COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETIETH CONGRESS

FIRST SESSION

PART 1—WASHINGTON D.C.

JUNE 22 AND 23, 1967

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
83-481 O WASHINGTON : 1967

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $1.00

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Part 1—Washington, D.C.
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(Additional hearings anticipated but not scheduled at the time of this printing.)

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COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS

THURSDAY, JUNE 22, 1967

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

The subcommittee met at 8:45 a.m., pursuant to call, in room 1318, Senate Office Building, Senator George A. Smathers (chairman), presiding.

Present: Senators Smathers and Moss.

Committee staff members present: William E. Oriol, staff director; John Guy Miller, minority staff director; J. William Norman, professional staff member; Dr. Austin B. Chinn, consultant; and Patricia G. Slinkard, chief clerk.

OPENING STATEMENT BY SENATOR GEORGE A. SMATHERS, CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE ELDERLY

Senator SMATHERS. The meeting will come to order at this bright and early hour. Of course, Senator Moss and I have been working for an hour or two already today.

As we begin today's testimony—the first to be taken at several hearings on the subject of costs and delivery of health services to older Americans—I would like to say that even with medicare paying a major part of their bills, many older Americans find that health services are still too costly, or too remote, or too forbidding for them to use.

The elderly are the major victims of the gap that exists between the kind of health care American medicine can provide and that which is available. The prevalence among the elderly of a high chronic disease incidence, drastically reduced income, frequent lack of transportation to services, and a fatalism that equates each passing year with worsening health, is clear evidence that a callousness exists in our society in regard to health problems of the elderly.

I think, too, that there is a great gap between what we say we want in the way of health services for all Americans and what we actually have. Perhaps this gap is due to selfishness or unawareness. I prefer to think it is the latter—though I might be wrong in light of the statement made by the new president of the American Medical Association at its annual convention on Monday. He seemed to oppose any Government health program on the grounds that such programs are socialistic. I think every responsible citizen—if he chooses to be discerning—can make finer distinctions than that. We all recall when social security itself was called socialistic.

The subcommittee will investigate our progress, or lack of it, toward several of President Johnson's health goals outlined in his January address on older Americans; and we will also ask many questions.

I am quite pleased that we are beginning our questioning only a week before the first of the National Conferences on Medical Costs. Our deliberations should help assure that the problems of the elderly receive adequate attention at the conference. More than that, I believe that the subcommittee and the conferees will benefit from exchanges of opinion and information.

In this introductory hearing, we can hope to sound only a few themes and gather only a small part of the information we need. But we are happy to say we have received wholehearted cooperation from the Department of Health, Education, and Welfare and from distinguished witnesses with much to tell us.

I would also like to say that, as former chairman of the Committee on Aging, I am pleased indeed to be able now to continue one part of the work of that committee, as the new chairman of our Subcommittee on Health of the Elderly. The new chairman, Senator Harrison Williams, has been both energetic and encouraging in showing his interest in the work of this subcommittee, and I appreciate his cordial leadership.

I particularly appreciate the presence of the distinguished junior Senator from Utah, Senator Ted Moss, who has long demonstrated his interest in the problems of the elderly.

Senator Williams.

STATEMENT OF SENATOR HARRISON A. WILLIAMS, JR., CHAIRMAN, SPECIAL COMMITTEE ON AGING

Senator WILLIAMS. Mr. Chairman, I want to take just a minute or two to comment on the timeliness and importance of the study you are initiating today.

It it quite apparent, I think, that in the wake of medicare we in this Nation are finally willing to reexamine our health resources and to determine whether widespread reorganization of health services is required.

And I might add that medicare's first birthday, now almost upon us, is as good a time as any to admit that health services for many older Americans today are minimal, marginal, and miles away.

Congress and the public can feel proud about the good done by medicare, but if anything medicare's record should make us wonder how we got along without it for so long.

Latest statistics show that 4 million persons had inpatient hospital services under medicare during its first year, and hospitals received $2.4 billion for those services.

Home health services went into action and served more than 200,000 people.

And, under medicaid, 25 million bills have been paid.

We can take comfort from that record, but a nagging question persists: How many individuals thus helped by medicare would have gone without hospital treatment if such programs had not existed?

And further, what services are still unavailable or too costly because we have not yet really mobilized medicine to help many of our elderly and others who need it the most?

As I understand it, Mr. Chairman, your subcommittee has already heard from many medical experts and others who believe that older Americans are major victims of present deficiencies in our health services.

Medicare after all, merely helps pay for hospitalization. It has little to do with the fundamental organization of health services. And it is because of deficiencies in organization that costs continue to increase.

Isn't it wasteful, for example, to require individuals to cross entire cities by bus in order to get an X-ray or some kind of laboratory test, when neighborhood health centers could provide one-stop service more efficiently?

And who suffers most from shortages of physicians or other health professionals? Those with limited income, and we should know by now that the income of most persons past 65 is just about half of what they earned before they had to retire.

I am sure that the subcommittee has many other questions to ask, and I will not delay your deliberations any longer. Senator Smathers, you have begun a challenging and very worthy inquiry. I wish you well.

Senator SMATHERS. Thank you, Senator Williams.

Before we have our first witnesses, I would like to say that we are pleased and honored to have with us as a consultant to the committee, Dr. Austin Chinn, previously the dean of the medical school at Cleveland, and who has a distinguished career in the Public Health Service. He is now a consultant for this committee.

We are delighted to have him and we want all you doctors to know that we Senators have somebody up here telling us what really is the truth, too. So be careful.

Our first witnesses will be a panel representing Secretary Gardner and the Department of Health, Education, and Welfare. Gentlemen, we are delighted to have you here this morning so early and looking so bright, intelligent, and alert. You may proceed.

STATEMENTS OF ALVIN M. DAVID, ASSISTANT COMMISSIONER FOR PROGRAM EVALUATION AND PLANNING, SOCIAL SECURITY ADMINISTRATION; CARRUTH J. WAGNER, ASSISTANT SURGEON GENERAL; AND GEORGE A. SILVER, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, ACCOMPANIED BY JEFFREY H. WEISS, OPERATIONS RESEARCH ANALYST, OFFICE OF THE ASSISTANT SECRETARY FOR PROGRAM COORDINATION, AND JOHN GRUPENHOF, LEGISLATIVE UNIT, OFFICE OF THE SECRETARY

Dr. SILVER. We appreciate the opportunity to appear before you to discuss some of the aspects of costs of delivery of health services to older Americans.

Mr. David, the assistant commissioner, will discuss the progress of the medicare program and Dr. Wagner, director of the Bureau of Health Services, will comment on the role of the Public Health Service in improving the delivery of health services for the aging.

Dr. Jeffrey Weiss, operations research analyst, who was actively engaged in preparing the report to the President on medical care prices, is also available.

Mr. Chairman, the President in his message on older Americans in January of this year, stated, "One of the tests of a great civilization is the compassion and respect shown to its elders." One of the ways that we can demonstrate this compassion and respect is by providing comprehensive, continuous, and personal health care to older Americans.

Prior to the enactment of medicare, millions of our older Americans were unable to obtain needed medical care. Now much of this care is being provided, but at the same time medicare has pointed up some of the very grave problems of cost and the delivery of health services which we were not, as a nation, so fully aware of before. The report to the President on medical care prices showed the serious problem we are facing in this matter.

As to delivery of services, a major thrust of the most important administration health bill this year is health services research—"how to bring a greater degree of coordination and efficiency and productivity into the whole health area" as Under Secretary Wilbur J. Cohen put it when he testified in the House Interstate and Foreign Commerce Committee on the partnership for health bill. He made the statement that though we are spending $43 billion annually for health and medical care, our system of providing health services is not operating as efficiently and effectively as it should, and though the public has an enormous stake in good health services the Government-wide total investment in health services research amounts to less than one-tenth of 1 percent of our total investment in health care.[1]

Mr. Chairman, you and your subcommittee, through these introductory hearings and those which will be held throughout the Nation, are performing a public service, alerting all of us to the potential dangers to the health of the whole public, not only to the aged, from rising costs and inefficient delivery of health services.

Now, Mr. Chairman, I would like to highlight for you the major point contained in a document before you updating the report on medical care prices.

In recent years medical care prices have been rising faster than consumer prices generally. However, the 1966 increases in medical prices were the largest in many years. In 1966 the index of medical prices increased 6.6 percent as compared to an average increase of 2.5 percent in the period 1960–65. Hospital daily charges which have been rising about 6 percent per year between 1960 and 1965 went up 16.5 percent in 1966. Physicians' fees which had been increasing about 3 percent per year in the period 1960–65 rose 7.8 percent in 1966. Drug prices have not been a major factor in rising medical prices.

In the first quarter of 1967 the rate of increase in medical care prices continued at about the same pace as in the last quarter of 1966. They rose 2 percent in the first quarter of 1967.

While physicians' fees continued to rise at about the same rate as in 1966, hospital daily room rates have continued to rise at a rapid rate, up 6.1 percent in the first quarter of 1967.

Increases in Physicians' Fees

The available evidence suggests that medicare has not had a significant effect upon the recent acceleration of the increase in physicians'

[1] Statement by Under Secretary Wilbur J. Cohen on p. 193.

fees. Although medicare will increase the use of physician services by the elderly, the impact of medicare upon the total demand for physician services is likely to be on the order of 2 percent.

In the past physicians' fees have tended to increase faster when other prices in the economy were increasing rapidly as they did in 1966. If the anticipation of medicare was a factor underlying fee increases, it would be expected that the fees charged the elderly would move up faster than fees charged younger patients in the period before July 1, 1966.

A special analysis by the Social Security Administration showed, however, that the price indexes for child and adult care moved up more rapidly during the 6-month period before medicare went into effect than the five special indexes of surgical and medical procedures particularly applicable to aging persons. In the absence of medicare the 1966 acceleration in hospital costs would not have been surprising. Rising prices in tight labor markets were bound to exert pressure on those costs.

Further collective action on the part of nurses became more predominant in 1966. Several nurses' strikes took place in major cities throughout the country. Thus hospital payroll per employee went up 9 percent in 1966 in contrast to an average of 4.7 percent per year between 1960 and 1965.

The influence of medicare on hospital charges probably came primarily through the impetus it provided hospitals to reexamine their cost and charges. It is likely that many hospitals decided to increase their charges sooner than they otherwise would have in the absence of medicare.

After an initial upsurge in hospital admissions in July and August of 1966 the number of hospital admissions for the balance of 1966 was not significantly different for the comparable months of 1965. Higher occupancy rates and numbers of admissions to hospitals would be expected to lower, not raise, hospital costs per patient day, although average hospital cost per patient day increased from about $45 in January of 1966 to $52 in June 1966, hospital costs per patient day actually declined slightly during the period from June to November 1966.

Therefore, the increase in the demand for hospital services attributable to medicare was probably not the most important causative factor influencing the recent acceleration in hospital charges.

Conference on Medical Costs

In that document that you have before you there is also a brief description of the forthcoming conference on medical care costs to be held next week which will examine this and many other problems.

I have in my hand also a copy of the report [2] of medical care prices which you have before you, I believe, and you may insert whatever portions you choose in the record.

Senator Smathers. The Department prepared this report?

Dr. Silver. Yes, sir.

Senator Smathers. All right. We will insert it into the record as part of the appendix.

[2] The report begins on p. 319 of the appendix.

(Subsequent to the hearing Senator Smathers wrote to Dr. Silver for additional views. The reply follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C.

DEAR SENATOR SMATHERS: The questions raised in your letter of June 30, 1967, have been carefully reviewed. The conference summary, and a few significant papers presented there are attached.

In reply to question #2, although specific plans for the operation of the Center are not yet fully developed, the National Center for Health Services Research and Development will be concerned with the whole spectrum of health services to all patient population groups. As such, the Center will necessarily devote substantial attention to the specific health needs of the aged and to patterns of health services necessary to meet those needs.

It is well known that the health needs of the aged are essentially the same as those of the general population. But specific social and psychological circumstances associated with aging mean that the delivery of services to the aged must take special forms. The Center will explore possibilities in the development of specialized health personnel—as well as sufficient personnel of traditional types—the organization of services, and rearrangement of institutional settings for the aged.

In reply to question #3, Under Secretary Cohen's testimony on H.R. 6418 is attached.[3]

In response to question #4 in your letter of June 30, 1967, I should point out that my statement of June 22, 1967, to the Subcommittee on Health of the Elderly did not explicitly discuss the effect of the 1966 rise in physicians' fees upon total medical expenditures. Instead, I addressed my comments to the question of the impact of the recent rise in physicians' fees upon the elderly. With respect to that, I stated as follows:

"The recent acceleration of the rate of increase in physicians' fees has not significantly affected the elderly. The coinsurance provisions of Medicare have blunted the impact of these price rises.

"However, this conclusion relates to physicians' customary charges—the fees the physician charges to most of his patients for his services. As of July 1, the average fees of physicians, and their incomes, have increased because of the payments of customary charges under Medicare. Many elderly persons previously were paying charges lower than the customary charges of physicians.

"Therefore, many aged persons, although the exact number is not known, will now find that they are being charged more for a given service, since their physician is now charging them the same fee he charges to the majority of his patients. This anticipated development will primarily affect those elderly persons who spend less than $50 on the medical and other health services covered by Part B of Medicare."

The 6.6% rise in physicians' fees in 1966 will have a significant effect on total medical expenditures. Since consumer expenditures on physician services account for nearly 30% of total consumer expenditures on health care, the rise in physicians' fees in 1966 has resulted in about a 2% rise in total medical expenditures.

Further, I would like to take this opportunity to comment on several of the points raised by Dr. Nolen of Minnesota in his testimony before the Subcommittee on Health of the Elderly.

Dr. Nolen believes that Medicare will result in some unnecessary utilization of medical services, as well as significant fee increases by physicians since the Government is paying the bill.

These problems exist with private insurance plans and there is no reason to believe that they will be more severe under Medicare. When a patient has already paid for a substantial proportion of his potential medical bills via the private insurance mechanism, this reduces the financial disincentives associated with utilizing services which are needed. However, one of the major functions of both private insurance plans and Medicare is to insure that the cost of health services will not impinge upon the patient's decision to utilize necessary medical services.

