illinois), Usually only the docile, less disturbed patients

those that are "acceptable" to the non-psychiatric facility are moved in any case. The transfer procedure is always sold to governors and legislators as "saving money."

More than 600 patients, senile but not really mentally ill, were transferred from the hospital to less expensive and more comfortable foster homes.

The Washington Post, May 26, 1970.

Among other economies, the health department saved \$750,000 due to a reduced patient load at St. Elizabeths Hospital.

The Washington Post, May 29, 1970.

Dr. Sherman N. Kieffer . . . has suggested that 1,000 more patients could be similarly discharged into such supervised care in the community.

The question is: Do we ordinarily receive more for less?*

Toward a Public Policy for the Mental Health Care of the Elderly is about to be published by the Group for the Advancement of Psychiatry (GAP), a national organization of distinguished psychiatrists. GAP has had a major influence in American psychiatry since it was founded in 1948 through the efforts of the Menningers and others.

This document is likely to be influential in policymaking in regard to 1) the nature and quality of services, 2) financing mechanisms and 3) training and research with respect to the mental health care of the elderly.

Crucial is the quality and nature of services rather than the setting per se. Both GAP and the D.C. Advisory Committee on Aging are more interested in the availability of skilled help for the well-being of elderly patients than in some fixed notions as to the location of the rendering of such services.

However, there is no evidence of improved services with transfer.

The Committee is not interested in seeing old people being made the basis for fiscal savings.

Indeed, the mission of the Committee, formed by Mayor Walter E. Washington in May 1969, is to see that the needs of the District's elderly are represented. Some elderly—such as the impoverished, the homeless, the physically weakened, the mentally ill—can not easily represent themselves.

There is no virtue to playing a game called "moving patients" where there is no change in services but only a change in the scene. Indeed, people may be moved from one inadequate facility for the elderly—St. Elizabeths—to other even more inadequate facilities—called foster care homes.

It is noteworthy that in most of the jurisdictions in which transfer has been tried, outstanding and advanced specialists in the field of aging have not been given major roles. Indeed the most distinguished American psychiatrists working and researching in aging have actively opposed wholesale transfer.

Once again St. Elizabeths did not seek the direct help and advice of such specialists.

The D.C. Advisory Committee also remains puzzled over the failure of St. Elizabeths to implement the Long Amendment to Medicaid which provides funds for the mental health care of the elderly. Because of this failure it is estimated that perhaps \$2 million has already been lost.

Despite efforts on the part of the Chairman over the last several years, he has never received an answer on this point.

The Rome Committee—chaired by Dr. Howard Rome of the Mayo Clinic—which is charged with advising on the wisdom and the mechanisms of turnover of the St. Elizabeths Hospital from the National Institute of Mental Health to the District also has no representative in the field of aging; nor has it—so far as is known—formally sought pertinent advice.

Yet nationally and at St. Elizabeths, about one-third of all patients are over 65 and as many as one-fourth of all new admissions are also over 65.

The Committee would like to see specialists of great reputations such as Dr. Alvin I. Goldfarb of New York and Dr. Jack Weinberg of Chicago be invited to study the alarming situation in the District.

*The Department of Public Welfare pays \$125/month, approximately \$4/day, to the foster care homes. This is far less than the amount available per day for care at St. Elizabeths (\$18/day).

Senator Frank Moss (D-Utah) has expressed concern about "warehousing" the elderly. Recently Rep. David Pryor (D-Ark.) disguised himself as a volunteer and worked in Maryland and District nursing homes. His report was devastating.

By the year 2000 there will be approximately 30 million elderly. Increasingly those concerned with medical and social problems must face up to the realities of aging, chronic illness and the mental disorders of old age.

Research—clinical and basic—must proceed. Training of nurses, psychologists, social workers, doctors must expand.

Neither research nor training is likely to occur if old people are sequestered in setting isolated from the mainstreams of services, training and research.

In November 1971, we will be reporting to the White House Conference on Aging. We would like to be able to describe imaginative, compassionate and comprehensive programs for the 70,000 elderly of the nation's capitol.

ROBERT N. BUTLER, M.D.,
Chairman, D.C. Advisory Committee on Aging.

EXHIBIT B—PERSONAL STATEMENT OF ROBERT N. BUTLER, M.D.

JUNE 5, 1970

Presently I am not in favor of another Blue Ribbon Committee as a device to quiet criticism while the transfers continue.

I want the practice stopped at one.

I want outstanding consultants in the psychiatry of aging to advise not only St. Elizabeths Hospital but the D.C. Department of Public Health and the Community Mental Health Centers.

We need—more precisely old people need—comprehensive programs of health services including mental health in the District.

One final point: Foster care invoked in the minds of many the idea of foster family care. However, that is not what is happening to the transferred St. Elizabeths patients; they are not receiving foster home care but are being abandoned.

EXHIBIT C—GUEST EDITORIAL

IMMEDIATE AND LONG-RANGE DANGERS TO TRANSFER OF ELDERLY PATIENTS FROM STATE HOSPITALS TO COMMUNITY FACILITIES

(Robert N. Butler, M.D.¹)

There are many grave objections to the often indiscriminate, at times wholesale, transfer of elderly psychiatric patients from mental hospitals to various care facilities that is practiced in several of our states. This practice is a tragic abdication of the responsibility of medicine, in general, and psychiatry, in particular to the patient, to education, and to the scientific study of the psychiatric problems of old age. In the larger sense, this practice reflects society's unwillingness to commit its resources to the adequate care and treatment of its older citizens and to support basic research.

Among these objections are:

1. Established scientific data regarding increased mortality associated with transfer of the elderly.²

2. Inadequate medical, psychiatric, and social preparation of patients scheduled for transfer.

a. Often the wishes of patients and their families are not taken into account. Indeed, decisions may be made in direct opposition to their wishes.

b. Movement of patients who have been in institutions 10, 20, 40 or so years creates major problems in adjustment. Confusion and depression have been observed. Some have worked for years in the hospital and now may have nothing to do. Patients in their 90s have been transferred.

¹ Research Psychiatrist, Washington School of Psychiatry, 1610 New Hampshire Ave., Washington, D.C. 20009.

² The Gerontological Society passed a resolution June 8, 1970: That the Gerontological Society should, upon request, provide governors, state mental health commissioners, and other policy makers with informational material regarding research results relating to transfer mortality.

3. Inadequate facilities which do not provide comprehensive care. Standards of admission and care are often inadequate and unenforced. Operators may be untrained. Nursing homes may have no nurses and do not qualify as homes. So-called intermediate care facilities have weak standards. Most residents of various care facilities are on public assistance and may live under deplorable circumstances. Food, clothing and shelter may not even be adequate let alone any medical or social care.

4. Chronic illness, mental or physical, is a major medical and social problem. The excellent Commission on Chronic Illness of 1956 insisted that chronic illness must not be segregated from the mainstream of medicine. Yet medical, nursing, social work and other educational systems do not offer teaching in proportion to the prevalence of chronic illness. Medical students, for example, may not see the inside of a nursing or old age home.

a. Teaching must expand its coverage of chronic illness.

b. Manpower must be developed to provide necessary services.

c. Research is not likely to occur outside of the mainstream of medicine.

Many persons, professionals, families, agencies, and organizations have been raising their voices in opposition to the practice. President's Taskforce on the Aging,³ and the Committee on Aging of the Group for the Advancement of Psychiatry,⁴ are two national groups who have expressed concern.

In the nation's capitol, the D.C. Advisory Committee on Aging⁵ has opposed the transfer of elderly and chronically mentally-ill patients from St. Elizabeths Hospital into unregulated so-called foster care homes.

It is worth citing aspects of the situation in the District because they are probably illustrative of problems elsewhere. Foster care does not mean foster family care as utilized in the placement of children. "Community" placement is a euphemism in the District for boarding house placement often in impoverished and crime-ridden neighborhoods. Indeed, "boarding housing" in turn, is often a euphemism for a flop house. Malnutrition was discovered. Some patients had been assaulted in those "homes" as well as while walking unattended on the streets. Often the assaults were not reported to the police. One patient had been bludgeoned to death. Some patients received inadequate medical coverage. Thus, diabetes might go uncontrolled. Racial segregation was practiced.

Only \$125 per month was paid by the D.C. Department of Public Welfare for each patient. It was difficult to conceive that the same or greater care was available at \$4 per day than at the \$18 per day cost at St. Elizabeths Hospital. The foster care operators had to extract their own profit from this sum as well. There were some 180 to 200 such "foster care homes" with from 2 to 40 patients. Operators were given only six hours of training.

It must be stated that some of these homes were well run and that operators could have the best of intentions. Moreover, there is no question of the usefulness of a range of diverse facilities disseminated throughout a community—in all its sections—not only its poor sections—to meet the diverse needs and the geographical origins of older patients.

But these facilities must come to approximate total care facilities with a range of available medical, nursing, psychiatric, social skills. Even so-called custodial care need not have a pejorative meaning; it can mean the creation of a socially and medically prosthetic environment. It can mean the application of psychiatric-psychological principles and the employment of various adjunctive services. Admittedly one is operating within the increasingly narrowing limits possible under the time-gradient of disease and dying. But, personal care—from hair grooming to passive exercises of limbs affects with residual paralysis—should be a daily occurrence. Social activities, occupational and physical therapies, must always be available. Old people must not be left "buried alive" or in "houses of death."

Facilities or parts of facilities used for custodial care, in the advanced meaning of the phrase, should be components of complex medical-social institutions wherein active diagnostic and treatment services are available.

There are two landmark legal opinions and one federal law of pertinence to the care of elderly mental patients who are of two categories with different diagnostic, therapeutic, and prognostic implications.

³ Toward A Brighter Future for the Elderly. The Report of the President's Taskforce on the Aging. April, 1970. Washington: U.S. Government Printing Office, 1970.

⁴ Toward a Public Policy for the Mental Health Care of the Elderly. Committee on Aging. Group for the Advancement of Psychiatry. In press, 1970.

⁵ Public Statement on Transfer of the Elderly from St. Elizabeths Hospital into Foster Care Homes. D.C. Advisory Committee on Aging. Chairman, Robert N. Butler, M.D.. May 1970.

The first group composes chronically mentally ill, such as chronic schizophrenic and manic-depressive patients. They constitute one-third of state hospital populations. They have grown old in the mental hospitals and, in effect, are the treatment failures of psychiatry or, more justly, the reflection of society's unwillingness to allocate sufficient funds for personnel and treatment.

The second group is composed of old people who have developed psychiatric disorders for the first time in old age. They account for one-fourth of all mental hospital admissions annually.⁶ Disorders may be organic, principally so-called senile brain disease and cerebral arteriosclerosis. These are distinct mental diseases. It is inaccurate to say, as some psychiatrists and others have, that the old mental patient is "senile and not suffering from a mental disorder." On the other hand, "senile" is a wastebasket, loose appellation and along with cerebral arteriosclerosis often is misapplied to the depressed, the anxious-confused, or paranoid old patient.

Organic brain disorders are not the inevitable consequences of chronological aging but distinct diseases. Old people, like young people, grieve, develop depressions, become suspicious and paranoid, become frightened and anxious. These conditions constitute the functional disorders of old age. Significant numbers of old people develop reversible confusional states associated with drugs, heart failure, and pulmonary diseases as well as with febrile and debilitating illnesses. These conditions may be subtle and go unrecognized. There can be no remedy without proper diagnosis.

The first legal opinion of pertinence concerns the right to alternative community facilities in a decision by the U.S. Court of Appeals in 1966 (*Lake versus Cameron*). This decision should not be misunderstood. It does not support the feeling current in some circles that any community facility may be more desirable than the mental hospital for any aged patient. It is obvious that small, privately managed nursing and boarding homes, with fewer staff, less state control, etc., will not, cannot, serve patients better. Although it would be desirable to have a range of services and facilities—and therefore a choice—by patients, families, physicians, social workers—such a range and choice does not presently exist in most American communities. This opinion may move communities in the direction of progress.

"Right to treatment" (*Rouse versus Cameron*) is the second legal development that may create changes in the delivery of medical care to the elderly in the near future.

One portion of the Title XIX (Medicaid) legislation with great significance for the mental health care of the elderly was sponsored by Senator Russell Long in 1965. The "Long Amendment" is a companion to the Title XVIII (Medicare) legislation that provides for acute illnesses. The Long Amendment provides for chronic disorders, organic or functional. As of September, 1969, 34 states had implemented the Amendment but, sadly, the monies have gone into the state general revenue funds and have seldom led to improvement of programs.

Coupling *Rouse versus Cameron* with *Lake versus Cameron* with suits over the Long Amendment may be on the horizon.

It is often said that older people are in mental institutions not because they are mentally ill, but simply because there is no other facility for them. This point has been over-stated and is misleading particularly as long as "other" facilities remain inadequate. It does not matter so much what the name of the institution is. What matters is the provision of quality services.

Certainly public mental hospitals are often under financed and under staffed, and some are "snake pits."