Moreover, under both private insurance and Medicare, since the physician and his patient will not be very concerned about the immediate impact of a rise in fee

[3] See p. 193, appendix.

levels, there will be a tendency upon the part of some physicians to raise their fees. As Dr. Nolen points out, however, the Medicare carriers have the responsibility for reviewing the services of physicians to Medicare patients to insure that the fees of individual physicians do not substantially deviate from their usual and customary charges to non-Medicare patients.

In summary, I believe that Medicare is fulfilling its major objectives. It has removed the financial barrier which prevented many elderly persons from seeking necessary medical services and it has resulted in an upgrading of the quality of medical services received by the elderly. Although some Medicare patients may seek unnecessary medical services and a few physicians may charge unreasonable fees, we must be careful not to impugn the ethical standards of the whole profession.

Now as to question #5, on physician assistants, even before the advent of Medicare the rapid growth of population, increasing affluence and rising expectations increased demands for medical care. The Department of Health, Education and Welfare is convinced that beside an increase in traditional professional health workers, there is a need for significant increase in the number and kinds of health workers who can assist physicians and other health professionals in providing health care. A variety of proposals have been made and a number of informal and some formal methods have been used to produce a group of health workers who are able to carry out functions which were formerly performed only by physicians. The training of health workers has been done in a variety of settings: physicians' offices, clinics, group practices, hospitals and other health agencies. Methods of training auxiliary medical workers have ranged from preparing them to carry out technical procedures to preparing such persons to carry out the more general functions of the physician including the medical interview and a screening physical examination.

At one level is the consideration of specialized physicians assistants: pediatric, obstetric, orthopedic, and so on. Several programs to train assistants to physicians have been planned or undertaken by the Department. The following are examples of such programs:

The Public Health Service is supporting, through its Bureau of Health Manpower, a program for the development of an orthopedic technician. The Presbyterian Medical Hospital and Center at San Francisco has received approximately $106,000 for a 2-year period to develop this physicians' assistant. Six trainees per year, for this 2-year period, are being trained to assist orthopedic surgeons in surgery, on the ward, in the plaster room, and in the physician's private practice. These trainees are all ex-medical corpsmen. They will be taught the mechanics and the uses of orthopedic tables, to set suspension equipment for physical therapy work, to assist in applying and removing plaster casts, etc. This is the first of at least two or more planned variations to evolve an approved and standard curriculum for replication and the training of orthopedic technicians in educational institutions.

A second example is the 2-year program being conducted at the University of Florida for the training of a psychology assistant. The estimated cost of this program is $115,000. These students, who are college graduates, are provided with work experience and study in inpatient and outpatient pediatric service, community psychology, neurology, and obstetric and gynecology. Areas of student activities which are being studied include general and administrative activities; conducting, scoring and some interpreting of charts and graphs; assistance with library research and manuscript presentation; etc.

Thirdly, the Bureau of Health Manpower is developing with Johns Hopkins University, a 1-year project to develop a master's degree program in public health with a specialization in nurse-midwifery. Many physicians feel that more of the care of the uncomplicated maternity patients could and should be delegated to the nurse-midwife.

Consideration is being given to the development of an anesthesiologist assistant at the master's degree level. This person would work under the direct supervision of the M.D. anesthesiologist. Discussions are currently underway with Emory University, the University of Florida, and the Medical College of Georgia, regarding a cooperative arrangement for the possible development of this program.

In addition, there is a wide variety of technicians who have emerged, particularly in the hospital and clinical setting in highly specialized and specific fields. Such programs have trained auxiliaries for clearly defined specialized technical duties in institutional settings which have been successful in extending the range of the physician. This has been true of such groups as inhalation therapists and technicians, orthopedic technicians and assistants, nurses in intensive and

coronary care units, and diagnostic technicians in screening clinics. All of these people function in a setting which can support technical specialization of rather high degree and where physicians are available to supervise their functions at all times. The Public Health Service has been specifically involved in the development of training and teaching materials for the nurses working in intensive and coronary units. A contract was recently let to a medical school for the development of training programs and for 10 teaching films for such health workers. Three of these films have been completed and reviewed.

Education for other types of assistants in the medical care field is also in the planning stage or underway. Negotiations are currently being conducted by the Division of Medical Care Administration jointly with the American Association of Junior Colleges to consider the feasibility of developing a pilot project for 2-year curriculum in the junior college in order to develop nursing home administrators.

In other areas, added efforts are underway: Through a cooperative program with the Office of Economic Opportunity, the Department of Health, Education, and Welfare is supporting the Development of Home Health Aides, an occupational group within the health field which can provide valuable assistance in meeting many of the health needs of the elderly. This program is funded by the OEO, however, several States have begun training Home Health Aides through the State's own employment and educational resources.

The Office of Education, through its Vocational Education Bureau, is also supporting programs which are aimed at development and most efficient use of several levels of health workers so that the most effective use is made of the level of skill of the person rendering care to a patient.

Under current program analyses now being conducted in the Department of Health, Education and Welfare, consideration is being given to the important role which physicians' assistants could play in extending the hand of the physician. The questions raised in the development of medical auxiliaries are complex, and it is of the utmost importance that any such training programs provide every safeguard for the well-being of patients. To this end, many of the major hospitals which are involved in the training of medical auxiliaries are doing their own studies of effectiveness. However, the only explicit studies of effectiveness of medical auxiliaries have been done by persons in the field of dentistry and nursing. Such an example is the Louisville study in which a careful job analysis has been done for dentists, dental hygienists, dental technicians, and dental auxiliaries. Evaluation is made of the productivity of each group and the quality of work performed. This evaluation study is a PHS intramural program done in connection with the PHS Dental Center in Louisville. The University of Louisville is serving in a consultant basis.

The Bureau of Health Manpower of the Public Health Service plans to explore this whole field in connection with the Allied Health Professions Educational Assistance Act. Again the Department is hopeful that similar thorough evaluation studies will be developed for other medical auxiliaries. A recent publication of the Bureau of Health Services of the PHS on "Training the Auxiliary Health Worker" is attached for your information.[4]

If I can be of any further assistance, please do not hesitate to ask.

Sincerely,

GEORGE A. SILVER, M.D.,
Deputy Assistant Secretary for Health and Scientific Affairs.

Dr. SILVER. Now, I would like to introduce Mr. Alvin M. David, Assistant Commissioner for Social Security.

Senator SMATHERS. Mr. David, you may proceed.

STATEMENT BY MR. ALVIN M. DAVID

Mr. DAVID. Mr. Chairman, Senator Moss, I am very pleased to have the opportunity to be here to report on the progress of the medicare program under Social Security.

[4] Retained in committee files.

In the first 11½ months of medicare the program has accomplished a great deal of good.

More older persons have received more health services and they have received improved services. The fear of large or unmanageable hospital bills has been erased from the minds of nearly all of our citizens over 65.

Because of medicare, more older persons have been able to seek hospital care with the dignity that goes with ability to pay. For the first time, many of them have been able to choose private care in the best hospital in their community. The transition from the status of the charity patient to that of a patient who is in effect paying his own way has changed both the level of care that many of the elderly could expect and the level of care that they actually receive.

In the past 11½ months there have been nearly 5 million admissions to hospitals under the medicare program. This represents about 4 million people.

The amount paid to the hospitals in that 11½-month period has been about $2 billion.

Medicare has also made available insured alternatives to hospital care. These include: Hospital outpatient service where that is appropriate for diagnosis or treatment; and posthospital extended care and home-health care where further stay in a hospital is not the most appropriate level of care.

Also included is the coverage of physician's services for home and office visits.

These alternatives have produced the following results:

Home Health Agency Service

About 220,000 patients have been cared for through home health agencies under plans that were prepared for them by physicians. Up until mid-June of this year—from January when the extended care facilities coverage went into effect—more than 180,000 admissions had been reported for care in these facilities. And, also, by mid-June more than 23 million bills, mostly physicians' bills, had been submitted for payment under the medical insurance part of medicare and payment for services under this part, we call it part B, has exceeded $600 million.

Medicare also has helped to upgrade the quality of health care in terms of facilities, personnel, and patient-care policy. To participate in medicare, institutions have been required to meet standards set forth in the law and in the regulations.

I might add, Mr. Chairman, that one factor that seems to be involved in the increased cost of hospital care in 1966 has been the upgrading that did occur in many hospitals and particularly in extended-care facilities, which upgrading they had to do in order to meet the requirements for participation in the medicare program.

The requirements for quality care have applied to 6,800 hospitals, about 4,000 extended-care facilities, nearly 1,800 home-health agencies, and 2,175 independent laboratories.

In addition to meeting standards on quality of care, the participating medical institutions are required to conform to title VI of the

Civil Rights Act, and therefore members of minority groups for the first time in many communities have access to high-quality care. Moreover staffing and service patterns have changed in such a way as to improve the service to all patients.

Progress on Medicaid

Older Americans who are medically indigent are also benefiting from medicare. In 29 of 54 States and other jurisdictions a medicaid program, as we call it, under title XIX of the Social Security Act is in operation. In 15 jurisdictions plans to install medicaid programs are underway and only 10 have no medicaid plans. All but 13 of the 54 jurisdictions are paying supplementary medical insurance premiums for the public assistance recipients on their rolls or are paying higher cash amounts to those recipients who have enrolled in the part B of medicare. This is the part where they pay the $3-per-month premium.

It is too early to say how much increase in the use of health services by older persons has taken place since July of last year, when medicare went into effect, or how this use compares with the use of such services by those under 65.

In general, it is clear enough that there has been no overwhelming rush to the hospitals and no swamping of doctors' offices, as some had predicted was going to happen.

Survey on Health Costs of Elderly

Shortly after medicare was enacted the Social Security Administration contracted with the National Opinion Research Center and the Columbia School of Public Health for a national sample survey of health service expenses of older persons before and after medicare. The survey will provide data on changes in the use of, charges for, and costs of, medical services covered under both parts of medicare as well as those not covered under that program. A national sample of 6,000 aged persons was interviewed in April 1966, on their use of hospital and medical services during the preceding 12 months. A similar sample will be interviewed in October of this year. We will have preliminary results of the April 1966 survey fairly soon; although we will not be able to complete the measurements of change from April to October until sometime next year.

Although there is a reporting lag, statistics derived from the operation of the medicare program itself; that is, apart from these surveys, are beginning to give us some idea of what is taking place. The data relate to claims that are paid—actually paid—and thus they depend upon the flow of bills and the claims from hospitals to the fiscal intermediaries that are set up under the medicare program and the flow of bills from doctors to patients, from the patients to the intermediaries, and then from the intermediaries to the Social Security Administration.

The intermediaries that I refer to are the organizations that are called for in the law to serve as agents for the Social Security Admin-

istration in making the payments for hospital and other provider services. The requirement, under the law, that payment for physicans' services which are a part of hospital services; that is, the services of hospital-based physicians, that the payment for these be separated from the payment for hospital services as such has forced many hospitals to work out new payment procedures with physicians who run and man their laboratories, X-ray rooms, and anesthesiology departments, some of the biggest administrative problems associated with this requirement would be eliminated with the enactment of President Johnson's recommended social security amendments that are now pending in the House.

These amendments include a provision that would eliminate the need for a breakdown of the two components of the hospital services performed by these hospital-based physicians. In other words, it would no longer be necessary to separate out for billing the services of the doctors themselves and the services of their staffs and other services provided by the laboratories.

Senator SMATHERS. Doctors are very much opposed to that, aren't they?

Mr. DAVID. Well, there is some opposition to what we call part C in the medicare bill, although the principle of the simplification that would result from moving the out-patient services out of part A and having them all under part B and the various other changes that would be made that would eliminate the need for separating out for billing purposes the services of the doctors from the services of their technicians and others and the need to separate out the services for diagnostic work as against therapeutic work would, as a general thing, not be objected to.

Senator SMATHERS. Do you know any doctor groups that are for it?

Mr. DAVID. For part C, yes.

Senator SMATHERS. No, for having their bills paid by the hospitals.

Mr. DAVID. As far as I know there are some who have no objection.

Senator SMATHERS. Are those individuals or are those groups?

Dr. SILVER. If I may interrupt, I would say as groups, Senator, the physicians are opposed to that change, particularly those that would be affected by that change.

Senator SMATHERS. I asked that because I recall last year on the Finance Committee when we had this actual legislation before us there, one of the things the doctors objected to most was having to go to the hospital to get paid because they don't want to become, in effect, payees for the paymaster at the hospital. They think this puts them under additional control.

Dr. SILVER. Of course, Senator, the point is that before medicare the majority of the hospitals did have such arrangements with the doctors and while they grumbled about it they accepted it. It has now become national policy with the opposition.

Senator SMATHERS. That is the record as I remember.

Go ahead, Mr. David.

Mr. DAVID. I might say that the precise method that is proposed in H.R. 5710 for dealing with the need for simplification of billing for

and paying for outpatient services and the services of hospital-based physicians may not necessarily be the only way to get at it. There is a need for simplification and I believe that in the end it will be possible to work out a way to get that simplification without any real serious basis for objection on anyone's part.

While the Social Security Administration as early as last August, authorized intermediaries, that is, the fiscal intermediaries I just mentioned, to make advances to hospitals to cover expected claims, and hospitals have been receiving their money under this procedure, bills have been slowed by the working out in some cases of the need to develop new hospital-physician agreements and billing arrangements.

Complaints from Hospitals

Senator Smathers. What are you doing to correct that? This is one of the criticisms that I hear wherever I go. Hospitals that actually enter the program, like the program, but they don't get paid. Redtape is almost impossible and there is no rationalizing away that hospitals think they are going to be able to get their money, they are bogged down in redtape.

What are you doing to stop that?

Mr. David. The first thing I would say, Mr. Chairman, is that, although there may be still some isolated complaints of that nature, hospitals are receiving payments very promptly now, and the record has been one of very rapid improvement.

Senator Smathers. You added the word "now." In other words, when you say "now," you would admit as all have to admit that in the institution of a new program of this size there must be some delays and some slowdowns in order to find out just how you are finally going to do it most efficiently. But when you say "now", do you distinguish between the former state of affairs when they were not getting their money promptly and now when you have begun to resolve the problem?

Mr. David. I am distinguishing on the basis that the situation has very greatly improved, and I am also distinguishing between the payments under part A to the hospitals and other providers under part A and, on the other hand, the payments under part B, which are essentially payments to the doctors. Now, part B is much more complicated to operate, especially because of the coinsurance and the requirement that the patient must have paid $50 before any of the bills can be reimbursed and the necessity for separating out these things that I mentioned—that is, the services of the doctor from the services of the laboratory technicians, and so forth, and various other separations that need to be made. These complicate the operations under part B. But in part A, for the most part, except for problems in the area of outpatient services and billing for X-ray and laboratory work—the hospital-based physicians which has been a cause of a great deal of administrative complexity there—by and large even with these problems, the situation in part A now is quite satisfactory.

Senator Smathers. All right, sir.

When you say it is quite satisfactory, you think at this point most hospitals and most doctors' associations agree with you?

Mr. DAVID. Yes, I believe that this would be the case. I hope that they would agree. There may be isolated cases, but, in general, they are being paid quite promptly.

Senator SMATHERS. All right, sir.

Mr. DAVID. There has been considerable discussion of medicare's impact on hospital use, particularly on average length of stay. To provide information as quickly as possible on this matter the Social Security Administration has been publishing in the Social Security Bulletin monthly data on inpatient hospital care showing the total days of care and the average number of days per claim. These data are based on claims for which reimbursement has been made and recorded in our accounting records that are maintained in Baltimore.

The figures are meaningful when they are properly used but unfortunately they are quite easy to misinterpret. Accurate and detailed figures on discharge rates, total patient days and average length of stay will become available in statistics that we will be publishing annually. For 1966, the tables will cover experience during the first 6 months of the program and we hope that the 1966 tables will be available late this summer or early this fall.

Senator SMATHERS. You don't have any statistics now, is that what you are saying?

Mr. DAVID. We do have some, but they are not of the kind that will give you an accurate picture of such a thing as average length of stay because we do not yet have enough cases which have remained in the hospital long enough to give a full picture of the situation.

In other words, you do have to wait until you get sufficient data on discharges and you can't get a fully satisfactory picture until you do have that. Until you have a backlog of discharges, you can't tell for sure how long the average length of stay is going to be.

For instance, we do have data now but they don't have in them the sufficient reflection of the long-stay cases.

Senator SMATHERS. I want to ask you this simple question of arithmetic. If you now have statistics on how many elderly people are using the program, why do you have those statistics and not statistics on how long they stay in the hospital?

Mr. DAVID. We can tell you how long these people stayed in the hospital but we don't have a fair representation yet of what will be the average length of stay when the program has been in operation for a substantial period.

Senator SMATHERS. What sort of answer would you give if somebody said the reason you have not produced those statistics as to how long they are going to stay is because those statistics at the moment are very unfavorable to the program? What would you answer to that question if it were asked you?

Mr. DAVID. Well, I would answer that, if such a question were asked, by saying that we have undertaken to get the statistics as quickly as we could. We do have a great many statistics and I will furnish the record the Social Security Bulletin articles that contain the statistics.[5]

The figures show that up to date the average length of stay has been 13 or 14 days or something like that and we know that that is too low.

Senator SMATHERS. You say 13 to 14 days is too low?

[5] The material submitted for the record begins on p. 161 of the appendix.

Mr. DAVID. Yes. Actually, when you finally get the figure over the full period of the year, which we, of course, don't have yet, when we get the figures from the claims that are made over a longer period, we will know more about the discharges and we will be able to get a more accurate picture. These figures, up to now, are loaded too much with shorter stay cases.

Dr. SILVER. May I interject, Senator?

Senator SMATHERS. Certainly.

Dr. SILVER. The way you asked the question I would respond by saying if we used the American Hospital Association data, the objection we have is that we think they are too favorable, not too unfavorable. The average length of stay is much too short and we are not getting the influence in there of long-stay patients at all and it is very misleading.

Senator SMATHERS. Originally, you will recall that it was said that what would happen would be that these elderly people would get into the hospital, that they would continue to occupy the beds, that there would be no way to get them out, and that, because we have a nationwide shortage of hospital beds, this would lead to a chaotic situation for those who had some serious illness and had to go to the hospital. Now, what you are saying, as I understand it—and I think the record ought to show this—is that as of today the figures that you have are so contrary to that charge that they would stay too long that you believe that you need more experience actually to demonstrate in point of fact that the charge is not true, or you are afraid people won't believe it when you bring these figures out; is that correct? Am I correct in saying that?

Dr. SILVER. Well, you are being too kind. Actually, we know that with the long-stay patient—information not available as yet—that these figures are incorrect and we are not afraid that people will accuse us of fudging the statistics.

Senator SMATHERS. Those are figures supplied by the American Hospital Association?

Dr. SILVER. Yes.

Mr. DAVID. Yes.

I might say, Mr. Chairman, that the AHA figures up to date have been tied to admissions into a hospital in a given month. We understand, though, that the American Hospital Association figures for March of this year, which will be available some time in the next few weeks, will be based on total inpatient days used by patients who are discharged in a given month and thus will, for the first time, reflect a true average length of stay.

We don't have any reason to want to give an overfavorable picture of the financing of the hospital insurance program, and we would not, in any circumstance, want to have the picture appear more favorable than it is.

Senator SMATHERS. Well, you just don't imply by that that because you want more financing you want it to be worse than it is, you want it to be actually what it is.

Mr. DAVID. We would like it to be exactly as it is—all the facts on the table.

Senator SMATHERS. And while we have an automatic increase with respect to raising money to provide for these things you do not foresee

at this moment any need for any additional increase other than that which is now projected by law?

Need for Additional Financing?

Mr. David. No, sir. At this time we do not see any need for any additional financing of the hospital insurance program. The program is financed, we believe, on a conservative basis and even though hospital costs in 1966 did increase by 16½ percent or so, this is within the range of the estimates made on the costs of the program, and there is no basis up to this point for changing the financing of the program or increasing the income of the program.

I might mention that one of the elements in the conservative financing of the program is that the cost estimates assume that the base on which the social security contributions are paid; namely, the base of $6,600, at present, will not be increased over the next 25 years.

Now, to the extent that wages do go up, as they have been going up over all the years and decades in our history, to the extent that wages do go up and this base is increased, as the Congress has increased it from time to time over the years, there is additional income to the hospital insurance system and there is no corresponding increase as a result of that in the cost except insofar as costs go up as wages go up generally.

Senator Smathers. Can you foresee the day when those who avail themselves of medicare will not have to make any $50 contribution, for example, themselves?

Mr. David. Mr. Chairman, I think that it would be foolhardy to say that one could foresee that day.

As you know, there are really three deductible provisions in the medicare program. One of them is the $40 deductible in the hospital part, and the other big one is the $50 deductible in the medical insurance part. Unfortunately the one that causes the greatest amount of difficulty in administration and understanding is that $50 deductible in the medical insurance part. That is a lot of trouble for the patient and for the doctor and for the carriers and for the Government and for everyone; but that particular deductible would be one that there would be less clear basis for cutting down or eliminating than would be the case with the $40 deductible in the hospital part of the program. That would be one on which I imagine that the day might come when we would find, on the basis of experience and surveys and the data growing out of the operations, that it might not be necessary any longer to have that deductible.

Arguments on Deductibles

There are certainly arguments both ways. It is clear that the deductible must have some effect on deterring people from going into the hospital and getting services that they do need, and there can hardly be any doubt that it has some effect in deterring people from getting services that they don't need.

I think that it has to work both ways but, on balance, it remains to be seen whether it will be feasible and desirable to either cut down or eliminate that deductible.

My opinion is that it may easily come to a point where we can say that it would be safe and prudent and that we will have the financing to cover the cost of the hospital services without that deductible. I think that is a possibility.

In the case of the $50 deductible for the medical insurance part of the program it is not quite so easy to see the time when that will be eliminatable, if I can coin a word there. If we were to eliminate that deductible right now the $3-per-month premium that is paid by the people 65 or over financed by the Federal Government would have to be increased to, we estimate, about $4.75 a month. It makes that much difference to eliminate the bills before they reach the $50 level.

Of course, another small item there in eliminating that $50 deductible would mean that we would be dealing with a great mass of smaller bills and administratively that would add quite a lot to the load.

Senator SMATHERS. It would be pretty difficult for you to say there is some administrative benefit in having this $50 medical deduction.

Mr. DAVID. Yes; I would say there is some benefit in it, but I want to be very sure I am not understood to be saying that we would object to the elimination of the $50 deductible for administrative reasons. I am sure we would not want to take a position like that.

It is true that it would increase the administrative load, but we would not object to it for that reason.

Senator SMATHERS. All right, sir. Go ahead.

Mr. DAVID. As to the services of physicians, our current information on use and charges is still scantier than what we have for hospitals. Under part B of medicare the patient must first incur $50 in costs to cover the deductible. Then he must pay the bill and get a receipt, unless his physician has agreed to accept assignment and to be paid by medicare directly for the reasonable charges that are determined under the program.

Senator SMATHERS. On that point, you say you don't have any experience yet?

Mr. DAVID. I didn't say we didn't have any experience. I said we have scanty experience so far.

Senator SMATHERS. Thus far what is your experience? I will tell you what mine is; you tell me what yours is.

Mr. DAVID. Well, we have quite a lot of experience, Mr. Chairman. Are you referring to the——

Senator SMATHERS. That is right. How many of the doctors would prefer to deal directly with the patient?

Mr. DAVID. Actually, as I remember it, it is very close to 60 percent of the doctors in the country do accept the assignments in either all cases or in some cases.

Senator SMATHERS. That has been my experience.

Mr. DAVID. Forty-three percent, as I recall it, refuse to accept assignments in any cases. There is a great variation in different parts of the country in this respect. In some parts of the country a very high percentage of them, like 80 percent, do accept assignment in some cases. Of course, obviously, there are some cases where the bill is very large or the patient is in a very low income bracket and it is pretty much out of the question for him to have paid the bill and then get reimbursed on the basis of the receipted bill.

Senator SMATHERS. I think doctors believe that it is a more certain source of payment to operate under the assignment method and to work with the medicare program than to wait for the individual to come in with $35 or $25 and build up to the $50.

Mr. DAVID. Yes.

Senator SMATHERS. It has been my observation from talking with them that they are happy to go that route.

Mr. DAVID. When the payment is made under the assignment method, the bills are prepared by the doctor or in the doctor's office and they are properly prepared and completely prepared in a very much higher percentage of the cases and they do go through much more rapidly.

Senator SMATHERS. Right.

Mr. DAVID. Well, after you have gone through all these steps of the receipted bill and the claim has gone to the intermediary, it is paid and a report is sent to us and we have to tabulate it—all that is a time-consuming process—and we don't have as much information yet as we are going to have.

There is no doubt that this process of paying the bill to the physician confuses older persons and causes real hardship for those whose physicans are unwilling to accept assignment and they do not have the cash to pay the large bills or the resources to cushion delays in reimbursement.

The Social Security Administration has made available the services of our district offices to help older persons with their claims. This has speeded the claims process, but it obviously cannot affect the basic character of a system which includes reimbursement of a portion of paid charges after a deductible is met. That is just inherently a complicated process.

SSA CURRENT MEDICARE SURVEY

Recognizing that delays in information would occur, the Social Security Administration began last July a current medicare survey. As with most of our major surveys, the Bureau of the Census is acting as our agent in the collection of the data. We are now getting information from a national sample of beneficiaries on their current medical care and expenses. We should have a basis for estimating how many people are meeting the deductible and what is the accruing liability of the system, for bills, that is, that may not come in for a number of months hence.

The survey suggests that during the first 6 months about two-thirds of the people enrolled under part B of the medical insurance part made some use of the services.

In the first month less than 4 percent met the deductible and were eligible for reimbursement. By December of last year 22 percent of all the enrollees in the medical insurance part, one-third of those using covered services, had met the deductible; 22 percent of all and one-third of those who had used covered services had met the deductible.

At the time medicare was adopted, we estimated that the program would cover perhaps 40 percent of the aggregate medical costs of the aged.

We do not have any basis, up to this point, for modifying that figure.

I might add, Mr. Chairman, that if we did not have the deductible and the coinsurance provisions in medicare that the 40-percent figure that I mentioned, the 40 percent of all medical costs of the elderly that are covered under this program would be increased, we think, to about 50 percent.

Senator SMATHERS. Say that again.

Mr. DAVID. Yes, sir. We estimate that at present, of the total medical expenses of people 65 and over, the medicare program covers about 40 percent of those total expenses.

I might mention here that outside of what is covered by the medicare program there are all the long-stay cases in psychiatric hospitals and the expenses that are covered in veterans' hospitals, which are not under this program, long-stay nursing home care cases, and drugs, of course, private duty nursing, and a variety of other things that are not covered and are not really subject to coverage under any kind of an insurance program.

But we have 40 percent in total, this is our estimate, 40 percent of the total expenses of the people 65 and over that are covered by medicare. That 40 percent would be increased, we think, to about 50 percent if there were not the provisions for the deductibles and the coinsurance, by which I mean, as you know, the payment by the patient of 20 percent of the cost.

Senator SMATHERS. However, as I understood you a moment ago, you don't want to eliminate all of that.

Mr. DAVID. No, I think it is much too early to say that it would be feasible or prudent or desirable on the basis of what we know now to eliminate those deductibles. We are recommending, though, that the deductible on the outpatient hospital services, the $20 deductible be eliminated.

Senator SMATHERS. This may not be the time to ask it, but it keeps occurring to me and maybe any one of you can answer. I was down making a speech in a town in Florida and the president of the local medical society apprehended me, I guess that would be the right word, and said, "I have a genuine complaint." I asked him what it was.

He said:

> It does not make sense under the Medicare Program to have the doctors who are today generally operating out of clinics with therapy machines and with radiologists operating the clinic for us to take a doctor out of there and go out 14 miles to see some out-patient. When we get out there we can't carry the equipment we need to take care of him so we have to tell him when we get out there, "You come back in." So what has happened? You have an hour out of the office driving out and driving back. We don't have the facilities with us. The only thing we can carry is the black bag unless we are strong as Teddy Kennedy, in which event we can carry a few more things. But we don't have the facilities with us so all we do is go out there and say to these people to come back to the office the next day and we have to charge them or get it charged to the clinic. It does not make any sense.

What kind of an answer would you give to that?

Mr. DAVID. Mr. Chairman, that trip out there for 14 miles is not in any way connected with the requirements of the medicare law or regulations or program in any way. There is nothing in medicare that calls for this doctor to make the 14-mile trip that he would not otherwise make.