By the year 2000 there will be approximately 30 million elderly in the United States. Increasingly, those concerned with medical and social problems must face up to the realities of aging, chronic illness, and the mental disorders of old age.

Research—clinical and basic—must proceed. Training of nurses, psychologists, social workers, home health aides, doctors, occupational therapists, and other paramedical personnel must expand.

Clearly society, and its instruments, medicine and psychiatry, cannot discharge their responsibilities for the study, evaluation, care and treatment of chronic mental illness and the disorders of later life if old people are sequestered outside the mainstream of American medicine and psychiatry.

⁶ Yet only 3% of the research monies of the National Institute of Mental Health are spent on the disorders of old age.

Appendix 3.

PAPERS SUBMITTED FOR DR. COSIN BY MR. HUTTON*

EXHIBIT A—CARE OF THE AGED MENTAL SICK

By Dr. L. Cosin

The number of admissions to mental hospitals, either voluntary or under certification, provides inadequate evidence of major mental health disturbances in the elderly. Often a family situation develops and then progresses to social collapse. Such a situation involving an elderly person occurs frequently because slow intellectual deterioration and decreasing ability to adjust has been complicated and worsened by other factors, some of which are reversible. Among these factors are cerebral hypoxia from organic disease, cerebrovascular accidents and trauma.

Of especial interest is the incidence of intellectual deterioration following prolonged falls of systolic blood pressure due to major anaesthesia, post-operative surgical shock, and a combination of these two factors. Even more common are the low cardiac output states due to cardiac infarction and pulmonary infarction. These conditions frequently are present with confusion without other symptoms and because of this, the appropriate aetiology may not be recognized. Other factors are malnutrition involving protein, iron, and vitamin-B deficiencies, emotional disturbances expressed as acute or long-standing anxiety states involving a family group, or individual dissonances in a household; an example of the latter occurs when conflict develops between an unsympathetic landlady and the elderly occupant of a furnished bed-sitting room. Other causes of financial, interpersonal or social stresses are often found when the history is obtained by a skilled social worker. Thus a mixed and complicated picture of slow and catastrophically rapid intellectual deterioration and emotional disturbance has only too often been followed by admission to a mental hospital.

Many statistical studies have demonstrated that as the proportion of the elderly increase in the population so does the problem of their mental ill health achieve greater prominence. I will not spend time describing the Oxford geriatric unit in detail but will indicate how a modern geriatric unit is geared to solving the many problems involved in treating mental ill health in the elderly.

First, I replace the old but enduring concept of "Episodic" care of the hospital patient by that of a program of "Continuing Care". Much hospital care is still organized on the basis of the 19th century subdivision of pathological processes into "acute" and "chronic". This suggests that the patient in whom an acute pathological process is diagnosed will make a complete recovery if he survives, and that there will be no disabling sequelae.

A similar and equally misleading over-simplification suggests that a patient in whom a chronic pathological process occurs is a "chronic patient" and needs the custodial care provided by the chronic sick hospital or nursing home. Where a patient displays evidence of mental ill health all too often permanent and custodial care is provided in the mental hospital.

There can be no doubt that many people with long standing clinical problems, (which we may call "chronic" only if we realize that this merely means "of long duration") either adjust or compensate, appropriately to their disabilities. They lead a full and active life in the community for many years. It is equally true that others may have too many or too large problems to enable them to adjust similarly unless far more consideration and care is applied to the accurate assessment and solution of their several problems. The necessary assessments may be multiple, and pave the way for more than one major therapeutic step to modify development of the disease and to halt or reverse its progress. Similarly the ap-

*See Mr. Hutton's testimony, p. 915.

propriate psychotherapeutic approach. Preferably in a community setting may alter or diminish damage to the patient's personal adjustment.

Many situations affecting elderly patients require that consideration be given not only to each aspect of the clinical and social problems, but also to the relationship between these various presenting factors.

It is fundamental to recognize that the major problems of elderly patients are frequently multiple; this is the main difference between treating the elderly and other age groups. It is therefore advisable that the Geriatric Unit should handle clinical problems on a basis of current multiple assessments, repeated as necessary, sometimes over a period of years.

This concept of "Continuing Care" of elderly patients replaces the inadequate Episodic Care which ends when either finance or tolerance is exhausted. It is too often incorrectly stated that no more can be done for an elderly person. In point of fact a great deal more needs to be done to assist patients, families and communities to adjust to the new situation. And with this much more positive attitude, the demand for plain custody grows less, not more, in spite of an aging population. The best way I have found of replacing the pessimistic and often penal program of custodial care is to use an optimistic program that I have named the Dynamic Quadruple Assessment.

The Assessment is dynamic because it is constantly concerned with the changing life pattern of the individual and the restoration of his social competence, and in some cases industrial competence, to the highest possible level. The term "Assessment" is preferred to diagnosis because I have accepted the hypothesis that no clinical decision at one point in time concerning an individual's health can be sufficiently accurate to determine how the development of the changing situation in which he finds himself may alter the clinical picture, and the prognosis of survival, of recovery, of rehabilitation, and of resettlement.

The four parts of the assessment are:

1. Pathological.
2. Sociological.
3. Psychological.—From these three primary assessments we are in a position to obtain a fourth.
4. The assessment of disability.—On this information a program of physical and mental rehabilitation is based which aims at the fullest possible restoration of physical, social, and where applicable, industrial competence. And in this last stage the facilities for assessment and occupational training provided at the pre-vocational rehabilitation unit, at Oxford, are proving increasingly valuable. Thus the evaluation of an individual's health, environment and prognosis is extended to become an assessment of his manual dexterity, emotional drives and intellectual competence, with the object of out-lining what we may describe as his "Rehabilitation Potentials".

The following explanation of the organization of Medical Care in the United Kingdom and the arrangement of resources for the Geriatric Service will serve to illustrate how the philosophy of continuing care can be effectively implemented.

The latest area in which I have introduced this type of program is in North Carolina, one of the southern states of America. In spite of cultural and racial differences, largely due to a scattered rural population, the philosophy of care that I have described seems to be adaptable under differing governmental systems.

By defining, utilizing and organizing local resources and integrating them with national facilities, the program is developing in a like manner to that described below.

ORGANIZATION OF GERIATRIC CARE IN OXFORD, U.K.

The first shows the structure of medical care in the United Kingdom under the National Health Service which provides for a department of geriatric medicine in each district general hospital. With this arrangement, Gerontology has access to all hospital facilities including the diagnostic departments, nursing service, other specialist medical and surgical departments, and the department of social work. Close liaison is kept with the psychiatric unit but primary responsibility for psycho-geriatric patients is maintained by the departments of geriatric medicine which provide short-term assessment and treatment and even long term care.

Because of its policy of replacing episodic care (appropriate in the remainder of a district general hospital) by a program of continuing care, the geriatric de-

partment at Oxford provides, in addition to acute treatment, facilities for rehabilitation, research, and resettlement.

This shows how this Department maintains a close working relationship with all domiciliary services, with housing authorities, with residential and sheltered homes for old people; finally it shows the continuing and permanent responsibility for the small group of permanently disabled and demented elderly patients.

The second phase shows the patient flow chart in the Oxford department of geriatric medicine. Based on a pattern of progressive patient care there is:

Zone 1—For Intensive Care which provides full medical services including monitoring for the short number of days that patients require to be under continuous observation or 24 hour nursing attention.

Zone 2A—Is the flexibly adaptable part of the intermediate care zone which is used for those patients who, by reason of clinical improvement, no longer need a 24 hour nursing service. During winter months or periods of stress it can even be phased into the small Intensive Care program to which it is adjacent.

Zone 2B—Represents the main part of the intermediate care unit and contains from 15 to 20 beds. Whereas in *Zone 2A*, a flexible task force of additional nurses can be phased into the intensive care service, in *Zone B* the full ward rehabilitation personnel take over many of the physical duties usually left to nurses. Thus a full program of physical and occupational rehabilitation is carried out by a trained and expert team which has the responsibility of implementing a scientifically and practically designed program of measuring the rate of return of individual competence for the environment in which each patient will be most independent.

This whole program of progressive patient care is linked with multi-disciplinary coordinated measurements of the rate of return of competence in different fields.

1) *The physiological rate* is measured by monitoring, biochemical parameters, and change in pathological signs carried out by nursing, medical and laboratory staff.

2) *The physical rate of return of competence* is measured by the physical and occupational therapists who are treating patients often within 5-7 days of admission to the hospital. The aim for the physical therapist to achieve in every patient is a full range of painless movement in all four limbs, the erector spinae and anterior abdominal muscles. It is obvious from the very pathological nature of the disease processes that many resultant physical disabilities will persist, but if they are reduced to a minimum they need not affect the patient's ability to lead an independent life. This will help him to return home, avoiding the much less desirable, as well as costly, institutional care.

3) The occupational therapist is chiefly responsible for measuring the rate of return of *social competence*; there can be many interpretations of this but I confine my definition to the ability of the patient to be responsible for his every day activities—feeding himself, dressing himself, attending to his toilet and like needs, and being able to act in an acceptable way with his peers.

4) In measuring *intellectual competence*, we are speaking of the simplest kind of functional intelligence enabling a person to reach a level of independence even with a certain amount of support. We must also recognize that with the geriatric population as with all other age groups the environment in which they are placed can turn a stable person into an incompetent nursing responsibility.

5) *The assessment of emotional consonance* follows the usual psychiatric diagnostic procedures and is referred to later in this paper.

6) *The domestic assessment* in elderly women is important and show how important it is to treat even the confused elderly woman in an environment with which she is very familiar. Pavlov would have approved of this reinforcement of essential conditioning processes.

7) *Industrial competence* to restore many old men to a real life situation (with which Pavlov would also have approved) the pre-vocational and vocational work shop is set up in which many old men in spite of their disabilities and progressive disease processes can be treated far more successfully than in an institutional environment.

By using the progressive patient care program in this way elderly patients have the opportunity of rapid recovery being further expedited by the active multi-disciplinary program of rehabilitation so that the number of hospital bed

days required is considerably reduced, and there is a comparable reduction in their total long term institutional needs. In patients admitted to the Oxford Geriatric Service in 1968 whose average age was 81.4 years, the average length of stay for 94% of them was 41 days (24% died within 30 days of admission, and 70% were resettled in their own homes) ; 5% were resettled in Old Peoples Homes and only 1% needed permanent hospitalization.

This is in part due to the changed philosophy and practice of care. Thus the patients proceed after periods of intensive and intermediate care to minimal care via the admission wards into the rehabilitation wards. One of these wards is "quick stream" (for minor cardiac, respiratory and cerebrovascular episodes) where the average length of stay is 25 days, and the other is the "slow stream" ward used for a smaller number of patients in whom the massive pathological changes have resulted in a major physical disability often complicated by psychiatric symptoms of depression, withdrawal, and affective psychoses. The length of stay in this slow stream ward is variable but ranges between 120 to 180 days. Even when this is measured against permanent hospitalization or institutionalization, the length of stay is comparatively short for many of these patients since they return to their own houses with continuing care provided by Day Hospitals and other organized community resources.

These domiciliary resources are provided by :

- 1) Statutory local authority agencies.
- 2) General practitioner service.
- 3) Volunteer services (Unpaid).
- 4) Deployment of the hospital department of geriatric medicine out into the community.

The Geriatric Unit has been designed both functionally and structurally to meet the changing needs and physical status of recovering or deteriorating elderly patients. A variety of facilities is provided which range from a 24-hour nursing service (Intensive Care Unit), through logically applied physical rehabilitation for convalescent patients, to fully independent living. An individual patient may experience the benefit of each of these in the space of a few weeks. If this flexible, rapidly adjustable environment can be provided for the changing health needs of patients in the 8th, 9th and 10th decades of life, I can see no reason why a comparable program of medical and industrial rehabilitation should not be attempted for aging workers. By refusing to confine our attention to purely medical problems, and by testing the stage of recovery at each step a progressive system of patient care is established which has substantial advantages over current hospital practice.

The pathological assessment, to which we must add the biochemical, is of fundamental importance in the management of mental ill health in elderly patients. Pathological processes are very often multiple and tend to be interrelated so that we must be aware of the likely development of the clinical course of illness, with a view to the anticipation and prevention of complications.

Take for example the possibilities for a mildly confused and quietly demented old man of 80 living with son and daughter-in-law and two young grandchildren.

Following a sudden posterior cardiac infarction the resultant period of prolonged hypotension may precipitate a considerable drop in cardiac output so that the systolic blood pressure may be too low to maintain renal function, itself already displaying evidence of diminished physiological reserves. As a result of the defective renal function, inadequate excretion of metabolites may precipitate renal failure, which may further increase the degree of dementia and confusion in the elderly patient.

The reduced cerebral blood flow in thickened, narrowed, tortuous arteries, may well result in a degree of cerebral hypoxia which causes further mental impairment. The patient may become noisy, and a further complication may be difficulty in phonation and swallowing due to a pseudo-bulbar palsy. The dysphagia can seriously complicate the patient's chances of recovery if food or high protein fluids, inexpertly administered, enter the upper respiratory tract and then the lungs. Thus an avoidable complication of an infected aspiration collapse of one or more lobes of the lungs renders the patient's chance of survival more slender while increasing the degree of confusion, and disorientation. The experienced geriatrician will not have further complicated the clinical picture by using barbiturates or other sedatives and tranquillizers which tend to increase noisiness, confusion, and hypotension.