Senator SMATHERS. Isn't there some provision in the law which does require that if a doctor signs up or takes an assignment of some kind that patients may call him?

Mr. DAVID. No, sir.

Dr. SILVER. The law makes no such requirement, Senator. It only involves reimbursement. The law does not prescribe in what fashion the physician is to be paid.

Senator SMATHERS. I thought he made a good point. The fellow was not so concerned about the fact that it would be the money involved, he said it was the time involved.

Now, you have a doctor there who raised his hand.

Mr. WEISS. Of course, time is money. One is that this is not the usual situation. According to the information we have, only one out of every 20 physician visits are out of the office or out of the clinic or out of the hospital.

Senator SMATHERS. I would suspect that is right, but one out of 20 is a pretty high percentage, I would suspect, in a situation where the doctors are getting together for, I think, sensible reasons. You can ask one fellow to look at your back and one fellow to look at your foot, and the dentist could do this, and so on.

The clinics are naturally becoming hospital centers and I think it is a good idea. The whole point this fellow was making, and he made it vociferously to the point that I got the idea that this was a rather common practice, that somewhere if they participated in this program they were required to go out and see these people.

Mr. DAVID. No, sir.

Dr. SILVER. This is a general problem in medical practice in the United States today. There was a time when most or almost the whole of medical practice was in visiting patients and in seeing them in their homes, and today this has been reduced considerably.

Senator SMATHERS. Right.

Dr. SILVER. For many of the reasons you point out, that so much more can be done and needs to be done in the hospital or in the doctors' office. But it is a general problem of medical practice.

Patients still like the comfort and security of having the doctor come visit when they feel sick.

Senator SMATHERS. I want to ask you this question as a blanket question because I am going to send this doctor your answer: Is it a fact that there is no provision of the medicare program which requires the doctor to make a visit to a patient's home on the call of the patient in order for the doctor or the patient to qualify under the medicare program?

Mr. DAVID. There is no such provision.

Dr. SILVER. No such provision.

Senator SMATHERS. No such requirement?

Mr. DAVID. Nothing remotely resembling it.

Dr. SILVER. The doctors don't sign up for medicare, a patient goes to see his doctor and then the bill that is incurred under those circumstances——

Senator SMATHERS. Suppose they come in and they are treated for awhile and you put them on an outpatient status, they are required to be on outpatient status. At that point is there a provision which would require that the doctor make the trip, 14 miles out to the farm?

Mr. DAVID. No.

Senator SMATHERS. And 14 miles back and take an hour and a half out of his office.

Dr. SILVER. There is no requirement in law, it is a matter of conditions of medical practice. If he is responsible for the patient, when the patient calls him, he has an obligation.

Senator SMATHERS. If he is doing it under his own decision.

Dr. SILVER. Yes.

Mr. DAVID. The only thing I can think of, and this is a pure speculation, is that the doctor has heard so much about socialized medicine, and he has heard so many times medicare is socialized medicine, he actually believes it and he thinks that maybe we have gone over to socialized medicine and that the Government has set up all the rules and has told the doctors that they have to go and make this trip. There is nothing at all resembling that in the medicare program.

Senator SMATHERS. All right. This fellow told me about taking some necessary gear for treatment in the back of his car and finally ended up breaking some of the gear and this general condition was chaotic because the machine would not work out there. He had to bring it all back broken and he had to call the insurance company, et cetera. But your answer is a flat blanket "no"?

Mr. DAVID. A flat blanket "no".

Senator SMATHERS. All right.

EXPENSES NOT COVERED

Mr. DAVID. Mr. Chairman, I might mention some of the expenses that are not covered by medicare programs. This relates to the point that I mentioned about 40 percent of the costs of the elderly are covered. The items not covered include such things as drugs, eye glasses, hearing aids, psychiatric care and hospital care beyond 90 days. Also excluded are expenses deriving from the coinsurance provisions that I mentioned and the deductibles.

The hospital and other benefits of part A of medicare probably pay for 25 percent of the aggregate costs of older persons and part B probably pays for another 15. That is where we get the total. For persons who are hospitalized the combined benefits cover perhaps half of their aggregate medical expenses. In other words, people who are hospitalized have higher expenses, and medicare covers a higher percentage of those expenses than is the case where the person is not hospitalized.

For older persons with very large medical bills in the year, of course, the portion covered would be much higher because the deductible has a smaller effect in those cases.

Mr. Chairman, we would like to submit for the record copies of several articles in the social security bulletin which present the statistics that we now have available, and also we have for the record if you would like to have them a number of charts that show data projected to the end of June to reflect the progress made in medicare in the first year of operation.

Dr. SILVER. I believe you have those in your folder, already, Senator.

Senator SMATHERS. All right. We will insert it into the record as part of the appendix.[6]

[6] The material submitted for the record begins on p. 159.

(Subsequent to the hearing, Senator Smathers asked the following questions in a letter to Mr. David:)

JUNE 30, 1967.

DEAR MR. DAVID:

* * * * * * *

1. On pages 26 and 37 of the typewritten transcript you discussed potential effects of reduction or elimination of deductible or coinsurance in Parts A and B in Medicare. To judge by your remarks, careful estimates on consequences of reductions in deductibles are now available. I would like a summary of such estimates.

2. On the matter of deductibles, I have enclosed statements from Mr. Langer and the Reverend Cervantes of St. Louis and Mr. William Hutton of the National Council of Senior Citizens. I would like to have your comments on their arguments for reduction or elimination of deductibles.

You also referred to H.R. 5710 and said it would simplify hospital procedures. I would like additional commentary on that bill.

3. In your testimony, you referred to a survey of health service expenses of older persons before and after Medicare, and you said preliminary results would be available "fairly soon". Will they be available by July 15? If not, we would like to have them as soon as they are available.

4. What is the rationale for the limitation in the Social Security Act upon mental health benefits under Medicare?

5. The President, in his message to Congress of January 23, 1967 entitled "Aid for the Aged", stated:

"I am directing the Secretary of Health, Education, and Welfare to undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under Medicare."

Can you provide any information for the record as to how that study is progressing, and when a report on this subject will be issued?

Once again, I would like to thank you for your help and interest. We will welcome any other information you may care to send to us as the Subcommittee inquiry continues.

Sincerely,

GEORGE A. SMATHERS.

(The following reply was received:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, July 19, 1967.

DEAR SENATOR SMATHERS: Please find enclosed the replies of Mr. Alvin M. David to your questions during testimony on June 30, 1967.

Sincerely,

JOHN T. GRUPENHOF,
Special Assistant to the Assistant Secretary for Legislation.

RESPONSE TO QUESTIONS POSED IN JUNE 30, 1967, LETTER TO MR. ALVIN M. DAVID FROM SENATOR SMATHERS IN CONNECTION WITH HEARINGS ON COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS HELD BY THE SUBCOMMITTEE ON HEALTH OF THE ELDERLY

1. We are not able to estimate the extent to which the deductible and coinsurance provisions have served to deter people from obtaining health services. There have been studies of other programs which give some indication, but no definite finding, that a difference in use seems to have occurred where the beneficiary pays a share of the cost compared with where he does not. These studies provide no data on the effect of cost sharing in relation to the medical necessity of the care.

We have developed estimates on the cost of eliminating the deductible and coinsurance amounts under part A and part B of the medicare program. The enclosed statement, Attachment A, prepared by Mr. Robert J. Myers, Chief Actuary for the Social Security Administration, provides information on the estimated costs associated with the elimination of these provisions.

2. Several witnesses commented on the deductible and coinsurance amounts under medicare and we share with these witnesses a concern that health services be available to all aged persons who need them and that medicare beneficiaries

should not be deprived of care they need because they cannot afford to meet the deductible and coinsurance amounts. However, we are not prepared to make any recommendation to modify the deductible or coinsurance provisions. One point to consider in this connection is that a reduction in cost-sharing which carried with it a substantial increase in premiums might have the effect of reducing enrollment in medical insurance with the entire medical care costs being borne out-of-pocket rather than only the deductible and coinsurance. Such larger out-of-pocket payments would have a greater inhibiting effect on use of care than would present cost-sharing. Mr. Robert Langer pointed out that States are faced with a heavy financial burden in making payments towards the cost of medical care for assistance recipients who are medicare beneficiaries and that the States are severely hampered in the assistance they can provide for their non-aged population. Of course, the States have been relieved of almost all of the cost for hospitalization of medicare beneficiaries and this reduction in the State burden amounts to a significant portion of the health care expenses for these beneficiaries that the States were responsible for before the enactment of medicare.

The enclosed statement, Attachment B, entitled Simplification of Medicare Procedures for Hospitals, furnishes additional information concerning the provisions of H.R. 5710 that I indicated would simplify medicare procedures for hospitals.

3. I am informed that the first results of the April 1966 survey of health service expenses of aged persons before medicare are expected to be available by the end of September and a full report by the end of the year. I will send you copies of these reports as they become available.

4. The law places a lifetime limit of 190 days on inpatient psychiatric hospital services that can be paid for under medicare. (However, this limit does not apply to any hospitalization for physical illness that a mentally ill person might undergo.) There is an additional restriction on the hospital insurance benefits available to a person who is an inpatient of a psychiatric hospital at the time he first becomes eligible for medicare. In the latter type of case, inpatient days in a psychiatric hospital during the 90 days immediately preceding the first day of eligibility are deducted from the 90 days of inpatient hospital services to which he would otherwise be entitled under medicare during the spell of illness beginning with his entitlement. Without these restrictions on hospital insurance coverage for persons in psychiatric hospitals, medicare would be paying in many cases for custodial-type care.

There is also a restriction on the amount of medicare benefits that will be paid in any one year for outpatient psychiatric care. This restriction was modeled on similar provisions in private insurance and specifically on the high-option indemnity plan of the Federal Employees Health Benefits program. We understand that these private insurance limitations were developed because some expensive psychiatric services are based in greater part than other medical services on a choice by the patient not necessarily related to the seriousness of his illness, as to the amount and nature of services he receives, as, for example, in the case of psychoanalysis. It was decided to follow the private insurance precedent and apply an annual maximum on the expenses for these services for which reimbursement can be made; this annual maximum is the lower of $312.50 or 62½ percent of the total bills for these services in a year.

5. On June 1, the Secretary of Health, Education and Welfare announced that a special task force had been selected to conduct a comprehensive study of prescription drugs. This study is now underway. The Chairman of the Task Force is Dr. Philip R. Lee, the Assistant Secretary for Health and Scientific Affairs. In announcing the formation of the Task Force, the Secretary stated that it would "examine a wide range of factors which are involved in the use of prescription drugs and will offer its recommendations within six months."

[Enclosures]

JULY 5, 1967.

MEMORANDUM

From: Robert J. Myers.

Subject: Cost Effect on Medicare Program of Eliminating Deductible and Coinsurance Provision.

Request has been made for the cost effect of eliminating all deductible and coinsurance provisions under the Medicare program. This proposal will be considered separately for the Hospital Insurance system and for the Supplementary Medical Insurance program.

Under the original cost estimates for the HI program, its estimated level-cost was 1.23% of taxable payroll. On the basis of this cost estimate, the estimated

effect of eliminating the initial $40 deductible and the $10 daily coinsurance for the 61st through 90th days was an increase in the level-cost of .14% of taxable payroll. This represents a relative increase in cost of 11%. In terms of dollars, on the basis of the present taxable payroll, .14% of taxable payroll represents about $425 million annually. It should be pointed out, however, that the cost estimates for the HI program are being revised upward so as to recognize the current trends in hospitalization costs. It would now appear that the revised cost estimates will show a level-cost that is about 20% higher than the original estimate and, accordingly, the figures given previously for this proposal to eliminate the deductibles and coinsurance provisions will be increased proportionately.

Next, considering the SMI program, the elimination of the $50 annual deductible and the 20% coinsurance provisions would result in the present cost of $6 per month (for the participant and the Government combined) being increased by about $8.25—a relative increase of almost 140%. Considering the fact that there are about 17½ million enrollees, the effect of an increase in the combined contribution rate of $8.25 per month would mean additional annual outgo from the General Fund of the Treasury amounting to about $860 million.

ROBERT J. MYERS.

SIMPLIFICATION OF MEDICARE PROCEDURES FOR HOSPITALS

H.R. 5710 would greatly simplify the medicare benefit structure and administration in two important areas of coverage: (1) services to outpatients of hospitals; and (2) X-ray and laboratory services to hospital inpatients and outpatients that are provided by physicians.

Hospital patients receive a broad range of services, including diagnostic and therapeutc supplies and services furnished by hospital presonnel and X-ray and laboratory services provided by or under the supervision of physicians. When the professional services are billed for by the hospital, they are customarily paid for by third parties on the same basis, and as part of the same claim, as the nonprofessional hospital services. The medicare law complicates reimbursement for hospital services and diagnostic specialty services by departing from this traditional billing and payment approach in two important respects:

a. Under the medicare law, payment for the nonprofessional services the hospital provides to outpatients is made to the hospital by the part A intermediary on a cost basis but the payment is divided between the two parts of the program: coverage is under part A subject to a $20 deductible, where the services are diagnostic in nature; and under part B, subject to the part B $50 annual deductible, if the services are therapeutic in nature. In both cases a 20-percent coinsurance applies after the deductible is met. Payments toward the $20 deductible under part A are counted as "expenses" of the patient covered by part B.

b. Payment for physicians' professional services direct to patients is covered only under part B. As a result, payment for diagnostic X-ray and laboratory procedures performed in hospitals is divided between parts A and B regardless of whether furnished to a hospital inpatient or outpatient. Under the law, the portion of the hospital's customary charges which is estimated to be attributable to a physician's services to the patient is covered under part B and subject to the $50 deductible and other part B limitations, whereas the hospital's expenses for nonphysician services to inpatients and for the physician's administrative services and his other services which benefit patients generally are covered under part A. The part B payments for the physician's services to the patient and the part A reimbursement are made by different intermediaries.

The present division of X-ray and pathology services between parts A and B makes it necessary for hospitals and physicians to agree, for medicare billing purposes, on a troublesome allocation of physicians' services into the so-called part A and part B components; and even where the hospital bills for both components, it must bill for and account for them separately under medicare. The additional work and complexity are a wholly additive administrative burden for hospitals since the charges which are established serve no purpose beyond medicare reimbursement. There are also the complications of having two separate intermediaries involved in the reimbursement of what other third parties treat as a single claim. Finally, inequities arise under present law when errors in estimating the data used in determining the charges for a hospital-based physician's service result in paying too much or too little.

H.R. 5710 would simplify administration by permitting payment for services to hospital outpatients to be handled as a single benefit, with a single rule for determining eligibility for payment, patient and medicare liability and fund accountability. Benefits for all services to hospital outpatients (including hospital diagnostic, hospital therapeutic, and physician X-ray and laboratory services) would be available to part B enrollees, subject to the limitations provided for under part B and paid from the part B trust fund.

X-ray and laboratory services to inpatients would also be handled as a single benefit. No deductible or coinsurance requirement would be applicable to these specialty services, so that where inpatient services are billed for in the form of a combined charge for physician and nonphysician services no breakdown would be required. The proposal would make it unnecessary to divide the responsibility for reimbursement for the services in question between two intermediaries where the hospital handles the billing for both the hospital and physician components. In these cases, a single intermediary could make all the required determinations on the basis of the compensation the physician receives and other costs the hospital incurs in making diagnostic services available.

Senator SMATHERS. Now, who else is to testify?

Dr. SILVER. I would like to introduce Dr. Carruth J. Wagner, Director of the Bureau of Health Services.

Senator SMATHERS. All right, go right ahead.

STATEMENT BY DR. CARRUTH J. WAGNER

Dr. WAGNER. Thank you.

I am pleased to appear before you to discuss the important questions of cost and delivery of health services to older Americans.

The Public Health Service is charged with assisting the development of quality medical care for all our citizens. Meeting that responsibility takes us into every aspect of medical care—from manpower development to facilities construction, from basic biomedical research to studies in the delivery of health services.

The health needs of the elderly are essentially the same as those of the rest of the population. But as the chairman has pointed out, age creates special social and psychological problems that frequently stand between the elderly and good health care.

My purpose this morning is to review the Public Health Service programs devoted to finding solutions to those problems.

At the outset, I would like to emphasize one major contribution of medicare to the entire health field and to the aged in particular, and that has to do with raising the quality of care provided older patients.

Providers of service have been required to meet specified standards. For extended care facilities and home health agencies, these standards were the first to be nationally recognized.

Professional organizations such as the Joint Commission on Accreditation of Hospitals and the American Osteopathic Hospital Association have been stimulated to reconsider their own standards with the aim of raising them.

States are reviewing and strengthening their licensure programs in ways closely akin to the certification process under medicare.

A special effort is being made by the Social Security Administration to assure the quality of performances by independent clinical laboratories through raising their personnel standards.

Medicare standards have provided benchmarks for determining the adequacy of care now provided by our health resources.

For example, the survey of hospitals—including both participants and those denied participation—showed that 46 percent had some deficiency and that 89 percent of the extended care facilities needed to improve their operations to meet medicare's quality goals.

With this information in hand, we developed a program of consultation and training for State health departments to assist them in their facility certification process and to equip them with sufficient technical and program know-how so they can, in turn, assist the operators of facilities in their efforts to achieve the standards.

For the elderly patient and his family, these standards and our efforts to improve them mean a growing confidence in the quality of care purchased.

Major Issues on Care

Beyond questions of quality lie the major issues of whether care is available, can older people afford the care, and will they use the services they need?

Central to these issues is the adequacy of our medical manpower supply. There are, as this committee knows, serious shortages in all the medical specialties. Perhaps the most significant for the elderly is the nursing shortage, where we estimate a current deficit of 125,000 nurses just to fill existing vacancies.

With the Office of Education, the Vocational Rehabilitation Administration, the Department of Labor, and with the assistance of such legislation as the Allied Health Professions Act adopted by the Congress last year, we hope to gain somewhat in the race to match medical manpower supply with the demands.

Last year, more than 35,000 nurses were graduated. More than 24,000 nurses came out of post high school programs. And approximately 20,000 hospital aides, orderlies, and attendants received entering training.

We have begun to develop another important resource in the nursing field by attempting to bring back into nursing a portion of the 300,000 licensed professional nurses in this country who are not practicing nursing.

Through contracts with States, we are supporting efforts to recruit these nurses, find employment for them, and through cooperation with the Manpower Development and Training Act, offer refresher courses. Our goal is to increase the number of nurses returning to active practice by 30,000 in the coming fiscal year.

Senator Smathers. Doctor, let me ask you a couple of questions right there. Has there been a decline in the hospital school of nursing?

Dr. Wagner. No, sir.

Senator Smathers. There has not been a decline?

Dr. Weiss. There has been a slight decline this year.

Senator Smathers. A rather substantial decline according to information on this side of the table.

Dr. Weiss. In terms of total number of schools there has been a substantial number.

Senator Smathers. Can we have you identified for the record.

Dr. Weiss. I am sorry.

My name is Dr. Jeffrey Weiss and I am an economist employed by the office for the Assistant Secretary for Program Coordination.

The total number of diploma schools has declined considerably in recent years but total output has not, that is number of graduates. However, this year, for the first time—that is this fall of this academic year—there was a perceptible decline in the number of first-year entering students, a decline of about 8, 9, 10 percent, something in that range.

Vacancies in Nursing Schools

Senator Smathers. Our information is that there are 4,000 vacancies in these schools and many hospitals that had previously been running nursing schools are now closing them because there is nobody coming to school.

Dr. Weiss. That information I would say is a general trend; it is substantially correct.

Senator Smathers. Why is that?

Dr. Silver. There has been an increase in places in the associate degree programs; that is, the junior college programs, and in the baccalaureate programs. The total number of nurses graduating is not declining. The decline is wholly in the area of the diploma school graduates. You see, the diploma schools have very special problems.

Senator Smathers. Like what?

Dr. Silver. I think young people want a college degree or they want training that will compare with college training. The people who would be teaching nurses want to be associated with teaching institutions so that hospital schools have problems in recruiting faculty and in recruiting students.

The vacancies that you describe in diploma schools are there and the fact is that hospitals are closing their schools because they cannot recruit faculty or students.

Senator Smathers. Is it a fair generalization to say that it is a little better status symbol to be able to say that you have graduated from a ——

Dr. Silver. You have a college degree.

Senator Smathers. That is right, rather than having graduated from the hospital nursing school where you get a certificate, but it does not look good on the wall.

Dr. Silver. Yes. You can go 2 years to an associate degree school and become an RN or you can go 4 years and get a college degree so that it sort of preempts the 3-year schools.

Senator Smathers. But you can state, as the good doctor over here stated, that there is an increase in those young ladies and men who are studying to be nurses and we can expect a greater increase in nurses?

Dr. Silver. This past fall the largest number of student nurses ever entered into nurses training, about 48,000 or 49,000 students entered into training this past fall.

Senator Smathers. Now, even with the fact that you are increasing the number of students who are attending courses calculated to lead to a nursing degree, would you not agree that in the light of the enormous shortage of 120,000 nurses that we somehow should try to get more of the girls and boys to go to the hospital nursing schools, too?

Dr. Silver. Senator, we are not trying to keep nurses out of training. We are trying to do everything possible to get them into training. I

think that one of the points that Dr. Wagner made, for example, was that by means of the nurse refresher program, which is a combined operation between the Public Health Service and Department of Labor and the Office of Education, we are trying to bring back 30,000 nurses this year, inactive—but licensed nurses—which would be the equivalent of 1 whole year's graduating class.

If the Congress would give us the ceiling of the opportunity grants that were voted in the legislation last year—no money was provided, only an authority that with those opportunity grants we might provide stipends for students which might encourage more students to go into nursing. We have the authority but we didn't get the appropriation.

Senator SMATHERS. How much of the authority was allowed you?

Dr. SILVER. $5 million is the ceiling.

Senator SMATHERS. Passed both Houses?

Dr. SILVER. The authority, yes.

Senator SMATHERS. All right, sir.

You go ahead, Doctor.

Let me ask you one other question. I notice you talk an awful lot about nurses here. Do you get anybody to talk about the shortage of doctors?

Dr. SILVER. What should we talk about?

Senator SMATHERS. Well, I notice the American Medical Association stated yesterday, was it not, that they were alarmed by the fact that there is now a considerable shortage of doctors and they recognized it.

SHORTAGE OF PHYSICIANS

Dr. SILVER. I think that there is and has been for some time a significant shortage in physicians which is ascribable to a number of factors only part of which has been the very slow increase in the total number graduated. The shortage is much more acute in some parts of the country. For example, there are almost twice as many physicians per 100,000 population in the Northeast as there are in the Southeast. Some of the conditions of life and conditions of professional life are less attractive in some areas than in others.

Most of the students now graduating from medical school go into specialty training so that the differential shortage is more in the areas of family practice and pediatrics than it is in some of the specialties.

We have to do many things to overcome the shortage and I would not consider simply producing more physicians as the essential answer. What we need to do is use the physicians more effectively to increase the productivity of doctors and to multiply their activity by providing physician assistants.

Now you mentioned, of course, sir, that more doctors are beginning to cluster together in groups which increases their efficiency and productivity. We think that this is something to be encouraged very strongly. We know that if you increase the productivity of the physicians in this country by only 5 percent it would be the equivalent of two graduating classes. This is one of the many things that we want to talk about at this conference next week; what things we are going to do to provide incentives and stimulus for more physicians to go into group practice.

We can multiply their efficiency, we can do far more than by simply working over a long period of time to turn out more doctors. It takes about 12 years from the time you start to plan a medical school until you have the product, the physician who can work with patients. We would like to do something more quickly than that.

PHYSICIANS' ASSISTANT

Senator SMATHERS. I don't want to delay this hearing but we have a lot of witnesses and a lot of ground to cover and I am talking too much. I am going to stop in a minute.

You said to develop a physician assistant.

Dr. SILVER. Yes.

Senator SMATHERS. What do you mean by that?

Dr. SILVER. Well, I have in mind a person who would be specially trained to work with the physician to do many of the things that require professional training that a physician is not required to perform. I have in mind, for example, the kind of study that was made among pediatricians in the State of Washington where it was shown that 50 percent of what the doctor was doing in his office need not be performed by someone with that much training. The business of taking the history and keeping records and handling telephone conversations in pediatrics, for example, rearranging the formula, consulting with the mother about guidance with respect to the growth and development of the child, many of these things would be carried on by people who don't need the advance training of 8 or 10 years of professional training that a physician has.

Senator SMATHERS. You know I happen to agree with you very strongly.

Dr. SILVER. Good.

Senator SMATHERS. I know the doctors don't like it but I was in the U.S. Marines for 4 years and I so well remember overseas where we had a sick call in the morning and you would see the fellows lined up to receive treatment for poison ivy, cuts, diarrhea, things of a minor nature, whatever it was. Then we had a couple of corpsmen there. The corpsmen had enough training and enough sense to know if a fellow came in there with a fever that he would set him aside and say "You have to see the head man; you have to see the doctor."

The doctors didn't mind this. Mind you, these were not Regular Navy doctors, this was World War II when these were private practitioners who, like everybody else, were going into service. It was a pretty good idea.

I have seen some of them since and say "Why don't you still have this same idea?" But they reply, "Oh, no, now we have to see everybody ourselves."

Well, anyway, this whole program, it seemed to me, took care of cuts, minor things of that nature, with fairly well-trained corpsmen who had some training, and was perfectly agreeable as far as the armed services were concerned. Four million people in service and nobody objected to it and it worked very well. You saved the doctors to do the very important and necessary things which they had to do and which only a doctor should do.

I never have understood why we cannot develop a system similar to that. I never heard it called a physician assistant before, but I like the idea. I don't know why we don't have a 2-year medical school for medical assistants.

Dr. SILVER. Dr. Wagner, himself, is involved in a program to develop specially trained assistants to work with purser's mates in the merchant marine.

Senator SMATHERS. We do this in all the services and it works well. I never have understood.

I understand there is a representative of the American Medical Association sitting out here this morning. I like doctors. I am for them. I think they render an enormous service and they should be respected. I know of no economic or political group in our society, next to the preachers, which gives more charity and gets more abuse for it. In this area I don't understand why they are not willing to go forward with a program of this particular nature, physician's assistants.

Dr. SILVER. The climate has changed, Senator. The doctors are not opposing. As a matter of fact, we have had expressions of cooperation from all kinds of physician groups to help us develop this. We now have on the agenda, for example, through the Health Services Research Center that we hope to establish in the Public Health Service and with which Dr. Wagner will be very intimately associated, to do some of the exploration and from the partnership for health bill hearings now in the Interstate and Foreign Commerce Committee. We need support for the programs that will help us accomplish this thing.

We know that it is necessary. We want to do it. We have the program ready to go and if we get the necessary appropriations and support from the Congress we will do it.

Mr. MILLER. I know from my own personal knowledge that the Michigan State Medical Society was promoting this idea at least 20 years ago. I am sure other medical societies have done so too. However, is not a basic factor in this the attitude of the patient himself? Isn't this an area that would require considerable educational effort to get a ready acceptance from the patient?

Senator SMATHERS. I think you are right. That is what some of the doctors have told me, that the patient's attitude is the critical factor. I think the reason is that the patient at that point has never talked with one of these qualified assistants. As patients see it, everybody's ailment is the worst. It does not matter what it is. They want the best. But once you get adjusted to talking to the physician's assistant, in some respects you might get a better, at least a longer treatment or a more thorough treatment from that physician's assistant.

I think it is a matter of educating the patients and public as well as the doctors. Every time I read of a doctor shortage I think, why don't we do this?

You call a doctor today, and I have an illustration right in my own office where we were trying to get a young lady in to see a certain specialist. She has to wait 3 weeks. She needs a doctor now. Now we can take her out and act like she is runover or something, maybe get some emergency treatment for her, but otherwise she has to wait 3 weeks.

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This does not make sense. She needs help now, not in 3 weeks. She needs prompt medical attention, but she does not necessarily need a graduate of the University of Florida Medical School, if I can give that a plug. She does not have to have someone who was an intern for 5 years and then went into some New York City college hospital and studied under a specialist, and so on, and so on, and so on. That guy ought to charge a fee; he is entitled to it. But he should not be seeing routine cases.

Dr. SILVER. You may be pleased to know that I have just returned from Gainesville, the University of Florida, where they are trying to develop a program, and hopefully will have a program in operation soon, for physician assistants, particularly in the area of pediatrics. I think that most of the kinds of objections that you are talking about are beginning to disappear.