In such a situation as I have described the strength of the family group may be seen to disintegrate rapidly if the appropriate dynamic assessments are not made quickly and in the right order. As a result of a series of inter-connected pathological and biochemical changes, the psychological and psychiatric status of the patient has deteriorated rapidly. The sociological assessment will have demonstrated the impending family disruption due to uninformed, un instructed and unassisted daughter-in-law whose very understandable emotional response may have adversely affected husband, children, herself, her neighbors, and patient care.

The clinical status of the patient might now be bedfast, hypotensive, hypothermic, incontinent, in biochemical imbalance, hemiplegic, dysphagic, dysarthric and with a degree of cerebral hypoxia due to cerebral infarction, diminished cardiac output and diminished respiratory exchange of oxygen and carbon dioxide.

It is wiser in this situation to arrange immediate admission to a medical unit experienced in treating this type of problem. The unit can be located in a general medical department, in a mental hospital, or perhaps more advantageously in specialized Geriatric Unit which is constantly recognizing and treating this type of clinical problem.

It can be accepted that many of these factors involved in mental ill health of old patients are reversible, provided that the integral parts of the dynamic quadruple assessment are used at the appropriate time.

I will not refer here to the common psychiatric disorder in the elderly, the affective psychosis, which responds rapidly to modern antidepressant drugs, electroconvulsive therapy, and milieu therapy. It is important, however, to differentiate the more severe forms of affective psychosis from cases of reactive depression following social isolation, from previously unrecognized chronic anxiety states in elderly people, from anxious agitated depressive states occurring de novo in the elderly, and partial personality collapse following social or surgical trauma. The trauma itself may be severe or only slight, but rehabilitation may be complicated by the patient's unresolved anxieties. Thus an elderly patient may sustain a fractured thigh bone and make an excellent recovery from operation but subsequent physical rehabilitation may be much hampered by the patient's fear of falling. This "timor cadendi", as I have called it, may pass off with reassurance and explanation, or it may persist and become even more marked until the patient lies in bed in a permanent anxiety state fearing even to move. This rarer phenomenon I call "timor movendi".

"Timor cadendi" is usually managed without difficulty, as long as it is recognized sufficiently early and handled sympathetically and fairly.

"Timor cadendi" can occur following a cerebral thrombosis, a fall, or a road accident, or even as part of a partial personality collapse following anxiety due to the patient's recognition of deteriorating intellectual function and loss of recent memory. "Timor movendi" can be a serious complication of postural hypotension following a cerebrovascular accident or ischaemic disease affecting the automatic nervous system through the baroreceptor reflexes.

CONCLUSION

I have pointed out the utilization of the dynamic quadruple assessment by the Oxford Geriatric Unit to provide a program of continuing care which has reduced the problem of mental ill health in the elderly in the community and in institutions. This can only be fully achieved where hospital resources and community and municipally financed social services are appropriately integrated.

It must be realized that the community supports, and will continue to support, a large number of elderly folk in spite of their decreasing intellectual ability and increasing incidence of affective episodes as long as the burden remains tolerable. The level of tolerance displayed by the community and the family is usually quite high until the burden becomes complicated by an unbearable interpersonal or social situation. The family or the community may not understand the clinical implication of the sudden catastrophic development of a confused, disorientated, wandering, agitated, aggressive, incontinent old man who frightens the children and upsets the household. If the medical care program fails also, either to recognize the problem or else to institute the correct therapeutic environment (usually in hospital) with the matter of a very few days, then we cannot blame the family or community for refusing to accept this highly

traumatic experience of unlimited responsibility for an apparently unlimited period of time.

The program of continuing care as defined by the dynamic quadruple assessment facilitates the maintenance of social competence which itself must be recognized as one of the main objects of a medical care program with the correct social orientations.

This integration of preventive, therapeutic, and rehabilitative social and medical services for elderly patients utilizes the appropriate type of facility for each patient's current problems, based on the Dynamic Quadruple Assessment. It is most economical and effective by reason of its relatively short duration, its rehabilitation potential, and resettlement program for most patients who survive. In this way they can be as independent as possible for as long as possible in their own homes.

EXHIBIT B—A PHILOSOPHICAL CONCEPT AND ARCHITECTURAL DEVELOPMENT
OF THE PSYCHO-GERIATRIC SERVICE OF EASTERN NORTH CAROLINA

By Dr. Lionel Z. Cosin, Director of Geriatric Services, Cherry Hospital

SUMMARY

A new concept for utilizing architectural design, to shape the environment, in the developing Geriatric Rehabilitation program for the Eastern Region of North Carolina is described in its philosophical basis, its strategic planning and its functional use.

It is shown how the single story multipurpose planning can be flexibly used for different programs in the Geriatric Rehabilitation service, such as Day Hospital, group psychotherapy, remedial physical medicine and intermittent residential management.

The importance of the design of some aspects of community care in association with the Mental Health/Vocational Rehabilitation program of North Carolina is suggested.

A basic research program into its architectural and functional value, in relation to milieu therapy and community mental health care is proposed.

A program could be worked out at Cherry Hospital if the medical care facilities which are presently available can be fully utilized and new facilities can be provided for rehabilitation, resettlement and a social retraining program. The community based programs for early diagnosis, follow-up, and regular reassessment could then be combined with a comprehensive and very workable program of service to the elderly.

HISTORICAL SURVEY

One of the first programs to provide better standards of patient care based on a rational analysis of each individual patient's medical and social needs was carried out in the immediate post-war years (Cosin, 1947). This provided, on a system of progressive patient care, various loci for acutely ill patients, and appropriate annexes for the ambulant, frail ambulant and the senile confused. It was soon found that little accommodation was needed for the permanently bedfast patients.

The statistical analysis was carried out with the help of Professor Major Greenwood and this showed that much ill health in the elderly was acute (Cosin, 1948, 1952). Multiple pathologies and abnormalities of physiological function were common; they produce complex clinical situations. Nevertheless, if the appropriate treatment was given at the correct stage of the patient's illness, recovery could confidently be expected in most of those who survived the acute phase of the illness.

Failure to obey the fundamental medical principle that there is an optimal time to treat illness at any age results in a greater degree of irremediability by the simple passage of time; ultimately secondary physical and mental disabilities will render a large number of patients bedfast, demented and depressed. This same phenomenon has occurred and can be seen in other groups: for example, mentally disturbed adolescents and young adults have spent as much as 40 to 50 years in a mental hospital. When, however, such patients are appropriately treated earlier in the pattern of illness, resettlement in the community in an earning capacity can often be achieved (Cosin, 1964).

On this philosophical and practical basis a program of progressive patient care was commenced at the Oxford Geriatric Unit in 1950, in which hospital structure was adapted to patients' changing needs so that seriously ill patients were treated in intensive care, the recovering patients in intermediate care and the patients awaiting resettlement in minimal and self-care units. This concept of progressive patient care in the management of elderly patients has formed the basis of the structural and functional development in the Oxford Geriatric Unit (Cosin and Wollner, 1963). This was also applied in Israel in the re-organization of the Maiben program in 1954 thereby turning a chronic shortage of beds into a planned reduction of beds. This was achieved by raising standards of patient care and increasing community facilities. This resulted in an economy of about 2,000 beds.

In the meantime at Oxford an increasing number of elderly patients with mental illness were being referred to the Department of Geriatric Medicine. In 1956 a Mental Health Research Program supported by the Nuffield Foundation was set up to define some of the problems of mental ill health in the elderly. In a small clinical demonstration area, one medical officer was appointed in the Department of Geriatric Medicine to be available for consultation with ten to twenty general practitioners who, between them, were responsible for a population of 30,000 (3,600 over the age of 65). During a six month period, of the patients referred, the ten who were at the stage of *early* manifestations of mental illness showed a wide range of potentially treatable social, medical and psychiatric problems. None needed to be admitted but were treated in the community at the Day Hospital and other facilities.

The reason why very few were referred for early preventive treatment was that the family and the community accepted gradual deterioration in the level of intellectual as well as physical and social competence, as a normal phenomenon of aging; it was not considered worthy of notice or of calling in medical aid. As soon, however, as a catastrophic deterioration occurred, permanent care either in a psychiatric or a geriatric unit was urgently requested. This catastrophic situation can rapidly overwhelm family and community resources yet need rarely occur. As Kidd (1962), Fish (1963) and others have shown, selection is often so haphazard that many patients are inadvisedly treated in an inappropriate environment.

A similar situation was found during 1956-57 in Syracuse, New York, by the N. Y. Mental Health Commission Research Program, where 10% of elderly men over the age of 70 were found to suffer from mental disability and, under their recommended standards, were legally committable, yet none had been referred to a psychiatric or other hospital service (Cosin, 1957).

In 1957 Dr. Felix Post, Consultant to the Institute of Psychiatry, Maudsley Hospital, London, demonstrated that the Oxford Psychiatric Hospitals were relieved, to a large extent, of the problem of mental ill health in the elderly by the Oxford Geriatric Service (Cosin, Post, Westropp and Williams, 1957).

Since that time an effective service for elderly patients with any problems of mental ill health has continued to be available in the Oxford Central Area. Experience has shown that a service immediately available on either an in-patient or day hospital basis at the earliest stage of declaration of need prevents long term disability, and results in a significant reduction in length of hospital stay with a consequent *reduction* in the number of hospital beds.

THE OXFORD GERIATRIC PROGRAM

Based on the findings of the Geriatric Program in Oxford, the following are given as the principles for an effective geriatric mental health program:

Assessment of medical, physical, psychiatric and social aspects of disease giving rise to disability, and resultant failure to maintain that level of social competence which would permit an independent or supported position in the community.

Management on the basis of progressive patient care which provides treatment, restraining and continuing assessment ranging from intensive care to minimal care. The aim is to provide the appropriate service at the right time in the development of the disease, and the natural history of the situation in a community setting. This is based on the patient's current needs on the one hand and on the degree of functional competence on the other.

Rehabilitation: A program of rehabilitation is planned and carried out by a therapeutic team of trained nurses, physical therapists, occupational therapists, speech therapists, public health nurses, social assessment officers and social workers, working together under the direction of the Geriatric physician.

Rehabilitation can be considered to be "a planned withdrawal of supportive services and facilities as based on a current assessment of changing function," and measured by the rate of return of physical, mental and social competence—as the impact of illness on the patient's personality and function lessens.

Resettlement in the form of a planned program where hospital, general practitioner and community services (local authority and other agencies) are closely linked. Illness and the type of complication to which these patients are prone is so frequently allowed to reach a point of social catastrophe that the scare left by this unpleasant experience imposed on the family and the community makes them very reluctant to accept the patient back for fear of having to face such a situation again. Resettlement must of necessity, therefore, often begin with a trial period, usually at home, until the family and the community can again adapt, adjust to, and provide support for a new situation. The community has to be reoriented and re-educated, for very often the situation as it existed at the time of admission is no longer operative at the time of *planned* discharge. Long term continuing support and immediate action, and where necessary, immediate readmission in case of social breakdown or new illness, is however, essential.

Continuing Care: This program necessitates medical and social follow-up to enable active therapeutic intervention in a changing situation at the optimum time, and immediate readmission where this is indicated for medical and social reasons. Planned short term intermittent readmissions are available for various periods of time at varying intervals dependent on the declared current need of the family or the community.

(The "Floating Bed" is used in the situation where five or six patients can utilize one bed over a period of two weeks by providing a combination of Day Hospital care and two, or three nights' residence in the hospital. This is a very valuable facet in maintaining family cohesion.)

To join the program of planned progressive patient care to the achievement of individual resettlement of the rehabilitated client back into a community and family situation, a new facility is described as follows. It is based on a combination of the Aesculapian concept of the healing environment together with the modern concept of rehabilitation. This necessitates a new philosophy, a new strategy and a new structure in planning. It departs from the concept of hospital treatment and is directed by the author's definition of rehabilitation. This is "a measurement of the rate of return of competence—physical, social, intellectual, emotional, domestic and industrial." The immediate corollary of this is complete or partial restoration of the personality to a community or family milieu.

THE GERIATRIC REHABILITATION AND RESETTLEMENT UNIT

(Refer to plan, p. 962)

The attached diagram gives the floor plans of the Oxford Geriatric Rehabilitation and Resettlement Unit. It is the experimental model for the unit proposed for eastern North Carolina and contains the most recent design for rehabilitation for several types. The planning and construction lend themselves to flexibility, which is of primary importance in a program of progressive care and rehabilitation. The structure can be easily adapted to many types of programs; it is not limited to the one described herein for geriatrics.