For example, at Duke where Dr. Eugene Stead has been developing a program of physician assistants, he has only had four students in training this last year, but he has 600 applicants for next year's program.

Senator SMATHERS. Great. That is good news.

All right. I will stop testifying so much and let you fellows testify more.

Go ahead.

Dr. WAGNER. I would like to emphasize again, Senator, that the very crucial element in the use of the assistant, whether it is the physician assistant or the nursing assistant, it is the clear-cut definition of the functions, responsibilities, and authorities of these people and the maintenance of supervision by the professional because it is only by managing the health needs of the patient through the allied health worker, whether he is a physician assistant or a nursing assistant or some other assistant, that the professional can actually function.

This is why it is so important, when we look at this, that we not generalize. We must look at the individual physician and the individual situation and then apply to the maximum the state of the art so that he can care for as many patients as possible while maintaining quality of care.

All of the efforts of the Public Health Service in the development of personnel are under this general policy.

HOME HEALTH AID TRAINING

In addition to the nursing and nursing assistants which I spoke about, we are also making progress in the training of home health aides with more than 1,300 now enrolled in 16 projects. These projects are funded by the Office of Economic Opportunity and the program not only develops an important occupational group within the health field but is directed at older, low-income workers for whom the training is a significant economic asset.

We have been very pleased at the leadership provided by many States in this program. In addition to the projects federally funded, several States have begun training home health aides through the States' own employment and education resources.

Every patient, Mr. Chairman, is entitled to receive the treatment and care appropriate to his needs. Determining the appropriate type of care is of a special importance for older patients because their medical

needs may be obscured by the social problems brought on by increasing age.

The utilization review process required by medicare brings physicians together with other service personnel to review the records of selected aged patients. Through this process, placement problems of patients can be detected and better choices made for him if indicated.

One result of this process has been to bring hospitals into closer association with extended care facilities so that transfer agreements can be worked out for the smooth transition of the patients from one facility to the other as his needs change.

We presently have five demonstration projects underway to test ways in which combinations of facilities and services can be arrayed so that dental care can be provided, for example, to patients in a facility that has no dental staff or equipment, or social services can be offered to patients by agencies that typically do not serve inpatient groups.

National Center on Health Services

Earlier this year, the President announced his plans to establish a National Center for Health Service Research and Development. One of the major purposes of this Center will be to seek new ways of delivering services to the aged and more efficient methods of using existing medical specialties.

Meanwhile, we are testing ways to bring services to the elderly for whom the lack of transportation is often a serious handicap. For example, at the Dexter Manor public housing project in Providence, R.I., 283 elderly with an average age of 72 were provided health services ranging from nutritional counseling to direct and preventive services such as X-rays, immunization, diabetes detection, and so on. An important element in this demonstration was the assurance to each resident that he could call upon a competent, concerned person who knew what to do when a crisis arose.

This particular project was so successful that the community is now supporting it although Federal funds, which were supporting it, have been withdrawn.

Closely related to the problem of obtaining appropriate care is the problem of belated diagnosis of disease conditions. We are testing methods of assisting physicians in their diagnostic workups by using computers. In four communities, New Orleans, Providence, Brooklyn, and Milwaukee, the use of automated diagnostic devices is being tested to determine how much time may be saved in a communitywide, multiphasic health testing program while improving the diagnostic procedure.

Nursing Home Studies

As earlier reports of your full committee have noted, we know too little about nursing homes, how they are used, the level of services provided, and their adequacy as a treatment setting.

The Public Health Service has designed a nursing home socioeconomic research program to develop a baseline on data on nursing home utilization and costs of services; patient needs and sufficiency of services; and methods of improving nursing home care.

The program began in July 1966, and the contract studies will be completed on December 31, 1968. We will have a report on baseline utilization and costs later this summer.

Until now, I have been talking about training, demonstration, and basic information gathering efforts of the Public Health Service to improve health services to the elderly.

PARTNERSHIP FOR HEALTH

The translation of this knowledge and experience into improved patient care will come about through implementation of one of the major achievements of the 89th Congress—the partnership for health legislation, Public Law 89–749.

Through the Federal-State-local partnership created by this legislation—which, incidentally, is now before the Congress for renewal—funds are available for gathering information about the health needs of all the population, the resources that must be developed, and the means of their development.

The importance of this information gathering cannot be overemphasized, Mr. Chairman. The general information that we gather at the Federal level is very valuable in developing administrative policy, but it does not tell us how to cope with the individual in a particular neighborhood who is cut off from health care for economic or social or any other reasons.

Only the community can overcome these specific obstacles, and the community can overcome them only when the facts are gathered and plans are made and implemented. We can advise, guide, and assist communities by helping them collect the data, working with them and State planning agencies on their planning, and offering alternative solutions for their consideration.

But the local and State planning effort is the place where the action is going to be. The partnership for health legislation offers the flexibility and financial resources needed at the community level to get the job done.

We expect the programs that will develop under the partnership for health to contribute significantly to the growth of services to the aged.

Thank you very much, Mr. Chairman.

Senator SMATHERS. Thank you, Doctor.

(Subsequent to the hearing Senator Smathers asked the following questions in a letter to Dr. Wagner:)

JUNE 30, 1967.

DEAR DR. WAGNER:

* * * * * * *

1. You referred to "progress in the training of Home Health Aides with more than 1,300 now enrolled in 16 projects."

I would like additional information on this program with special reference on its usefulness to older Americans.

2. In his testimony before us, Dr. George James said that there are only 70 medically directed home-care programs in the nation and that they serve only 5,500 persons. Doesn't this indicate that there are serious deficiencies in the availability of such services? If so, what additional efforts are needed to develop home-care programs?

3. The Dexter Manor project is of great interest to this Subcommittee. We have the excellent pamphlet describing that project in detail, but I wonder if a more recent and more succinct report is available for inclusion in our hearing record.

4. May we have a progress report on the multiphasic screening projects described in your testimony. I would like specifically to know when operations

will begin, how many individuals will be served, and what variations there will be in services. I would also like to have your personal views on whether health screening should be included among Medicare benefits.

Once again I would like to thank you for your help and interest. We will welcome any other information you may care to send to us as the Subcommittee inquiry continues.

Sincerely,

GEORGE A. SMATHERS.

(The following reply was received:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
BUREAU OF HEALTH SERVICES,
Silver Spring, Md., July 14, 1967.

Hon. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This will reply to your letter of June 30, 1967, in which you ask for additional information related to testimony before the Subcommittee on June 22. The requested information follows:

1. Training of home health aides

The U.S. Public Health Service in cooperation with the Office of Economic Opportunity and Administration on Aging is currently sponsoring 16 Home Health Aide Pilot projects in ten States: Two are in Florida. Qualifications for the trainees for this project included age (over 45) and income (under OEO poverty levels). Both of these factors tend to increase the number of older Americans involved in the program.

The 16 projects have individualized programs of training. All, however, include classroom instruction as well as on-the-job supervised training as set forth in the guidelines for the program. The aides are trained in those aspects of personal care which a knowledgeable family member could undertake. All personal care is under the supervision of a registered nurse. The aides also learn to perform such household services as are essential to the patient's health care at home and necessary to prevent or postpone institutionalization.

Home Health Aide Service is one of the kinds of service which may be provided by home health agencies under Medicare. More than a third of the 1,800 home health agencies that have been certified include this service. Thus, both the aide and the recipient are often senior citizens.

2. Dr. George James' reference to "70 medically-directed home-care programs"

Dr. James was referring to a 1964 survey of "coordinated home care programs," a copy of which is enclosed. The study was limited by definition to programs that are "centrally administered and through coordinated planning, evaluation, and follow-up procedures provide[s] for physician-directed medical, nursing, social, and related services to selected patients at home." The term "physician-directed" means that the direction and supervision of all patient services (medical, nursing, social, and related) are the responsibility of the attending physician —that is, the patient's personal physician. This does not mean that the agency which administered a home care program is directed by a physician. In the 70 programs to which Dr. James referred, only 39 were directed by physicians.

The significance of that study lies not so much in the number of such programs or how many patients they served in 1964 as in the pattern the programs provided for home health services under Medicare. As Dr. Cashman stated in the foreword to the study (see p. iii):

"Coordinated home care programs were the prototype for the development of the conditions of participation for home health agencies in Medicare. While, at the onset, these agencies can qualify for participation with only one therapeutic service in addition to skilled nursing care, they must have built into them the features that heretofore have been described as coordinated home care."

Charts 4 and 10 of the enclosed "Medicare—the First Nine Months," provide information on the extent to which home health services are available under that program to persons 65 years of age and older. There are 1,800 agencies. In the first nine months of Medicare, 173,000 persons were accepted for home health services (227,000 during the first full year). Thirty-five percent of the agencies provided skilled nursing and one additional service, the minimum required for

certification, but sixty-five percent provided two or more of the additional services which include physical, speech, or occupational therapy, medical social work, and home health aide service.

Although the recent increase in number of home health agencies has been significant, many are having financial problems and some of the new small ones are struggling to achieve the financial stability needed for survival. The enclosed "summary of developments in home health care following the enactment of Medicare and Medicaid" describes some of the additional efforts needed to strengthen existing programs and develop new ones where none now exist. We also enclose a "Guide for the Development and Administration of Coordinated Home Care Programs" which is used in these efforts.

3. Dexter Manor

As I stated in my testimony, the Dexter Manor project is now being supported locally; therefore, we no longer have a constant monitor of its progress. In order to get the latest information, we contacted Mrs. Raoda Plaza, Director of the Providence District Nursing Association—the sponsoring agency. Mrs. Plaza said that she would be pleased to prepare a brief report for the Subcommittee and that it would be sent to you promptly,

4. Multiphasic screening projects

The four adult health protection projects which involve automated multiphasic screening are moving into the operational phase. Pilot testing begins this month in Milwaukee. In New Orleans services will be offered by September; in Brooklyn, by November; and in Rhode Island, by May 1968. By the end of the first year of operation, the centers will have developed capacity for service to 6,000 persons per year.

There is little variation between centers in the services offered. Each program performs tests or measurements to obtain an array of similar data on composition of body fluids, functioning and condition of the organs and systems, and the like. There is, however, some variation in the techniques used to obtain the data. For example, identification of breast tumors is being accomplished in three of the projects by mammography—x-ray—and in the other by manual examination. As another example, in glaucoma testing, one center is using an electronic instrument to measure intraocular tension, while the others employ a manually-operated instrument.

The primary variation between projects is in the type of sponsoring agency. They are being done by a State health department (Rhode Island), a city health department (Milwaukee), a community hospital (Brooklyn, N.Y.) and a school of public health (New Orleans). Since a critical objective of the program is to develop and demonstrate methodology for providing these health protection services in an open community, this variation is an essential aspect of the activity. With a different relationship to the total health service system in the community, each type of agency may employ a different approach to providing a community service. These projects offer a mechanism for testing and evaluating these approaches.

A second important variation is in the character of the populations served. Activities to inform and educate the population about this service, and to encourage participation, are being designed to reach different kinds of populations. Also relationships of the program to the medical care resources vary according to population, and techniques of working with, for example, both private and clinic physicians are being developed.

Finally, I feel that screening should not be given high priority—as a Medicare benefit. Screening is certainly valuable when applied to the aged population. However, it is much more valuable when applied among aging adults. Early identification and control of disease in this group would prevent much of the long-term illness and disability we now see among our older people. I feel, however, that regular health testing of those in the 35 to 60 age group is a related but separate issue and should be so dealt with.

For the population considered "aged" and now covered by Medicare, I believe there are other benefits which ought to be proposed before screening comes under serious discussion.

If we can be of further assistance, please let us know.

Sincerely yours,

CARRUTH J. WAGNER, M.D.,
Assistant Surgeon General,
Director, Bureau of Health Services.

Senator SMATHERS. Let me ask a couple of questions of Mr. David again about medicaid. How many States did you say have it and how many don't have it?

Mr. DAVID. Of the total of 54 jurisdiction, Mr. Chairman, including the District of Columbia and Puerto Rico, 29 have a medicaid program in operation. In 15 more, plans to install these programs are underway.

There are only 10 jurisdictions that have no plans to establish a medicaid program under title XIX.

Senator SMATHERS. What are those 10? Do you have them with you?

Mr. DAVID. No, sir.

MEDICAID SITUATION IN FLORIDA

Senator SMATHERS Do you know whether my State of Florida has a medicaid program?

Dr. SILVER. The Florida State Legislature voted down the program that had been submitted to them and there is considerable agitation now for reconsideration. The medical society wants it.

Senator SMATHERS. The Florida Medical Society is for it. I assume the old people are for it.

Dr. SILVER. Yes.

Senator SMATHERS. Who is against it?

Dr. SILVER. The legislature.

Senator SMATHERS. Do you know whether the Florida State Senate voted up or down?

Dr. SILVER. I really don't know, sir.

Senator SMATHERS. I am informed this morning that the Florida State Senate has passed it, but the lower House voted it down. Is it not a fact that under medicaid that the Federal Government provides funds on a ratio of 3 to 1?

Dr. SILVER. It varies, sir.

Senator SMATHERS. What would be the situation in Florida?

Dr. SILVER. I would have to find out precisely. I would not want to say.

Senator SMATHERS. If I stated it is 3 to 1, would you say I would be very far off base?

Dr. SILVER. That is reasonable.

Senator SMATHERS. So if Florida put up $15 million, Florida would have gotten back $45 million; is that correct?

Dr. SILVER. That is about right.

Senator SMATHERS. Do you think that Florida has many old people? What is your information on that?

Dr. SILVER. Florida has more than its fair share of old people as compared to the national average, sir.

Senator SMATHERS. We are delighted to have them. However, we have a large number of them who are in need. Does it make much sense to you that the Florida State Legislature would turn down an opportunity to take care of its medically indigent, when by putting up $15 million they would get back approximately $45 million?

Dr. SILVER. No, sir; not when they are spending more than that now and that they would be getting a greater share from the Federal Government if they participated in the medicaid program.

Senator SMATHERS. Right.

Well, I want to state for the record that I think the legislature did a very unwise thing in turning it down and I am satisfied that if most of the members of the legislature had understood what the problem was and what the answer to the problem was, they would not have turned it down. I don't want to turn this into a political forum at the moment other than to say that I think our distinguished Governor, who advised against it, made a very serious mistake and I think he will live and learn that he has made a mistake.