The building is rectangularly shaped with basically four quadrants (A, B, C, D) designed around a center courtyard (13). The design is such that groups of patients at different stages of rehabilitation can be accommodated in the same building. Each quadrant consists of a self-contained living unit comprising:

- (a) Intermediate Care Area with two dormitory units of four beds each (3);
- (b) Minimal Care Area with a single two-bed unit (3a);
- (c) Living and Dining Area (4) immediately adjacent to the dormitories;
- (d) Three Toilets (6) provided as close as possible to the living and sleeping areas; and
- (e) A Kitchen (5) shared with only one other quadrant.

(a) The intermediate care area (3) is of modular construction such that each area has six picture windows equally spaced for maximum flexibility. The flexible design of this area enables it to be divided, as in the diagram (A-3) into the two 4-bedded sleeping units (3 windows each) or rearranged (B-3) into three 2-bedded sleeping units (2 windows each). Adequate personal washing area and clothes closets are built into the design. In this way one quadrant could serve entirely as a minimal care area with a total of four two-bed units.

(b) The minimal care area has much value in the physical, social and even domestic rehabilitation which it affords. It also can be used to provide a room for the severely disabled client and the spouse; in this way a program to rehabilitate not only the individual but also the basic social family unit is available.

(c) The obsolete sociological concept of the separate dining room which is used only three times a day (for the convenience of the Staff) has been replaced in this model building by a living area (4) for this "synthetic psychotherapeutic family group situation." Here true healing on a modernized Aesculapian principle, utilizing modern concepts of rehabilitation can be achieved. In this area of dynamic living the milieu for group psychotherapeutic sessions are also apposite. In addition, recreational activities, rehabilitative activities, art classes, and sedentary domestic activities can be performed singly or in groups. Group physical remedial exercises to music can also be conducted in this multipurpose room.

(d) The three toilets (6) are strategically located in the quadrant and are designed to afford room for assistance to the patient. It is very interesting to note that the close proximity of the toilets to the living and sleeping areas has eliminated much of the problem of incontinence in the patients in the Oxford Geriatric Unit.

(e) Each two living areas is completed with the kitchen (5) which serves a two-fold role. It is the serving station for patient meals as well as a source of rehabilitative activities in achieving domestic competence. There is adequate space provided in the kitchen for supervised patient activities with food preparation. For a patient's readjustment to his responsibilities towards his own care and feeding, this is an essential part of rehabilitation.

A valuable feature of the design of this unit is the Endless Corridor (2, 2, 2) which it contains. The primary purpose was to manage the common problem of the wandering, confused, elderly patient in the first building designed for this purpose, the Day Hospital in Oxford, England, built in 1957. The Hospital has been in constant use for the last twelve years and carries an average weekly case load of 160 patients. The success of the Endless Corridor was clear in its primary use of limiting, without restricting wandering elderly confused clients. It was also found to have a secondary effect of easing staff tension and anxiety when freedom of movement was thus increased. As a result, staff confidence and a definite improvement in the emotional milieu has become apparent. Further advantages of the Endless Corridor are:

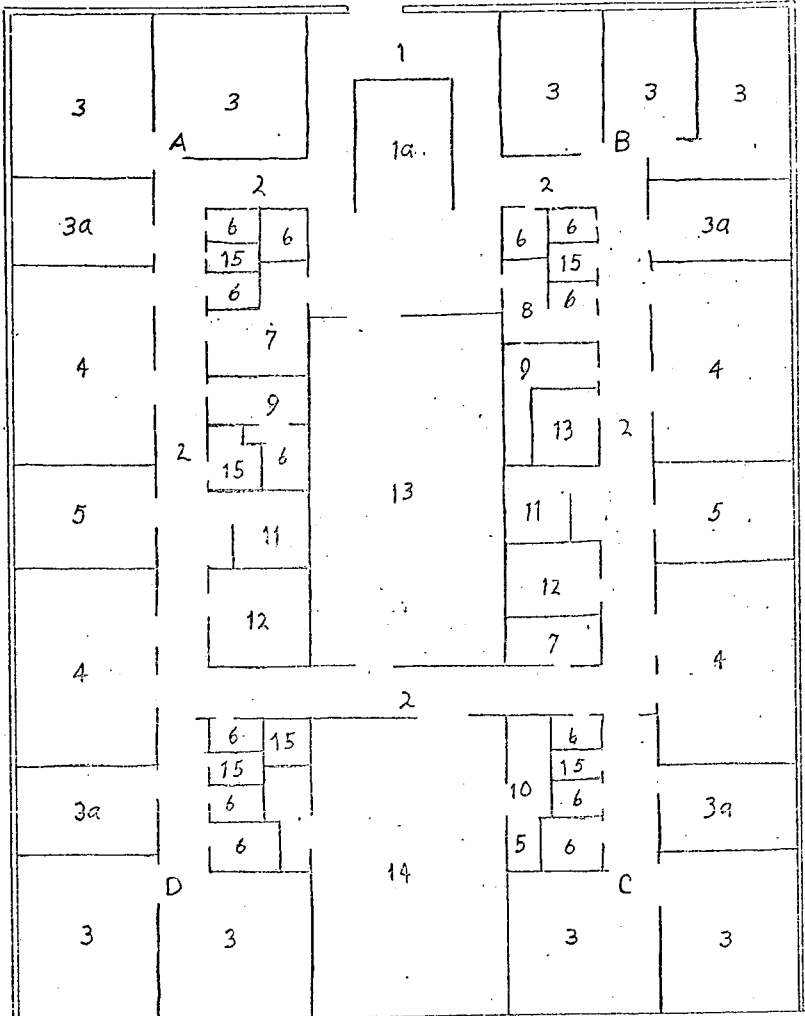
- (1) Providing better communication ;
- (2) Providing a means of separation ;
- (3) Assisting in the physical therapy program which require a wide walking space and continuing supervision of the therapist in a living situation closer to normal than a gymnasium ;
- (4) Contributing to the sound insulation by virtue of the 90° angles provided by the rectangular design. In the Endless Corridor, short plywood partitions are suspended from the ceiling to trap sound.

The courtyard (13) in the center of the four quadrants provides an excellent area for recreational activities and rehabilitation in fair weather. It is paved for easy movement and, as conceived in the design, has flower plots and planters for the patients to work with. This is a vastly improved functional change from the out-moded situations where elderly patients are unable to get outside due to lack of elevators, ramps, etc.

VARIATION OF USE FOR VOCATIONAL REHABILITATION PROGRAM

The flexibility of design has already been described here within the context of the Geriatric Rehabilitation Program. A part of each section can be used for Intermediate and Minimal Care or the section can be used wholly for Minimal Care. At the same time the other sections can be used as a small community Day Hospital (as at Oxford), while others could be used simul-

taneously for out-patient physical rehabilitation and group psychotherapy sessions.



- | | |
|--|--------------------------|
| 1 - Entrance Hall | 6 - Toilet |
| 1a - Sitting Room | 7 - Nurses Office |
| 2 - Endless Corridor | 8 - Doctor's Office |
| 3 (A,C,D) Dormitory Spacing for 2 four bedded units | 9 - Male, Female Staff |
| 3 (B) Alternative Dormitory Spacing for 3 two bedded units | 10 - Therapist Office |
| 3a - Living and Dining Area | 11 - Bath |
| 4 - Kitchen | 12 - Utility Room |
| | 13 - Courtyard |
| | 14 - Rehabilitation Area |
| | 15 - Storage Space |

More than one activity in the whole Mental Health/Vocational Rehabilitation could be involved. Thus, there would be no difficulty in utilizing a segment for the residential rehabilitation of physically disabled clients suffering from paraplegia or multiple fractures, or cerebro-vascular accidents (strokes).

RESEARCH

The new functional design of this Multipurpose building has been very successful in the Psycho-geriatric service of the United Oxford Hospitals, England. A similar building is proposed for use in the developing psycho-geriatric service of Eastern North Carolina based at Cherry Hospital. It is suggested that a program of research into its architectural, building, and financial value be combined with a careful functional evaluation of each of its separate uses as described herein.

A current estimate (November, 1969) for this type building in North Carolina is \$30 per square foot which would yield an approximate price of \$370,000, which would also include much of the necessary physical rehabilitation equipment vitally needed.

EXHIBIT C—THE PHILOSOPHICAL CONCEPT AND FUNCTIONAL USE OF THE DAY HOSPITAL

(By Dr. Lionel Cosin)

The later years of the 20th Century have brought about a reconsideration of the value of hospital treatment, of the family physician, of the delivery of medical care, and of the concept of "episodic" care.

To explain this concept, I must draw attention to the general philosophy controlling the delivery of medical care, which is still based upon the 18th Century management of Infectious Disease. This management was most concerned with the protection of the immediate community by the isolation of the "peccant" patient until he was no longer dangerous. This removal of danger seemed to coincide with the patient's clinical recovery, but the consideration was not primarily therapeutic or orientated towards his recovery.

This "episode" then of infectivity and clinical illness appeared to be terminated by the patient's recovery, and as a corollary, no more isolation, treatment, or consideration of his problems appeared to be indicated.

Before rising hospital costs have made it necessary to consider and reduce, where possible, the number of days of in-patient hospital care, it was the end of such an "episode" that terminated all medical care. It is this concept which still too frequently controls the delivery of medical care, especially when based on the "fee for service" "doctor-patient" relationship.

Where social or medical problems could not be solved in such an episode then the program of custodial care was considered to be the only solution for chronic physical disability, short term or long term mental disease or abiotrophy, and financial destitution due to age or disability.

The scene has now changed and we are actively concerned with reconsidering the problem of delivering medical care on an epidemiological basis. I have unfortunately, little time now to introduce to you my concept of Continuing Care which is predicated by a program of rehabilitation measuring the rate of return of competence—physiological, social, physical, intellectual, emotional, domestic, and finally industrial.

Suffice it that any program of delivering medical care to many of the elderly or disabled necessitates the following services:

(1) Good follow-up, both medical and social, prevents premature collapse of a community situation involving an elderly or disabled patient.

(2) The administrative and organizational ability to readmit, immediately, to a good medical service, a patient whose medical or social needs can no longer be sustained without a good 24 hour nursing service, is a fundamental part of the Oxford Geriatric Service.

(3) Regular planned intermittent readmission for therapeutic, rehabilitative, or social reasons, and the planned relief of measured family stress is another preventive approach in community medical care. Indeed, the better planning of programs of Medical Care involve a far higher percentage of planned readmissions, while the high incidence of unplanned readmissions of elderly disabled frail patients is to be questioned, if not condemned.

(4) Day Hospital Care.

THE PLACE OF THE GERIATRIC DAY HOSPITAL IN PATIENT CARE

Since Descartes most of Medicine has considered man as an object to be observed, examined and treated. Or as Buber would describe it, the patient-doctor

relationship has been of the "I-It" type. But Buber clearly defines the other more acceptable "I-thou" doctor relationship where empathy is a far more important consideration. This is one of the aims of the Day Hospital, orientated to this concept, because it begins to approach in depth of knowledge and breadth of understanding that continuing clinical picture only gained in community practice by the experienced and expert general practitioner: this knowledge and understanding must be superior to the episodic experience of the patient and his family's problem by a doctor based on a program of short term hospital care.

The great difference between the usual cold intellectual study of a patient in hospital and the existential realities of the patient's problems in a family setting, lies in the insufficiently considered conclusions in management and care based on diagnosis obtained from In-patient analytical procedures which would not necessarily be correct in the community setting in which the patient, with his long suffering family have to live.

Because the Day Hospital can be used for In-patients before discharge or for Out-patients, it can adopt a median position in planning community programs of continuing care and help to produce the most warm, empathetic and accurately tailored solutions for a given milieu.

THE DAY HOSPITAL IN RELATION TO THE DYNAMIC QUADRUPLE ASSESSMENT

Our Day Hospitals are, in Oxford, an integral part of a dynamically functioning Geriatric Unit because they meet so many of the desiderata essential for the continuing care of the elderly and disabled. By integrating a Hospital Service with the maintenance of many patients in their own homes, the Day Hospital service forms a firm and adequate link between Home Care and hospital care without breaking the family or community ties. In this way institutionalization, with all its social deprivations, personality collapses, anxiety states, psychoses and unrecognized cruelties, inevitably offered to long term hospital patients, is avoided.

The elderly patient with decreasing intellectual powers, weakening ego and tendency to withdraw from society, has additionally a far greater tendency to suffer from several pathological and biochemical upsets, partly because of lower physiological reserves and the greater incidence of an inadequate vascular supply to vital organs. Because degenerative processes, which so frequently but not inevitably, accompany aging, physical disabilities are also common.

I have elsewhere drawn attention to the need for a holistic approach in the care of the elderly, especially when there are signs of intellectual blunting combined with mental confusion, which is often associated with lowering of cardiac or respiratory reserves whatever the aetiology.

This holistic approach I have defined as the "dynamic quadruple assessment". The term "assessment" is used to imply a repeated need to assess and re-assess the dynamic interplay between the four factors causing disharmony in the elderly patient's appreciation of environment, care and comfort. The dynamic aspects of medical care programs need to be stressed repeatedly because the unfortunate approach to the clinical problems facing the elderly patient is still far too often a static diagnostic and unreasoned prognostic exercise, practiced by doctors and taught to medical students whereby pontifical and weighty opinions consign many patients with remediable conditions to less expensive and lower standards of care. This inevitably precipitates irremediable clinical and "life" situations.

"Planned Obsolescence" is said to be a symptom of an affluent society, but "Unplanned Obsolescence" is diagnostic of a society afflicted by guilt concerning the social management of the elderly or disabled patient when led by medical opinion insufficiently experienced in the deeper appreciation of the problems facing these patients.

The academic assessment and re-assessment of the four major factors responsible for the widely disparate clinical pictures of the disabled, sick and socially incompetent patients are appropriate in medical practice all over the world.

These four major factors consist of:

I. *Pathological*. Here it is imperative to realize that multiple causal pathologies are the rule rather than the exception and that to ignore this fact leads to failure to appreciate and, therefore, treat adequately, many remediable conditions.

II. *Psychological Assessment*. The second factor which plays a considerable part in the symptom complex of the elderly patient is the Psychological aspect. Here, the life pattern of harmony or lack of harmony in the individual's drives, ambitions; fears, feelings of guilt and inadequacy, and depressive states, have to

be measured against the lessened intellectual performance, inadequate motivations, diminished learning ability and tendencies to social withdrawal. These must be considered against a current background of catastrophic intellectual loss, disorientation, confusion, hallucinations and delusions due to pathological and biochemical factors.

III. *Social Assessment.* The Social assessment is of obvious importance in this field of Social Psychiatry. Here the changing relationship of the individual to the community, the family group and the newly created psychotherapeutic group in the Day Hospital replace the sterile anti-social approach of institutionalization and a 20th century version of the 18th century rejection of the deviant individual by the family and community. No Social Assessment is complete without due attention being paid to cultural factors. What might be socially acceptable in the European or allied cultural pattern might not be acceptable in other cultures.

IV. *Assessment of Physical or Muscular Ability.* Physical factors involved in Physical Assessment include not only the clearly demonstrable physical disability but also underlying psychological problems of motivation and problems of biochemical homeostasis and inadequate social milieu.

The use of a Day Center or Club is not to be decried when used to solve social problems of loneliness, nutrition or financial support, but it *cannot* be expected to carry out the many therapeutic functions of the Day Hospital because of its lack of appropriate facilities.

THE PURPOSE OF DAY HOSPITAL

The purpose of a Day Hospital are :

1. To treat by an individual behavioural approach or in a psychotherapeutic group situation.

2. To measure improvement of social and other parameters of competence by retraining in old skills or acquisition of new skills.

3. To facilitate and assist in an active program of Community Care by planning responsibility for that part of the week for which relatives need to be freed for work or other home activities, or for periods when community resources (Home Help, Home Maker, Health Visitor, Visiting Nurse, Social Worker, Voluntary Visitor or friends) are not available.

4. To provide a more humanitarian management of sick, disabled, or confused old people than is otherwise provided by neglect in the community or profound demoralization that can often follow institutionalization. The advantages of a full therapeutic program available to In-patients is thus made available to Day Hospital patients. Serious illness at the Day Hospital can be most appropriately treated by immediate admission. The skillful and practiced use of the Day Hospital now makes it possible to vary the milieu and approximate it much more closely to the patient's current and changing needs. This is in contradistinction to the old but still prevalent management of elderly confused patients by an episode of medical care lasting a few days, followed by permanent custodial care. The alternative for many is still chronic neglect in the community because of the increasingly large numbers of old people with unmet medical and social needs.

This unorganized neglect of increasing numbers of old people whose gradually increasing degree of intellectual blunting, with memory loss for recent and remote events, with loss of recall, with withdrawal from social activities, with lessening affect, with increasing anxiety and depression for financial, social and psychological and even poor housing reasons, cannot be faced any longer on a basis of individual care by an individual doctor; it must now be accepted as an epidemiological problem and faced like other epidemiological problems with an appropriately planned Preventive Health program that practitioners of community Medicine and the closely linked Social Psychiatry are experienced to organize.

Medically placed between individual medical attention and the pandemic Geriatric problems of the community, the Day Hospital skillfully and appropriately used, is the most valuable therapeutic agent as a part of the comprehensive Geriatric Service that has been developed in the last two decades.

While I have described the Oxford Day Hospitals with especial reference to their value in the treatment of the elderly, the principles of use are also applicable in the rehabilitation, resettlement, and maintenance in the community of the physical disabled, the prevocational and vocational rehabilitation

and training of psychiatric, emotionally disturbed, orthopaedic, chronic neurological and post-traumatic clients. This constitutes a very important part of the policy of Continuing Care shared by the Hospital Service with community responsibility and family care.

THE OXFORD DAY HOSPITAL

The Day Hospitals in the Oxford Geriatric Unit differ from a Social Center in that there is a close and intimate link with a hospital giving full scope for medical In or Out-patient treatment; there is full medical control and psychiatric advice. Moreover, the Oxford Day Hospitals have a dynamic function in the maintenance of individual independence in the community while, at the same time, sharing responsibility with the family and the community for those patients who are more frail. It has available the resources of immediate admission or re-admission to an active medical unit, facilities for physical electro-convulsive treatment for affective psychotic cases, and the possibility of In-patient "treatment through experience" in an environment far more pleasant than that of the usual hospital. As the Day Hospitals are an integral part of the Geriatric Unit, their facilities can be accurately applied in the most appropriate cases. It can also be used experimentally in handling situations which have only been solved previously by permanent hospitalization.

Often a request for entry to the Day Hospital is made by a general practitioner because of a deteriorating family situation. A domiciliary or Out-patient consultation will then decide the most appropriate course of action. It may well be decided that, for medical or physical reasons, the patient should be admitted for a short course of In-patient treatment in the first instance.

THE IMPORTANCE OF THE FAMILY GROUP

In the type of elderly or younger disabled patients we see, they often make a better adjustment if they are referred to the Day Hospital, after, rather than before, In-patient treatment. In fact, many In-patients first experience the helpful environment of the Day Hospital in the Occupational Therapy Department. I would say that in many cases admission of the patient to the Geriatric Unit was the most important step in breaking a vicious circle in poor inter-personal family relationships, in which a rapidly deteriorating sociological unit in the community had to be supported before total collapse resulted in the inevitable permanent admission to hospital or to a home. It is often the sociological status of the family unit, rather than the psychiatric status of the elderly patient, which determines admission, which is then all too often permanent—again for sociological rather than psychiatric reasons.

Thus, I agree with Bierer in treating the individual and the situation in the family group by utilizing the centripetal-centrifugal interaction. When adjustment to the new situation has been made by the family, the patient's return home is facilitated by the offer of a shared responsibility for the patient for a period of time that can be limited by the voluntary action of the family group. This compares favourably with their unlimited responsibility for a dirty, demented, deteriorating patient for an unlimited period of time. As a result, we find much less difficulty in arranging the patient's return home. This is made easier by the paralled offer of the Day Hospital for from one to five full days a week. As a means of reducing stress in the individual family and of improving the sociological climate, the Day Hospitals can be seen to be playing a growing but important part in more than one area of the country.

It is widely quoted that old people are sent in to Hospital because of the deteriorating relationships between the representatives of different generations, and that once an old person has entered hospital, the relatives will not take him out. That may well be the case, but in many areas, it is a superficial and often incorrect observation. Superficial because the circumstances of an old person's return home after an acute pathological process has been resolved, in no way solves the family's total problem so far as the patient is concerned. Other problems, emotional, physical and interpersonal have not been examined, let alone solved. If no examination of the circumstances of an often difficult interpersonal relationship is made, how then can we doctors correctly say that the family will not take on its social responsibilities? It is rather like a patient being sent home with the appendix removed, but the peritoneum and abdominal muscles unsutured while the skin has been neatly sewn up to conceal any examination of what lies below.

There is great additional diagnostic value in the Day Hospital environment. For only there is it possible for repeated accurate diagnoses of evidence of improvement or deterioration to be made by the skilled observation of occupational therapist, clinical psychologist and physical therapist. In this way a longitudinal study of behaviour in a true life situation can be made. I find it of far greater value from the point of view of prognosis than the usual medical diagnostic methods.

The dynamics of the Day Hospitals in the Geriatric Unit differ from those in mental hospitals, community mental health centers; social psychotherapy centers or in social clubs. In the former there is a constant dependency of the main group and individuals upon the therapeutic team, whereas in psychiatric social groups the aim is the democratic organization of the participants. Although Slavson insisted, in his group of psychotherapy, upon the passive role of the observers and therapists, this could not be possible in the Geriatric Day Hospital. More likely there is still a hierarchial pattern utilizing the skills and greater psychological insight of the Occupational Therapists and medical Social Workers. The main group is essentially dependent upon the organizational ability and the therapeutic approach of the Occupational Therapists. The individuals in the group, however, acquire a maximum of permissiveness and independence as their levels of measured competence improves.

STRUCTURE OF OXFORD GERIATRIC SERVICE DAY HOSPITAL BASED ON FUNCTION

Many Day Hospitals have been started in Occupational Therapy Departments, old houses, unused wards, and indeed any unused accommodation. As far as I know, however, the first purpose built Day Hospital in a Geriatric Service, was planned at Oxford in 1954, following a gift by the Nuffield Provincial Hospital Trust, to become the most important part of the Oxford Geriatric Service's extension into community care.

The author planned the first around the need to provide continuing services for the increasing numbers of elderly confused old people being cared for in the community, and for whom very little chance of permanent admission to a Mental Hospital or to an Old People's Home seemed likely or perhaps desirable.

In the area served by the Oxford Geriatric Unit comprising Urban and Rural areas in a radius of 20 miles from Oxford and serving a population of over 300,000, it is becoming apparent that the family group, neighbours, friends and the Community Services often combine to provide a massive support to confused old people, provided that there is a degree of social competence which allows them to require only minor personal attention, and when they are appropriately supported by a Day Hospital. However, when cerebral function is so impaired that the old person is rendered very confused, disoriented, agitated and wandering, hospital admission should be very rapidly arranged.

As there is not space or time to describe the architectural details in this paper, of this first purpose built Day Hospital for the elderly, I can only point out here that I followed the physiological principle that "Function determines Structure", and not the usual Architect's approach of making structure determine function.

That great planner Winston Churchill wrote "We shape our buildings, and our buildings then shape us". We social planners of the delivery of medical care could not do better than to heed his words and follow his practice.

SUMMARY

The author first draws attention to the still prevalent, but in his opinion, obsolete methods of management of the problems affecting elderly, the younger disabled and other chronic sick patients. He demonstrates that the only alternatives previously, and in many cases presently, to neglect in the community was custodial care in an institution or Home. This was sometimes preceded by a brief period of "episodic" care in an acute hospital where even today the "chronic sick" are to be moved out of sight as soon as possible.

The author compares this management with his concept of Continuing Care and Management where hospital facilities increased by Day Hospitals and Rehabilitative facilities, then share the responsibility for the patient with the family group and community resources.

By preplanning appropriate programs of care, and insisting on the physiological principle, when planning buildings, that function determines structure he describes the rationale of a new therapeutic revolution.

Appendix 4

STATEMENT BY THE NATIONAL COUNCIL OF HEALTH CARE SERVICES

ABOUT THE COUNCIL

The National Council of Health Care Services, formed in July 1961, represents a select group of ten high quality, patient-oriented, multi-facility health care companies who operate approximately 21,000 convalescent care beds as well as several thousand acute hospital beds throughout the United States. Formed to represent multi-facility health care companies in Washington, the Council was reorganized in January 1971 and presently accepts as members only those companies whose facilities meet the stringent accreditation standards of the Joint Commission on Accreditation of Hospitals.

Approximately 80% of the National Council's member companies are publicly held.

In addition to ownership and operation of convalescent care facilities and acute hospitals, Council members are actively planning to participate in innovative health care delivery options of the future, such as Health Maintenance Organizations or prepaid health care plans.

Council members recognize that their first obligation is to the patient entrusted to their care, and believe that any health care facility or operator that fails to show proper concern for the patient's welfare does not deserve to stay in business.

The National Council of Health Care Services was created in the belief that the existence of healthy competition between voluntary and proprietary health care facilities will work to improve the quality of care and efficiency of operation of each type of facility. Council members are united in a common objective: to promote and maintain a professionally and economically sound health care program, with emphasis on providing the best possible care for the patient at the lowest possible cost.

The National Council of Health Care Services strongly believes that there is no reason that any legitimate and properly motivated provider of health care should apologize for the fact that in providing that care, he also realizes a profit. The Council is dedicated to creating a national climate where that provider who provides the best health care for the dollar is allowed the opportunity to make a profit.

We have read and studied the Nader Report on Nursing Home Conditions, and we respectfully submit the following commentary on sections of that Report, not as a diametrically opposed criticism, but in the hope that our wider knowledge and expertise in the health care field may allow us to expand upon and clarify sections of the Report and its recommendations. In addition, we have gone beyond the scope of the Nader Report and have offered some suggestions of our own which, we believe, could go a long way toward improving the lot of our nation's elderly—both in and out of institutions.