Now, after making that as a sort of nonpolitical statement, we will proceed with our hearing.

Gentlemen, Bill Oriol wants to make a contribution.

Mr. ORIOL. I want to note that several questions will be sent in writing because of our time problem this morning from the chairman and possibly from Senator Moss, too. So there will be additional questions.

Senator SMATHERS. Now, gentlemen, we are through with you. You did fine. You are not only good speakers, but you are good listeners.

Dr. SILVER. Thank you, Senator.

Senator SMATHERS. Thank you.

Our next witness is Dr. William A. Nolen of Litchfield, Minn. He is going to testify with respect to the charges made for patients under medicare. We might later put his article about medical economics into the record.

Doctor, we are delighted to have you and you may proceed as you like.

STATEMENT OF DR. WILLIAM A. NOLEN, LITCHFIELD, MINN.

Dr. NOLEN. Thank you very much for the invitation to testify, Senator.

Perhaps I better identify myself so that my remarks can be taken in the proper context. I am in the private practice of general surgery. I do the surgery for a clinic in a small town in Minnesota. I am the only surgeon in the county. I am a fellow of the American College of Surgeons and diplomat of the American Board of Surgery.

My coming here was precipitated by an article which I published in Medical Economics in February entitled, "Are Doctors Profiteering on Medicare?" [7]

This stimulated some queries from your committee and some suggested questions and the suggestion that I might expand on this testimony or on this article a little bit in my testimony today. This is what I have done.

I will quote the questions and then testify with the answers that I have written.

Your article in the February 20 issue of Medical Economics was a forthright account of disquieting questions you are now asking about charges made to patients under Medicare. I would very much like to have you elaborate on the matters you discussed in that article.

My article in the February 20 issue of Medical Economics was written as a warning to my associates in the medical profession. I was

[7] See p. 49.

and am afraid that doctors are going to take advantage of the medicare program to get as much money as they can from the Government. If this happens it will, I suspect, lead to increasingly strict control of medicine by the Government, an eventuality that no doctor engaged in the private practice of medicine wants.

This is, of course, my own personal fear. It is reflected in many of the articles that I read in the medical——

Senator SMATHERS. Run that by me once more.

You said you are afraid that the doctors are going to do what?

Dr. NOLEN. We are afraid that our medical practices are going to come further and further under the control of the Government and my purpose in writing this article was to warn my colleagues in medicine that if we do not use the medicare program with extreme discretion that we are apt to bring this down on our heads even more rapidly than we assume it will——

Senator SMATHERS. If you don't use it with discretion you will bring what down on your heads?

Dr. NOLEN. Further Government control of medicine.

Senator SMATHERS. OK.

Dr. NOLEN. We doctors, like our patients, act as if the Government's money is nobody's money. If the patient isn't going to have to pay us for our services out of his own pocket then he doesn't care how much we charge—and neither do we.

I realize that the Government will only pay 80 percent of our usual fee; but if the other 20 percent hurts the patient, we can always discount it.

As long as the Government is paying out money, let us get as big a share as we can. After all we're just getting back some of our tax money.

I am aware of the fallacies in this reasoning; I am simply presenting what I conceive of as the doctor's attitude toward medicare.

EXPOSURE TO PHYSICIANS' ATTITUDES

Why do I think this is the attitude that dominates the thinking of the medical profession? From personal experience and my exposure to medical practices in various places.

When I was at Bellevue Hospital in New York City, as an intern and resident in surgery, I never worried about the expense incurred in caring for a patient. Neither did anyone else on the house staff. We knew the patients weren't going to pay for it. Money was never a factor.

As a consequence we were, in retrospect, exceedingly wasteful. We ordered X-rays, laboratory studies, and medications many times when we didn't really need them. It was easier to order them and they might serve a purpose. There was certainly no financial reason not to order them. We didn't make any money for ourselves but we didn't worry about wasting the city's money.

Now, there are arguments that can be advanced to the defendant's position. We can say this is a training institution and that it is actually necessary for doctors to order these studies in order to learn that they don't need them.

This argument has been advanced in other articles. However, this argument to my way of thinking does not carry much weight because

if the economic situation were different you could learn in a much more rapid time some of the things that take 5 years to learn.

At this point, Senator, I was just expanding on this comment about wasteful ordering of X-rays and laboratory studies that went on at Bellevue. The justification that is presented for this many times in the medical literature and by those in teaching is that we allow interns and residents to do these things to order, probably considerably more than needs to be ordered, because they need to acquire the experience that the older man already has.

My argument is that this could be learned a lot more rapidly and it would be learned a lot more rapidly if the money for every one of those studies was coming out of the patient's pocket.

Attitudes in Private Practice

When I went into private practice, my attitude changed. Every time I ordered a laboratory test or an X-ray, I knew that the patient was going to have to pay for it, if not personally at least through his insurance premiums. I thought a little longer about what I was going to order and why.

The same philosophy prevailed in areas of medicine where I had some financial incentive. I might make $10 if I did a proctoscopy on a patient, $15 if I read an electrocardiogram, $20 if I burned off some warts. But the money was coming out of the patient's pocket and I made certain he or she needed the procedure before I ordered it.

This was the philosophy that prevailed in dealing with private patients who were going to pay their own bills. Welfare patients, for whom the county picked up the tab, were managed in a different fashion.

With welfare patients it was back to the Bellevue thinking, only more so. Let me make it clear we did not and do not skimp on care of welfare patients. On the contrary, we are more apt to overtreat them than undertreat them.

Here are some specific examples of what I mean.

If a private patient comes into my office with symptoms suggesting a lung infection I might examine him and start his treatment possibly without getting an X-ray, if I didn't feel an X-ray was imperative at the time. I would tell him to call me if he didn't improve or if he got worse, and I would explain to him that it might be necessary later to take a chest film.

With the welfare patient who present the same chest symptoms I would do as I did at Bellevue and order an X-ray immediately. Why worry about the expense. The patient isn't paying for it. It is easier and less time consuming to get the film right away.

Similar thinking might influence the prescription I wrote. For the private paying patient I might order a 5-day supply of medicine and ask him to check with me by phone when it was gone. If he needed more medicine I could prescribe an additional supply at that time. For the welfare patient, who gets his medicine "free," I might prescribe a 7-day supply immediately.

If there are 2 days of pills left over, well, so what.

But with the welfare patients, as opposed to Bellevue patients, another factor came into play—money. I didn't make any money when

I ordered a chest X-ray on a Bellevue patient. I might make money on the X-ray I took on the welfare patient. So, consciously or subconsciously, money might motivate me to order the X-ray on a welfare patient when it was not absolutely necessary.

Experience With Laboratory Services

Let us take another example—laboratory studies. On welfare patients, before medicare, the county would pay us only $2 for an office call. Our charge to private patients was $4.

But the county would also pay us $1 for a hemoglobin determination and $1 for a urinalysis. So there was a temptation to order these studies whether they were entirely necessary or not. By ordering them we could at least break even financially, and we could hardly say ourselves whether we were motivated by money or just good, thorough, medical practice, when we ordered them.

Now if this has been the prevailing medical attitude toward financial matters where indigent and welfare patients are concerned, why shouldn't it be the prevailing attitude toward medicare patients? In my opinion it is—and in one respect it is worse.

With medicare we live in constant dread that at some point the Government is going to set rigid fee schedules for us. We fight constantly, therefore, to keep our "usual" fee as high as we can. If we are going to have our fees fixed let us have them fixed at what is, temporarily at least, a satisfactory level.

I would guess that this is the reason that in 1966, as was just reported, doctors' fees and hospital fees went up far above the anticipated level.

Senator Smathers. Let me ask if I get that straight.

Dr. Nolen. Just before medicare came in there was a rise in doctors' fees and hospital charges. This was just testified to by the group here. I would guess that much of this was in anticipation of medicare.

We didn't want to get caught with our fees outdated.

Senator Smathers. Just too low.

Dr. Nolen. That is right.

We wanted to be sure that we were at a decent level in anticipation of the fact that they might be frozen there and we might have to sit around bargaining to increase them.

Senator Smathers. You are not old enough to remember at the beginning of World War II when people who had apartments to rent suddenly realized that rents were going to be frozen and thought as a matter of good judgment and precaution that they had better raise their rents a little bit at that time, so that they would be frozen at what they figured was a level that would be able to return to them some profit over the course of an indeterminate number of years.

Now I gather what you are saying is that it is your feeling that one of the reasons that the doctors' medical fees have gone up this past year over 7 percent is not necessarily because they are spending more time on the patient or because they are actually doing more, but that it is a natural hedge against the eventuality they fear—and we all fear for that matter; I would not like to see this happen—they fear that their fees may be frozen.

If they are going to be frozen, they want to have them frozen at a good level.

Is that what you are saying?

Attitudes on Surgical Fees

Dr. Nolen. That is exactly it, yes.

I would like to talk specifically about surgical fees for a minute, since, as a surgeon, these are of some concern to me.

Before medicare, as I said in my article, I individualized in many cases—in all cases really. The philosophy of the doctors where I practice is to charge only what we think a procedure is worth and not to increase the charge just because the patient is wealthy.

I am sure you are aware of this philosophy, this "Robin Hood" idea that you charge more for the wealthy so that you can treat the charity patients for less. We have never subscribed to that and I have never subscribed to that.

Whether a patient makes $7,000 a year or $50,000 a year, I charge him $150 to take out his appendix. I never raise that fee.

But I would lower it. An old man who couldn't stand to pay $150 just paid what he could and I would write off the rest. But not since medicare. The Government pays, so everyone is charged the maximum.

This attitude stems, as I mentioned, partly from fear of future rigid Government regulations, but it also stems in part from experiences like some of those I've already had with medicare.

Let me give you one example. I operated on an elderly woman some months ago and I did a hysterectomy for cancer. My usual fee for this operation is $300 but this particular patient had had deep X-ray therapy just prior to operation and the postoperative care was much more time consuming and demanding than is ordinarily the case. So I sent her a bill for $350.

I got a letter back from medicare asking for an explanation of my increased charge. I had to dictate a letter justifying my charge to a layman somewhere who probably didn't know a thing about surgery.

Now I realize that I may be wrong about this, very probably these things are scanned by doctors, but this is the way the letter comes to me and this is the way I react. I would have to take time to get the chart out.

This sort of timewasting incident aggravates me and other surgeons. We resent having to justify to the Government any deviation from our standard fees. Maybe it shouldn't bother us, but it does.

Attitudes Toward Hospitalization

Before leaving the first topic I would like to say a few things about the attitude of doctors toward hospitalization and how it is affected by the patient's status—private or medicare.

Private patients want to get in and out of the hospital as expeditiously as possible, if for no other reason than a financial one.

Medicare patients, not all, but many of them, have no such desire. They are elderly, many of them come from nursing homes or from the homes of their children, and the break in routine that hospitalization affords them is a welcome one. The children with whom they live welcome the break, too.

I am not criticizing them for this attitude. It is a perfectly understandable one.

The end result, however, is that pressures are put on the doctors by the elderly patient and his family, to hospitalize the patient when he could be managed at home. And when he is hospitalized more pressure is exerted to keep the patient longer than is necessary. If you would like specific examples I can give them to you.

I am very surprised at the questions that you have asked of the recent panel. This may be true that the statistics won't bear me out, this is a personal impression from my own experience with elderly patients that they want to stay in a few extra days and you let them stay in a few extra days.

Senator SMATHERS. In other words, when I was asking him about the statistics which they say are going to show that they do not stay as long?

Dr. NOLEN. Yes.

Senator SMATHERS. I was surprised about that indication, too.

They are not staying as long as they thought. What you say here seems to my ordinary layman's experience to be the case.

Dr. NOLEN. This, of course, is just based on my opinion. I have been chairman of the utilization committee on the hospital since it started so I have, at least in our hospital, a pretty good picture of what is going on.

The easy out for the doctor is to surrender to the pressure and keep the patient. Not so long that the utilization committee investigates the case; just 2 or 3 extra unnecessary days. But multiply these extra few days by thousands and the total extra expense is quite significant.

We realize this but it is very difficult to repeatedly spend our time arguing and explaining to patient and family that they must go home. Far easier to just give in.

A SWING OF THE PENDULUM

What I hope I have said, probably in a roundabout way, is that where before medicare the elderly might not have been getting enough medical care and the medical profession was not being adequately compensated for the care it did provide, now the pendulum has swung the other way.

The medicare patients are being overhospitalized and overtreated and, correspondingly, the medical profession consequently is being overcompensated for its services. The medicare program is and will be far more expensive than it should be.

Patients, hospital administrators, and doctors, like most other people, function on the premise that Government money is nobody's money and spend it carelessly, holding on to as much of it as they can for themselves.

The second question: "What kind of response did you receive to the article? Do you believe that many other physicians share your views?"

Senator SMATHERS. Could I interrupt you there?

I don't know what you are going to say later on. You say patients are overhospitalized and overtreated, and that, correspondingly, the

medical profession is being overcompensated. I think that is a very important statement.

Do you agree that if the Members of the Congress finally come to this conclusion, as you have stated it, that greater impetus would be given to that which the doctors fear the most, Government regulation of fees and drug costs, et cetera?

I personally am opposed to such regulation, and I think most Senators are. But if what you say gets to be the general practice, then I don't know what other alternative there is, other than to bring on that which they most fear.

Now does that make sense to you?

Dr. NOLEN. I could not agree more. This was the purpose of the article as I wrote it. To emphasize that if this builds up into a significant factor then we are going to get just what we don't want.

In other words, when I say we are overcompensated, I am talking about situations where a patient comes in and she is in the hospital, you feel it is time that she can go home.

The family says, "Well, let her stay 3 or 4 more days." If we give into this, then we get paid for every day she is in the hospital, whatever we charge for a routine hospital call and the Government has to pay for those 3 or 4 extra days of hospitalization and they have to pay our fee.

What this medicare program has done is—it throws a tremendous burden on us to get these patients out, it demands more time of us and diplomacy and everything else. We have to sit and argue with the patient that just because the Government says they can have all this time that it is not medically necessary and that they should be going home at this point.

I will give you another example. There is another article just this week in the Medical Economics and the title is "Medical Ethics and Medicare." He raises a question, he referred to the article I wrote. He said this is just bad ethics.