We have not commented on all sections of the Report, but only on those sections which are of particular interest to elderly patients and their care and where we feel that our comments and additional suggestions may be of assistance to the Committee in its endeavors.

I. THE PROBLEM

1. The Nader Report notes that "society's attitude toward the elderly is a crucial factor in understanding why nursing homes are so often places of pain and despair rather than comfort and hope." (Preface, pg. vii). The National Council of Health Care Services strongly supports this contention. In too many cases, nursing homes and the care they render have become the scapegoats for the guilt feelings of a society no longer desirous of or equipped to care for the elderly at home.

2. The Report states that "Lack of alternatives to expensive hospital care is one of the most serious problems for the elderly." (pg. 23) The National Council of Health Care Services has brought to the attention of HEW and the Congress

this problem, although perhaps not in the sense meant by the statement in the Report. What the Report actually refers to is alternatives to institutional care for the elderly. In response, the National Council agrees that alternatives must be found for "expensive hospital care" for the elderly. One major alternative, in the Council's view, however, is the extended care or skilled nursing facility where the elderly person in need of continued medical and nursing care is able to receive appropriate levels of care at a reasonable cost. For those of the elderly who are ambulatory, who do not require constant medical supervision and care, the Council strongly supports the development of such "out-patient" alternatives as home health agencies, day care centers, "meals-on-wheels", homemaker services, etc. However, we note that in many instances, the tendency of health insurance programs, Medicare and other private plans—to concentrate benefits on stays in the expensive acute care hospital—has made the stay in the hospital the least expensive alternative for the elderly themselves. Insufficient benefits and retroactive denials in the Medicare ECF coverage force many elderly patients to pay for care themselves in less expensive and more suitable extended care and skilled nursing facilities. In addition, there still is no adequate provision for coverage of long term care for those of the elderly who require it.

3. (Pg. 24) "The Federal government has so far failed to enforce standards for nursing homes . . ." The National Council of Health Care Services also believes that, with some 75% of Medicare-certified extended care facilities still certified as "in substantial compliance", the Federal government has indeed failed to enforce its standards for nursing homes. However, we believe that the Federal government has been hampered in its efforts to enforce standards by some provider organizations who publicly call for high standards and privately lobby effectively against raising or meeting standards. The National Council of Health Care Services is actively promoting high standards and calls for the closing of any substandard facility which refuses or is unable to meet required standards. At the same time, however, we must point out that high standards of nursing care and physical facilities are only possible where the payment for these services is sufficient to cover the cost of providing it.

4. (Pg. 25) "A major result of this study has been the conclusion that no one group—the government, the nursing home industry, or the medical profession—looks on itself as responsible for achieving adequate institutional care for the elderly."

The National Council of Health Care Services supports the statement's conclusion, but doubts that any one group of those named above can be held solely responsible—or should strive to become solely responsible—for the institutional care of the elderly.

What is needed is a working partnership among government, the nursing home industry, health insurance companies, Medicare intermediaries, the medical and nursing professions, the community, the relatives of the elderly, and the elderly themselves. Each of these groups should contribute to and accept a share of the responsibility for making good institutional care for the elderly a reality.

5. (Pg. 26) "The bedsores and boredom visible on the bodies and faces of nursing home residents are only symptoms of a national diseases. The course of that disease can be traced through government programs that are ill-managed, under-financed, and fragmented and through a failure of our national leaders to make a firm commitment to adequate health care for elderly Americans, as indicated by the fact that the U.S. House of Representatives does not yet have a committee specifically assigned to deal with problems of aging. It can be traced through a medical profession that places professional jealousy before professional responsibility, and through a profit-oriented nursing home industry that assesses health care on P & L sheets. It can be traced through a society whose aversions to the very condition of old age, the crushing costs of medical care and the shattering psychological costs of retirement."

The National Council of Health Care Services is deeply concerned over the American public's almost complete ignorance of the interrelated problems of the 65-plus generation. We question, however, that the lack of a committee on the problems of the aging in the U.S. House of Representatives (when one already exists in the Senate) is a valid indicator of a failure of our national leaders to make a firm commitment to adequate health care for elderly Americans.

The National Council of Health Care Services, while admitting that some "profiteering" undoubtedly does exist in the nursing home industry, rejects out-of-hand the report's contention that proprietary nursing home "assess health care on P & L sheets." The responsible segment of the proprietary nursing home

industry does have a deep and abiding concern for the welfare of the patients entrusted to its care. The National Council of Health Care Services further—and strongly—contends that the opportunity to make a fair return on investment and high quality, humane patient care are NOT mutually exclusive. In addition, the existence of investor dollars in the health care field allows care to be provided at less cost both in absolute terms and in terms of cost to the taxpayer, as well as contributing its tax dollars to the treasuries of States and the Federal government.

II. OWNERSHIP

Since the Nader Report's chapter on "Ownership" is almost entirely devoted to the subjects of "hidden chains" and "large chain operations", the National Council of Health Care Services, in the interest of accuracy, feels compelled to clarify some of the points raised in this section of the Report.

On page 157, the Report notes that "Today, the majority of owners are corporations or individuals who own a number of homes". This statement is simply not true. Less than 7% of all nursing home beds (defining nursing home beds as those which provide some form of medical and nursing care) are owned by corporations or individuals who own a number of homes.

On the following page, the Report, while reporting that 90% of all nursing homes are "privately-owned, profit-making operations", goes on to suggest that "stricter regulations may be needed to prevent abuses by owners, particularly in the case of entrance contracts that require patients to sign their possessions over to the nursing home for life . . ." Since almost all of the nursing homes requiring entrance contracts are voluntary, it appears to the National Council that this is a misleading statement to appear in the same paragraph which begins by stating that 90% of all nursing homes are proprietary. In fact, it is the non-profit, religiously oriented facilities that follow such a pattern of admission contracts.

While it is neither the responsibility nor the desire of the National Council of Health Care Services to defend an entire industry, we feel compelled to note that all "business" (as opposed to non-profit) corporations are open to public scrutiny by their stockholders. In the case of public corporations, the Securities and Exchange Commission is also empowered to act as watchdog.

The chapter on "Ownership" devotes substantial space to a series of articles which appeared in Barron's Weekly in March 1969. The National Council of Health Care Services must point out that the Barron's series is not relevant today. The health care field has moved too far for that. We would, however, support its contention that many health care companies have suffered and are still suffering from a lack of medical management. Those responsible and innovative health care companies who will continue to exist, however, have realized the need for medical management and are taking steps to insure that their companies are staffed with properly-trained health care experts.

(Pg. 165) "Desire for profits may lead owners to seek administrators who are good businessmen. But the same desire for profits may prove a negative influence on the patient's demand for personnel trained in health and for other services that prove costly. Additional pressures on the owner are needed to insure that patient care does not give way to profit-making."

In response, the National Council of Health Care Services would like to note that the better managers and administrators recognize that well-trained and highly-motivated employees are more economical in terms of long run production and lower turnover. Production and turnover, which have a deep and lasting effect on the quality of patient care have been and continue to be problems in the hospital and nursing home industry because of the depressed wage scales of the past. For this reason, the members of the National Council of Health Care Services are committed to working with their employees to gain for them a fair and competitive wage. This can only be accomplished when the rate of reimbursement is such that the nursing home operator is able to pay his employees a decent wage.

In addition, the National Council of Health Care Services supports the strict enforcement of existing regulations for nursing homes, in the belief that, where this is the case, "profiteering" at the expense of patient care will be almost non-existent. We further look toward the development of methods of measuring patient care more realistically than the present "hours of nursing time per patient per day" effort.

III. DRUGS

"Government statistics suggest widespread carelessness in the handling of drugs in nursing homes—drugs are administered incorrectly or not at all, drugs prescribed by physicians are allowed to continue too long, or too many drugs are prescribed, or drugs are administered that have not been prescribed by the physician." (Pg. 191)

The National Council of Health Care Services shares the concern voiced by the Nader Report over the problems of drug control in the nursing home. The American Society of Consultant Pharmacists, formed in January 1969, has as its "raison d'être" the education and continuing training of the nursing home's consultant pharmacist and the development of drug control training programs for the nursing home personnel. Under both Medicare and Medicaid regulations, spelled out in 20CFR 405.1127, extended care facilities and skilled nursing facilities are required to utilize the services of a consultant pharmacist. All too often, this requirement has been ignored and has not been enforced under either Title XVIII or Title XIX. The results of this laxity are made clear in a limited study made by ASCP. 75% of nursing home patients do not receive adequate pharmaceutical services and drug controls. A recent study suggests that many hospitals have even less control and more drug abuse.

The National Council of Health Care Services calls for the stringent enforcement of 20CFR 405.1127 for both extended care facilities and skilled nursing homes. In addition, the Council recognizes the need for the development of innovative approaches to the problem of drug distribution and control in the nursing home, such as various unit-of-use drug distribution systems which have recently been developed. The community pharmacist must be educated so that he will be able to fulfill his role as consultant pharmacist. And, in fulfilling his role, the consultant pharmacist must undertake the responsibility of educating nursing home personnel involved in actual drug distribution. The development of a high "state of the art" in consulting pharmacy will be a major breakthrough in cutting down to the irreducible minimum problems of drug control in the nursing home.

IV. RECOMMENDATIONS

1. (Pg. 269) The Nader Report recommends "strict federal enforcement of present standards for nursing homes receiving federal funds. This will mean elimination of the 'substantial compliance' approval given homes that are in violation of the law."

The National Council of Health Care Services supports this recommendation (with the exception of minor physical deficiencies which do not affect patient care in any significant way), but would like to point out that the enforcement of standards for nursing homes varies from State to State. In addition, the Council recommends that training of inspectors, as proposed by the Public Health Service (see Pg. 269) should be encouraged and should signal meaningful progress in achieving uniform standards. However, the Council goes further in its recommendation and suggests that standards for all skilled care and extended care facilities be set on a national level and enforced by federal inspectors, or by inspectors federally trained. We realize that such a step appears to be impractical, given the present governmental system of allocating all such inspection powers to the various States, but it is a goal well worth shooting for.

2. (Pg. 270) "As another incentive to homes to achieve high quality care, the Department of HEW should consider publishing ratings for homes that receive federal funds. Quality ratings, along with a label of the level of care offered by homes, should also help the elderly avoid an unfortunate choice through ignorance, where a choice is available."

The Senate Committee on Finance added an amendment to H.R. 17550, the Social Security Act of 1970 (which did not become law due to lack of time), designed with this in mind. The Finance Committee's Companion Report to its version of H.R. 17550, discussing Section 274, states that "Easy public access to timely information about deficiencies (such as in areas of staffing, sanitation, fire and other safety requirements) would help significantly to encourage facilities to correct their deficiencies and, at the same time, enable physicians and patients to make sound judgments about their own use of available facilities in the community. The committee bill, therefore, requires the Secretary of HEW to make information on the significant deficiencies of individual providers a matter of public record readily available on request at all Social Security district offices and

centrally at Social Security Administration headquarters. The Secretary would make this information available only after the provider has been fully informed about the significant deficiencies that have been identified and has been given a reasonable amount of time (not to exceed 90 days) to correct the deficiencies."

The National Council of Health Care Services supports enactment of Section 274 and believes that it represents a more realistic and desirable method of giving nursing homes incentives to maintain high standards, and, at the same time, educating the consumer than a system of publishing "quality ratings" recommended by the Nader Report.

3. (Pg. 270) "Medical review should be implemented by the Department of HEW. The medical profession should cooperate in developing the means for making medical review a viable and efficient exercise of professional responsibility in insuring adequate medical policies and practices in nursing homes."

Again, the Senate Committee on Finance added two amendments to H.R. 17550—Section 245, Professional Standards Review Organizations, and Section 265, Inspector General for Health Administration—designed to give physicians the responsibility for medical review in the first instance (Sec. 245), and creating a new and powerful office in HEW to monitor health programs and the performance of the PSRO's in the second instance (Sec. 265).

The National Council of Health Care Services applauds the intent behind both the Nader Report recommendation and the Finance Committee's amendments. It is hoped that the Professional Standards Review Organizations will function as expected and will have the effect of bringing the physician into the nursing home. Past experience has indicated that getting physicians into nursing homes has been extremely difficult for a variety of reasons, most of them revolving around the physician's lack of interest in the chronic illnesses of the elderly and his wish to have all of his institutionalized patients concentrated in one location—the hospital. The members of the National Council of Health Care Services support the concept of medical review at all levels as necessary to the provision of good patient care and hope that the solutions proposed by the Senate Committee on Finance will, in fact have the desired effect.

4. (Pg. 270) "Training of aides is another area where much remains to be done. The crucial role of the aide makes inservice education a priority item in any campaign for improving nursing homes."

The National Council of Health Care Services strongly supports this recommendation. All of the Council's members do conduct inservice training programs for aides in their facilities. A concurrent and major problem, however, in the training of aides, is their high turnover rate, caused mainly by low wages and lack of motivation. If an aide's average length of employment is 4-6 months, the training process must be repeated so often, on so many different people, that continuity becomes difficult, and the training may never be put to use.

Therefore, the National Council of Health Care Services proposes that inservice training programs for aides become mandatory, and concurrently, that reimbursement for nursing home care be adjusted to allow the nursing home operator to pay aides a fair and competitive wage. The member companies of the Council will be happy to place their expertise in conducting inservice training programs for aides at the disposal of those persons in the Department of HEW who would be responsible for setting standards and devising guidelines for inservice training programs. However, we do believe that the proper place for conducting inservice training is in the facility—and should NOT be the responsibility of HEW or any other government agency.

5. (Pg. 270) "As licensing of administrators gets underway, State governments have the responsibility for seeing that high standards are set, especially for educational qualifications. The nursing home industry should use the licensing process as a means of attracting qualified administrators. They should also support educational programs for health administrators. To meet the goals envisioned by the licensing law, the federal government should tighten its regulations to insure, without doubt or evasion, that no single interest group dominates the State licensing boards."

First, the National Council of Health Care Services believes that the federal government and not the States should set minimum and specific standards for the licensure of nursing home administrators. This would include any written examination required for licensure. The National Council of Health Care Services and its members are concerned that at this time difficulties are being experienced in arriving at some agreement among various States for reciprocity

agreements for licensed nursing home administrators. Further, the Council believes that if an individual is adjudged qualified to administer a nursing home in one State, he should be qualified to administer a nursing facility in any other State. Patients in nursing homes suffer from the same conditions in all parts of the country, and the nursing home administrator is faced with similar problems. It would appear that the only equitable method of setting standards for the licensing of nursing home administrators is on a uniform, national basis.

Second, the National Council of Health Care Services, while recognizing the necessity for a nursing home administrator to possess certain educational qualifications, takes issue with the overriding emphasis given to educational qualifications in the Nader Report's recommendations. If it is true that the provision of humane and high quality patient care should be the object of nursing home, then it must also be stated that the acquiring of several degrees will not be any assurance of either proper attitude or administrative ability. The latter two qualities, and a method of discovering their presence and degree in a potential nursing home administrator are at least as important as the wording on his sheepskin(s).

Third, the Council agrees that there is a need for educational programs for nursing home administrators. All member companies of the National Council conduct training and "apprenticeship" programs for would-be nursing home administrators in their facilities. The ability to develop a tested training program which provides the junior administrator with experience in many and varied situations is a major advantage of the multi-facility health care company, as opposed to single home operations.

Fourth, with regard to the recommendation that no single interest group should be allowed to dominate State licensing boards, if standard-setting and licensing of nursing home administrators were the responsibility of the federal government, domination by a single interest group would be a virtual impossibility.

We do, however, recommend that responsible nursing home administrators and representatives of the industry be given equal voice with other interested parties on all such State licensing boards, as long as State boards are given the responsibility for licensing nursing home administrators.

6. (pg. 271) "The federal government should actively promote alternatives for the elderly outside the nursing home: 'integrated' community housing through Model Cities and other programs, employment opportunities, service programs like homemakers, home health and other services."

The National Council of Health Care Services supports the finding of non-institutional alternatives for those of the elderly who are not in need of institutionalized care. In addition to the suggestions made in the Nader Report, other alternatives suggest themselves:

Day Care Centers, either in a nursing home, or in a facility used only for that purpose, provide a less expensive way to give meals, recreation, companionship, and a sheltered daytime environment to those senior citizens able to live elsewhere at night and on weekends.

Since the nursing home provides such an ideal setting for day care centers, it is unfortunate that several States prohibit the existence of day care centers unless there is a bed set aside for each senior citizen participating in the day care program. The National Council recommends that all such statutes be abolished. In addition, we recommend that the federal or State government pay for day care services for those elderly who are unable to afford the cost themselves. This would be a logical step for government welfare and/or medical insurance programs to take, since it is a far less costly alternative than full-time institutionalization.

Meals-on-Wheels is another service which could function hand-in-hand with homemaker and home health services.

Some members of the National Council of Health Care Service run free training classes in caring for the elderly, first aid techniques, and recognizing symptoms of illness for families who have an elderly relative living in their homes. Programs such as these should be expanded so that those families who do have the room, resources, and ability to care for an elderly relative at home will have the necessary training to care for that individual properly.

The "Foster Home" concept for the elderly person in need of a sheltered environment, but who is not in need of constant medical care, could be developed if requisite standards and safeguards were in force. One necessity in

implementing a "foster home" program will be an areawide clearing house to insure that the foster home, suitable for one or two persons, cannot become another "converted" home where 20 persons are kept where only one or two should reside. This will require also that either the State or federal government undertake to pay for the individual's care in a foster home, in much the same way as is now done with foster parents caring for children.

However, the Council must point out that all of these non-institutional alternatives are only applicable in the case of those of the elderly who are not in need of medical care in an institution. One of the sorriest failures of the Medicare program has been its failure to make provision for long term medical care for that sizeable number of the elderly who have chronic, long-term illnesses or conditions requiring constant medical care or nursing care. We strongly recommend that some provision be made for long term medical care for those of the elderly who require it.

Finally, the National Council of Health Care Services urges that government programs for the elderly should pay for and encourage rehabilitative services for all elderly institutionalized patients who have rehabilitative potential, so that, even if total rehabilitation is not possible, and institutionalization continues to be necessary, those persons are able to live up to their greatest possible potentials.

7. (Pg. 271) "Expenditures to enforce standards in nursing homes—mainly for increased manpower—will help insure that the already massive public support of these institutions is actually buying good care, and not merely enriching the coffers of private industry. It will also help eliminate abuses, such as higher charges for government-subsidized patients, oversized drug charges, and others."

Before commenting on the recommendation's merits, the record must be set straight on certain statements contained in the preceding paragraph:

1. "Public support"—or government reimbursement for care rendered in nursing homes is NOT, under any government programs as presently constituted, "merely enriching the coffers of private industry."

2. "Higher charges for government-subsidized patients" is absolutely UNTRUE.

Both of these well-intentioned, but false allegations may be answered in the same way. Medicare pays "allowable costs" only for extended care benefits. In addition, instances of retroactive denials of payment for care rendered in ECF's are too numerous to attempt to document. Medicaid payments for skilled nursing home care are generally a flat fee, which, in many States, does not cover the cost of providing the care, not to mention the possibility of a profit. Under the present system, it is the private-pay patients who are charged more than government subsidized patients, and who, in effect, are subsidizing the government-subsidized patients.

The National Council of Health Care Services does support government expenditures to enforce standards in nursing homes. We believe that government standards, as presently written are achievable and should be enforced—but only if the rate of payment or reimbursement is sufficiently high to allow the achievement of the desired high standards by the provider. Good nursing home care is not cheap.

At a hearing held by the Senate Subcommittee on Long Term Care in December 1970, some additional recommendations were made by the Nader "Raiders".

1. "That the federal government require that from now on, all nursing homes that wish to receive federal funds be constructed either as a wing to a general hospital, or within a short distance from a general hospital."

While the National Council of Health Care Services believes (and both Medicare and Medicaid regulations require) that an extended care facility or skilled nursing home must have a workable transfer arrangement with a hospital, we add that the concept of locating all nursing homes in such close proximity to a hospital is neither practical nor will it be well received by the elderly or their relatives. In many cases a particular nursing home is chosen for its proximity to friends and relatives and known surroundings. If this concept were adopted, many elderly residents of small rural communities would have to find a nursing home that might be 50-100 or more miles from their homes and family. This situation would not be conducive to frequent visits by family and friends—or even the local physician, and it is likely that the patient would be very unhappy. In addition, the cost of land would be prohibitive in many instances.

2. "That the federal government require every nursing home, regardless of whether it is receiving federal funds or not, to have either one resident physician whose only job is to oversee the care of the patients in that nursing home, or else to have a nearby physician on call 24 hours a day."

The first alternative in this recommendation is simply, in the view of any knowledgeable observers, well-intentioned but unbelievably naive. First, unless the nursing home had upwards of 500 beds (a very rare occurrence), a physician-in-residence would be a waste of an already scarce resource. Second, it would be a very rare physician who would agree to serve in such a capacity. Many nursing home patients have limited potential for being "cured" and most physicians do not find this type of medicine challenging or rewarding.

As for the second alternative, federal regulations presently do require that nursing homes have a physician on call 24 hours a day. The National Council of Health Care Services agrees that the actual availability of physicians is a major problem for most nursing home patients. However, we submit that this is a problem whose solution must come from the medical profession and from a stricter enforcement of the already existing regulations.

3. "That the medical profession encourage medical schools across the nation to require their students to spend significant time in a geriatrics ward, or in a nursing home, or in some other way, be exposed to the health needs of the elderly."

The National Council of Health Care Services concurs strongly with this recommendation and further suggests that the recommendation should apply to schools of nursing as well. We believe that the federal government, through Public Health Service grants, as well as foundations and groups or associations concerned with the welfare of the ill-elderly, through grants-in-aid, scholarships, etc. should provide incentives and opportunities for medical and nursing students to become familiar with the health problems of the elderly.

Going beyond the scope of the Nader Report's recommendations, the National Council of Health Care Services supports the development of innovative approaches to health care for the elderly. In particular, the Council believes that prepaid health plans, or Health Maintenance Organizations as they are termed in the pending amendment to Medicare, offer real possibilities for preventive and comprehensive medical care for the elderly at a great savings to both the government and the elderly.

Perhaps most important, we are hopeful that the government will recognize in the immediate future, the symbiotic relationship which exists between high standards of care for the elderly and adequate reimbursement for the provision of that care. As soon as this critical relationship is acknowledged, many of the problems facing both the elderly public and the nursing home provider will be solved.

Appendix 5

STATEMENT AND REPORT SUBMITTED BY WILLIAM R. HUTTON,* EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

STATEMENT REGARDING THE COMPOSITION OF STATE BOARDS OF EXAMINERS OF NURSING HOME ADMINISTRATORS, SUBMITTED BY WILLIAM R. HUTTON, EXECUTIVE DIRECTOR OF THE NATIONAL COUNCIL OF SENIOR CITIZENS

I wish to draw the attention of the Subcommittee on Long-Term Care of the Senate Special Committee on Aging to a serious situation which has arisen concerning the licensing boards for nursing home administrators set up by the States in accordance with Section 1908 of the Social Security Act as enacted in the 1967 amendments.

The intent of the Section 1908 amendment was clearly to safeguard the health and welfare of the nearly two million patients in the nation's nursing homes through the licensing of competent administrators. The licensing boards are charged with developing, imposing and enforcing standards which must be met by individuals in order to receive a license as a nursing home administrator.

The boards develop and apply appropriate techniques for determining whether an individual meets such standards and the boards conduct continuing studies and investigation of nursing homes and administrators to improve the standards so that eventually, the nursing home administrator, after training and professional examinations, can become a licensed professional administrator.

Early this year, reports began to reach the National Council of Senior Citizens that the State Licensing Boards, created in compliance with Section 1908, were being dominated by the Nursing Home Administrators requiring licenses.

On April 14, 1970, I wrote to John D. Twiname, Administrator of the Social and Rehabilitation Service of the Dept. of HEW, to protest against the use of Medicaid funds to pay for nursing care in establishments whose administrators are licensed by agencies dominated by the administrators requiring licenses.

I reported that the National Council of Senior Citizens wanted agencies licensing nursing home administrators to operate in the public interest. We told SRS we favor equal representation of nursing home administrators, other health professionals concerned with the care of the chronically ill, *and the public*.

SRS Administrator Twiname replied on May 8, 1970, that SRS shared our concern and recognized the danger that regulatory boards composed exclusively of members of the group to be regulated, could well perpetuate abuses the nursing home licensure program was designed to eliminate. His letter said, "There is no doubt that both the letter and the spirit of Section 1908 of the Social Security Act reflect the Congressional intent to protect the nursing home patient."

The National Advisory Council of Nursing Home Administration, set up by the 1967 law, recommended that State Boards not contain a majority of members from any one profession.

However, the truth is, the Social and Rehabilitation Administrator who served before Mr. Twiname, ignored this advice. On January 29, 1970, this administrator conceded in a letter to Mr. Walter Kyle, past president of the Iowa Nursing Home Association, that a simple majority of members representing one group on the Iowa State Licensing Board would be acceptable, providing the remainder of the Board is representative of the other professions and institutions.

Even though this letter was written to a private citizen in Iowa, it was widely distributed as HEW policy. Unfortunately, to date this letter has not been repudiated by the present SRS Administrator even though in his reply to the National Council on May 8, he has admitted that an "overwhelming majority" of any one group could impair the effectiveness of the board.

The National Council of Senior Citizens has continued to press the Social and Rehabilitation Service for information regarding the composition of State Licensing Boards.

I would like to introduce for the record a letter on this subject I have received from Howard N. Newman, Commissioner, Medical Services Administra-

*See statement, p. 909.

tion. It shows 21 States where Nursing Home Administrators have a dominant majority of the Licensing Boards. In 13 States where Nursing Home Administrators are listed as less than a majority it is not known whether other members of the board have financial interests in nursing homes.

In addition, among boards having less than prescribed powers beyond home administrator licensing, there are eight States (Oregon, Utah, Florida, New Jersey, Nebraska, Rhode Island, Montana and Pennsylvania) where the control of the licensing board is held by nursing home administrators.

Howard Newman's letter quotes one example—in Texas—where by law the board has a simple majority of nursing home administrators (five of a total of nine). Further imbalancing the board, however, the Governor appointed an osteopath who also administered the nursing home as the "physician" on the board. Thus the Texas board has, in fact, six nursing home administrators on a board of nine.

The National Council of Senior Citizens has received evidence of other states where the composition of a board has been altered through the appointment process or by virtue of the fact that other professional members have financial interests in nursing homes.

In our view, more than 60% of the State Licensing Boards for Nursing Home Administrators are being dominated by nursing home administrators—merely from a study of the professions making up the boards. If other professional members were asked to reveal their financial connections with nursing homes, however, the domination of the proprietary nursing home industry over the State Board would, we believe, be revealed as being much higher.

Consequently, the National Council of Senior Citizens has urged the Senate Finance Committee to amend Section 1908(b) of the Social Security Act to read as follows:

(b) Licensing of nursing home administrators shall be carried out by the agency of the State responsible for licensing under the healing arts licensing act of the State, or, in the absence of such act or such an agency, a board representative of the professions and institutions concerned with care of the chronically ill and infirm aged patients [*and of one or more representatives of the public*] and established to carry out the purposes of this section. [*Less than a majority of such board shall be representatives of a single professional or institutional category; less than a majority of such board shall have a financial interest—direct or indirect—in an institution concerned with care of chronically ill and infirm aged patients; and less than a majority of such board shall be a combination of owners and employees of institutions concerned with care of the chronically ill and infirm aged patients.*]

(Bracketed italics indicates new language.)

Regarding the establishment of incentives for States to emphasize outpatient care under Medicaid programs, the National Council of Senior Citizens:

Opposes Section 225(a) which would establish the norm for length of care upon the institutional category of the facility providing the care rather than upon the specific diagnosis of the patient's illness and the condition of the patient.

Opposes Section 225(b) which would establish reimbursement upon the basis of the institutional category of the facility providing care rather than upon the basis of the *actual* care and services provided by the facility to the individual patient.

Urges that the provisions of Section 1902(a) (13) (D) of the Social Security Act as amended by Section 229 of H.R. 17550, which presently apply only to hospitals, should also be made applicable to Title XIX skilled nursing homes and Title XI intermediate care facilities, that is, that the State should be required to pay the reasonable cost—as determined by the State—of the care and services actually provided by the facility to the individual patient.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE ADMINISTRATOR,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., May 8, 1970.

DEAR MR. HUTTON: This is in reply to your letter of April 14, 1970, expressing your views on the composition of State boards established to administer the nursing home administrator licensure programs.

We share your concern and recognize the danger that regulatory boards, composed exclusively of members of the group to be regulated, could very well perpetuate abuses the nursing home administrator licensure program was designed to eliminate. There is no doubt that both the letter and the spirit of Section 1908 of the Social Security Act reflect the Congressional intent to protect the nursing home patient.

In general, we believe that in establishing standards for an emerging profession, such as nursing home administration, it is most desirable to have as broad representation as possible in the board membership. An overwhelming majority of representatives for *any one* professional or institutional group might tend to submerge the board with many preconceived concepts, some of which might already be outmoded by research and the rapid advances in the field of geriatrics and gerontology.

While the Department of Health, Education, and Welfare does not approve or disapprove State nursing home administrator licensure legislation, the program as it is administered by the State board, must adhere to the provisions of Section 1908 of the Social Security Act and the Department regulations as published in the *Federal Register* on February 28, 1970.

Sincerely yours,

JOHN D. TWINAME,
Administrator.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL AND REHABILITATION SERVICE,
Washington, D.C., September 10, 1970.

DEAR MR. HUTTON: Thank you for your letter of September 8, 1970 regarding the composition of State boards established to administer programs of licensure for nursing home administrators in compliance with Section 1908 of the Social Security Act. The compilation which I referred to in my letter of June 12 was completed August 29, 1970.

Using information available up to that date, it appears that the boards in 21 of the existing 47 programs have a majority of nursing home administrators.

I would welcome a visit from you to discuss this subject in detail.

Sincerely yours,

HOWARD N. NEWMAN,
Commissioner.

[Enclosure]

REPORT AND ANALYSIS OF THE COMPOSITION OF STATE BOARDS OF LICENSURE FOR NURSING HOME ADMINISTRATORS, AUGUST 29, 1970

Of the 50 States and four territories of the United States, two States—Alaska and Arizona—do not participate in the title XIX (Medicaid) program, and two territories—Guam and the Virgin Islands—have no nursing homes. These four jurisdictions are therefore not obliged to have programs for licensing nursing home administrators.

Of the 48 States and two territories that are required to have programs for licensing nursing home administrators by July 1, 1970, three have not yet enacted enabling laws. These are California, Massachusetts and Puerto Rico.

Thus, there now exist 47 programs for licensing nursing home administrators. Thirty-six of these programs include nursing home administrator licensing (nha/1) boards having substantially the powers, duties and functions prescribed by Section 1908(c) of the Social Security Act; seven assign the licensing of nursing home administrators to a State department, an agency, or a board of health; and four have nursing home administrator licensing boards which have substantially less than the prescribed powers, duties and functions. In these four cases a department, an agency, or a board of health assumes major responsibility or power of review.

The composition of two of the 36 "real" nursing home administrator licensing boards is not specified in State law. Of the 34 "real" boards whose composition is

more or less clear in the statute, 21 have a majority of nursing home administrators as members, and 13 have less than a majority of nursing home administrators. That is, of the 34 "real" boards whose composition is statutorily defined, 21 have a membership that reflects a clear majority of nursing home administrators. (Table I)

As important as the fact of domination by nursing home administrators is the number of representatives of other professions, agencies or the public on the boards. Of the 21 boards dominated by nursing home administrators, two have only one other member, six have two other members, and six have three other members.

A total of 15 of the 21 boards having a majority of nursing home administrators have three or fewer representatives of other professions, agencies or the public. Nine have two or one. (Table II)

It should be noted that it is possible to alter the statutory composition of a nursing home administrator licensing board through the appointment process. There are a number of ways this can be done, but the case of Texas is illustrative.

Texas' law calls for a nine member board appointed by the Governor consisting of two State officials (ex officio), one physician, one educator, and five nursing home administrators. By law the board has a simple majority of nursing home administrators (five of a total board of nine). Further imbalancing the board, however, the Governor appointed an osteopath *who also administers a nursing home* as the "physician" on the board. The Texas board thus has, in fact, six nursing home administrators on a board of nine members, resulting in a 2-to-1 ratio of nursing home administrators to all other members.

This sometimes subtle altering of the composition of a board through the appointment process is not by any means unique to Texas, although its extent has not yet been fully determined.

In some cases State laws specify that a nursing home administrator be also representative of another profession. New Jersey's law, for example, specifies that one of the nursing home administrators on the board be a physician, and two of them be nurses. In this analysis we have considered the occupation of "nursing home administrator" as the primary basis for classification, and have noted other professional qualifications or representation in footnotes. This has been done for analytical purposes, but it is possible to argue that the occupation of "nursing home administration" is paramount for practical policy-making purposes as well.

TABLE I

Jurisdiction having no program for the licensure of nursing home administrators (NHA)

1. Alaska.....	No title XIX.
2. Arizona.....	Do.
3. Guam.....	No nursing homes.
4. Virgin Islands.....	Do.
5. California.....	No law.
6. Massachusetts.....	Do.
7. Puerto Rico.....	Do.

Jurisdictions assigning the licensing of nursing home administrators to a State department, an agency, or a board of health

1. Arkansas.....	Board of Health, with Advisory Council (AC).
2. District of Columbia.....	Commission on Licensure to Practice the Healing Art, with discretion to appoint a NHA/L board and AC.
3. Hawaii.....	Department of Health.
4. Kansas.....	Board of Health.
5. Michigan.....	Department of Licensing and Registration, with AC.
6. Oregon.....	Board of Health.
7. Utah.....	Department of Registration.

Jurisdictions having nursing home administrator licensing with substantially less than prescribed powers, duties, and functions, a State department, an agency, or a board of health having major responsibility or powers of review

1. Florida----- Nursing Home Council, subject to review by State Board of Health; 5 NHA's of 9 members.
2. New Jersey----- NHA/L board, but the State Board of Control appears to have final authority and powers of review; 7 NHA's of 9 members.¹
3. Nebraska----- Department of Health with 3 member board "for purpose of giving examinations."
4. Rhode Island----- NHA/L board, but major functions assigned to Department of Health; 5 NHA's of 5 members.

¹ New Jersey—1 physician and 2 nurses who are also nursing home administrators.

"Real" nursing home administrator licensing boards, composition not specified in law

1. Montana----- 5 members appointed from a list of 9 names (including NHA's and rep's of university units) submitted by MNHAssoc. (& 2 non-voting members).
2. Pennsylvania----- Composition not specified, refers to NHA/L board as "departmental administrative unit in Dept. of State."

"Real" nursing home administrator licensing boards with less than a majority of nursing home administrators as members as specified in the State law

1. Delaware----- 3 NHA's of 7 members.
2. Indiana----- 5 NHA's of 11 members.
3. Kentucky----- 4 NHA's of 9 members
4. Louisiana----- 4 NHA's of 10 members.
5. Maine----- 3 NHA's of 7 members.
6. Maryland----- 4 NHA's of 9 members.
7. Minnesota----- 4 NHA's of 9 members (& 2 non-voting members).
8. Mississippi----- 3 NHA's of 7 members (& 1 non-voting member).
9. Missouri----- 4 NHA's of 9 members.
10. New Hampshire----- Do.
11. South Carolina----- Do.
12. West Virginia----- 2 NHA's of 9 members.
13. Wisconsin----- 4 NHA's of 9 members (& 1 non-voting member).

"Real" nursing home administrator licensing boards with a majority of nursing home administrators as members, as specified in the law

1. Alabama----- 5 NHA's of 9 members until 7/1/75, then 7 of 11.
2. Colorado----- 5 NHA's of 9 members.
3. Connecticut----- Do.
4. Georgia----- 7 NHA's of 13 members.
5. Idaho----- 3 NHA's of 5 members.
6. Illinois----- 5 NHA's of 7 members.
7. Iowa----- 5 NHA's of 9 members.
8. Nevada----- 3 NHA's of 5 members.
9. New Mexico----- 4 NHA's of 5 members.
10. New York----- 6 NHA's of 11 members.
11. North Carolina----- 3 NHA's of 5 members (& 1 non-voting member).
12. North Dakota----- 5 NHA's of 9 members.
13. Ohio----- At least 4 NHA's of 7 members.¹
14. Oklahoma----- 7 NHA's of 9 members.
15. South Dakota----- 4 NHA's of 5 members.²
16. Tennessee----- 6 NHA's of 9 members.
17. Texas----- 5 NHA's of 9 members.
18. Vermont----- 6 NHA's of 9 members.
19. Virginia----- 4 NHA's of 7 members.
20. Washington----- 6 NHA's of 9 members.
21. Wyoming----- 3 NHA's of 5 members.

¹ Ohio—the board as appointed has 5 nursing home administrators out of 7 members.

² South Dakota—1 nurse who is administrator or director of nursing services in a nursing home. (Appointed a nursing home administrator with a R.N. degree.)

TABLE II

Rank order of boards on which there are by law a majority of nursing home administrators, by number of "others" on board

1. 1 "other": 4 NHA's of 5 members (2 States)-----	2
2. 2 "others": 7 NHA's of 9 members (1 State), 5 NHA's of 7 members (1 State), 3 NHA's of 5 members (4 States)-----	6
3. 3 "others": 6 NHA's of 9 members (4 States), 4 NHA's of 7 members (2 States)-----	6
4. 4 "others": 5 NHA's of 9 members (5 States)-----	5
5. 5 "others": 6 NHA's of 11 members (1 State)-----	1
6. 6 "others": 7 NHA's of 13 members (1 State)-----	1
Total States (21)-----	21

TABLE III

Rank order of boards on which there are by law a majority of nursing home administrators, by percentage of board which is nursing home administrators

1. 80.0 percent: 4 NHA's of 5 members-----	States 2
2. 77.8 percent: 7 NHA's of 9 members-----	1
3. 71.4 percent: 5 NHA's of 7 members-----	1
4. 66.7 percent: 6 NHA's of 9 members-----	4
5. 60.0 percent: 3 NHA's of 5 members-----	4
6. 57.1 percent: 4 NHA's of 7 members-----	2
7. 55.6 percent: 5 NHA's of 9 members-----	5
8. 54.5 percent: 6 NHA's of 11 members-----	1
9. 53.8 percent: 7 NHA's of 13 members-----	1
	21