Well, I am not going to argue that point. I discuss it a little further here. But he raised the question of this type. A patient that he has, he is a urologist, has a chronic urinary tract infection.

THREE-DAY REQUIREMENT QUESTIONED

This man should be in a nursing home. The nursing home will charge for, we will say, 2 weeks or something like that. At any rate, the total bill for the nursing home would be $1,400.

Now if he admits that patient to the hospital for 3 days or whatever the minimum requirement is, he can then transfer the patient to the nursing home and instead of paying $1,400 the patient pays $400.

In other words, by admitting this patient to the hospital for a workup which is not really necessary but which could be medically justified, he will save the patient $1,000.

Now in a situation like that what do you do? Do you admit the patient for 3 or 4 days of hospitalization so you can save him $1,000 or do you send him directly to the nursing facility?

These are tough questions in medical ethics.

Senator SMATHERS. Let us stop right there.

I agree with you, it is tough, but this is where we have a responsibility here in Congress and the executive branch of the Government not to make that necessary. This is where we are at fault.

I am sorry that these administrators didn't stay here to hear this because these are the kinds of things that should be changed. The statute says that you have to be 3 days in the hospital before you can be eligible for extended care benefits under medicare, and because that is the law, as you say, you have the problem of putting him there first, so you can take him out and put him in the extended care facility.

So our laws are sometimes unrealistic.

What can we do? We put the doctor in this case in a situation where he has to decide, "Well, I have to help the patient even though he really does not have to go to the hospital for 3 days."

That is what you are saying, is it not?

Dr. NOLAN. That is right. He does not need to.

Senator SMATHERS. He has to go to the hospital to qualify for extended care.

Dr. NOLAN. That is right.

Senator SMATHERS. Somewhere in there we have to turn back to the doctor a little more discretion. I think there are a number of illustrations of areas where we must trust the doctor's discretion.

What I am interested in as an individual Senator is how do we get the doctors and the executive branch of the Government to get together and eliminate these kinds of little silly rules and regulations which unnecessarily put the doctor on the spot, cost the Government more money, and encourage a doctor to do noneconomic things?

Dr. NOLEN. I could not agree more with that.

Senator SMATHERS. The 3-day requirement in the statute—why did we put that in the statute? That does not make a lot of sense. The doctor ought to decide that.

Isn't that right?

Dr. NOLEN. I certainly agree; yes.

Senator SMATHERS. Why don't we get something to change that?

Mr. ORIOL. Doctor, would you care to see something which would enable the doctor to certify that this patient should receive nursing home care rather than going through the 3-day process?

How would you like to see it done? Do you have a suggestion for the ultimate process?

Dr. NOLEN. Well, I am inherently against a lot of regulations but I certainly think this would save a lot of money and it would take a lot of strain off of the problem of ethics that the doctors face.

I mean, I don't know, myself, how I would react to a situation like that. This is one of the points I am making, we react to medicare patients in a different way than we act to the private paying patient.

Mr. ORIOL. Take it back to the hospital care that he does not really need but it can be justified if he has to——

Dr. NOLEN. I would forgo this.

Mr. ORIOL. Send him to the nursing home at the great additional cost.

Doctor, if the law were changed, could we rely on the doctor's sense of ethics and his knowledge of medicine to give him the ability to sign a certificate saying that this person should go to a nursing home?

Dr. NOLEN. Certainly. There is no advantage to the doctor putting him in the hospital first. Yes; I certainly agree.

Mr. ORIOL. What is your idea?

Dr. CHINN. As I remember it, if this provision did not exist there would be a great many people in nursing homes in whom there was inadequately documented medical data.

If I understand it properly, this is one of the reasons that this was put in there. Now, how you can resolve this, I of course, don't know at this point, what mechanisms one might design to resolve this.

Senator SMATHERS. Mr. Frantz reminds me this was an issue during 1965 in the conference on the social security-medicare bill that year. I was in the conference which acted on the House and the Senate versions of that bill, and I recall that Congressman Mills was concerned about the possibility you have discussed, and he held the view that if the medicare beneficiary went to the hospital it would prove that he was sick enough to justify his receiving extended care benefits under medicare.

Now we come back to the reverse: by putting medicare beneficiaries in the hospital sometimes we are giving them a treatment that they don't need when in fact all they ever needed was to go to extended care facilities.

This is a situation we will try to resolve, because obviously, eliminating this requirement would save the Government a great deal of money and at the same time take the doctors off the spot. It seems to me we've got to trust the doctors somewhere. We're encouraging the doctor to do an unethical thing by the present rule. We are encouraging the doctor to send him to the hospital when he does not need to go to the hospital.

Is that right?

Dr. NOLEN. Yes, that is right.

Dr. CHINN. Do you feel, Dr. Nolen, that, generally speaking, economic considerations are as great as you are portraying here today? Do you feel that, indeed, both from the point of view of the physician and from the point of view of the patient that this overall dominance of money is dictated for medical care to the degree that you imply?

Dr. NOLEN. Not at all. I am sorry I am implying this.

ATTITUDES TOWARD GOVERNMENT FUNDS

Probably I am because I am trying to emphasize a point. The point that I am trying to make is this: that actually we think less about money with the medicare patient, we think more about money with a private patient. We are not so conscious of what the medicare patient has to spend, what his medical care costs him as we are with the private patient.

We are careless with the funds of the Government. We are not out to make a fortune on the Government. We are afraid for our own livelihood, we are afraid for what is going to happen to us in the future.

I say, "we." I am using this rhetorically. I think that it is not that we are dominated by the money; I don't think this is the point that I am trying to make at all. I am just saying that we are kind of careless about the Government's money. We are not as thoughtful about it.

If a man has to reach into his pocket and pull out $10 and hand it to your secretary for a chest X-ray, you think a little longer about it

and you are apt to discuss the situation with him some more than if the $10 is going to come from this nonentity, this Government—not nonentity.

I am sure that is a very poor choice of terms, but it is an impersonal thing. You don't worry about it. This is what I am afraid of. We have got to convince doctors that they have to give just as much thought to the charges to a medicare patient as they do to a private patient and it is a very difficult thing to do.

These are the examples that I am giving you. I have been exposed to it before in my practice in the city hospitals, in the State hospitals, and in the Army and you just do not think about money. You are careless with it because it is the Government's money and you don't have to worry about it. Let us just get away from the doctors' ethics and the profit motive.

I brought in this because I am not sure but what it might be a factor. It is hard to say about some of these things; it is very difficult to say why you ordered the X-ray. You are going to make $6. Let us assume you are going to make $6 and you order the X-ray.

If the man says, "You ordered this because you wanted to make $6," and you say, "No, I ordered it because the patient might need it," now he is not going to believe you and subconsciously I don't know myself sometimes why we do these things.

I can justify it, though, in any court. I can say he needed this but with the private patient I would wait a while.

If we could only convince doctors that they would have to think about medicare patients the same way they think about private patients, then I don't think this problem would exist.

I am very cynical about the probabilities of convincing them along those lines because we are skeptical about the Government.

Shall I go on?

Senator SMATHERS. But you have got to keep making that speech of yours to the Medical Society and hope they will continue to invite you to make it.

Dr. NOLEN. I hope they do.

Senator SMATHERS. Because what they fear the most is likely to happen just as a result of what you are talking about here, a feeling subconsciously that it is nobody's money. I think that is a very apt illustration.

Dr. CHINN. Regardless of whether the money comes from professional judges or whether or not quality medical care calls for this X-ray is indeed true regardless of where the money comes from.

This is an issue that the medical profession must face, what is quality medical care regardless of where the money is coming from, whether it is out of the pocket of the individual or the Government Treasury, it seems to me, not as to whether that person needs that X-ray in order for the doctor to deliver quality service.

This is idealistic. I am quite aware, I agree it is a very delicate subject but still basic to the whole problem which we——

Dr. NOLEN. I agree this is the decision but what I am saying is that subconsciously your term of "quality medicare" is modified by economic circumstances.

Senator SMATHERS. All right, sir.

You go ahead now.

Dr. NOLEN. All right.

I was asked about the response to my article.

Some doctors felt I had overstated the case, but no one argued that the basic premise was untrue.

Some of them felt that I should have emphasized the patient's role a little more. They felt that patients were putting a lot of pressure on the doctors for medical services that weren't warranted, particularly for unnecessary hospitalization, and that doctors were simply giving in to these pressures; that we weren't necessarily motivated by an opportunity to increase our income but simply couldn't be bothered arguing with patients who wanted what the Government said they had coming.

The letters from physicians, subsequently published in Medical Economics, supported my point of view. I will quote one of them which I think expresses the feelings of many doctors.

"The overriding fact is that the Government volunteered to get into the medical services act, muscling in on the physician-patient relationship and saying: 'Here, let me pay for it, cost is no object.' The latter half of that statement is, of course, pure hogwash. Our fantastically wasteful Government can, and will eventually, go broke. And as the deficits pile up, the first costs to be cut will be doctors' fees. In the past it was possible to control medical extravagances because there was a price tag that discouraged overdemanding patients from pampering themselves. But now that rich Uncle is paying, there's no limit. How this can be blamed on the doctor is beyond me." The attitude of another respondent seemed to be "Why get so steamed up? This is the way things have always been, and always will be."

As an example, he quoted a patient who comes in and has hospital insurance. You keep him in maybe an extra day or two because the insurance company will pay for it. This has been more or less common practice, where if a man has no insurance he gets out of there a little bit more quickly.

WHAT IS OPTIMUM CARE

Now, again, what is optimum care? Here it is pretty difficult to define. If you give him 2 extra days, is this bad medical care, is that a lowering of your standards? It is difficult to define it. I think the medical profession generally, if the money is not coming out of the patient's pocket, tends to give a little more hospitalization, a little more medicine, a little more everything else.

Senator SMATHERS. Do you have any suggestions for improving the situation or at least exploring the ethical questions you mentioned?

Dr. NOLEN. I am not optimistic about improving the situation. The ethical questions I mentioned all have to do with our attitude toward Government money—not our attitude toward the patient.

I don't believe there are many doctors who are not most sincerely dedicated to providing optimum care for their patient, be he a private patient, a welfare patient, or a medicare patient. None of the patients I have mentioned—Bellevue, welfare, medicare, or private—suffered in the least because of the different approaches used in treating them. The end result for all was and is high quality care, but the private patient received it economically.

I admit the practice of doing procedures that don't need to be done and inflating fees just to get more money from the Government is ethically bad. But the philosophy that seems to prevail everywhere is that if you can get extra money from the Government go ahead and do it. Our practices relative to medicare are not unlike the approach we use when we pay our income taxes. Try for all the deductions, justified or not. If the Government disallows them you are not out anything; and if you can get away with them so much the better. The ethics of those practices theoretically leave something to be desired—but it doesn't bother our consciences.

So I don't think a simple appeal to doctors to please keep their medicare fees low will be efficacious, unless they can be convinced that it is to their own self-interest to do so, which was another point I tried to make in my article. I would suggest that if doctors can be assured by the Government that strict regulation of fees and medical practice will not be forthcoming as long as the medical profession follows reasonable policies in setting fees, then perhaps doctors will police and regulate themselves effectively. Exactly how this can be accomplished, I don't know. Most doctors are convinced the eventual aim of Government policies is more or less completely socialized medicine.

I do think it might help if the administration of the medicare program were, at least to a significant extent, put under the control of doctors who were acquainted with the attitude of private practitioners of medicine and had some good rapport with them. I won't expand on that now.

Senator SMATHERS. You started out to answer our question as to the reaction to your article among your brethren of the medical profession and as I understand it they all sort of admitted you are right but they didn't want to do much about it.

Have you had an opportunity to discuss this, for example, with the Minnesota State Medical Society?

Dr. NOLEN. No, I have not.

Senator SMATHERS. Have you had an opportunity to discuss it with your local county medical society?

Dr. NOLEN. No; not formally.

Senator SMATHERS. Have you had an opportunity to discuss it formally with any of the medical organizations or medical media?

Dr. NOLEN. No, sir.

Senator SMATHERS. To what extent would you think that the doctors throughout the Nation have read your article?

Dr. NOLEN. Well, I can give you the readership figure on Medical Economics if you want. Seventy percent is the figure that they quote, it is one of the most widely read magazines that is circulated of this type.

Senator SMATHERS. Has the magazine subsequently printed any letters on your article?

Dr. NOLEN. Yes. I quoted one letter quite extensively in here, and there were two or three other letters. I think it also precipitated the writing of subsequent articles.

In this week's issue there is one, as I mentioned, and then there is another article that came out approximately a month after mine, or 2 months after mine, on the same subject, entitled "Are Medicare Scandals Brewing?"

So it is, I would guess, quite widely read.

Senator SMATHERS. All right, sir. I would like to have your views on actions that can be taken to provide high quality health services to elderly persons who do not now have such services.

Dr. NOLEN. Frankly, I am not aware that elderly persons do not already have high quality health services. I suppose this depends to a large extent on how one defines the term "high quality health service."

In my opinion the doctors in our area are providing high quality medical care to everyone, including the elderly, whom we serve. And we serve everyone in our county and its immediate environs.

If we choose to define "high quality medical care" as that care which can only be administered in university centers or hospitals of over 1,000 beds, as some people now try to define it, then of course the elderly, along with most of the general populace, don't have immediate access to such care.

SERVICES IN SMALLER HOSPITALS

I contend that an 80-bed hospital, of the type we have in Litchfield, can provide excellent medical care for 95 percent of the population 95 percent of the time. The other 5 percent who, 5 percent of the time, need the elaborate facilities available only at a huge center, can be referred there for such care as the need arises. This is what our practitioners of medicine have done, are doing, and will continue to do for the elderly as well as for anyone else who needs it.

I had better emphasize that when I say the elderly are now receiving optimum medical care, I base my statement only on my own personal experience. What is true in Meeker County, Minn., obviously may not be true elsewhere.

I have already elaborated on why I think Government programs are inevitably wasteful and expensive. I could expand on this subject further, citing examples from my experiences as a physician in city, State, and Army hospitals, but I am not certain that this is a field you want to explore at this time. If it is, just say so.

I hope this statement deals with the aspects of health care of the aged that you wanted me to consider. I will be most willing to give you whatever assistance I can be commenting on them.

Thank you again for giving me the opportunity to testify.

Senator SMATHERS. Doctor, thank you very much.

Do we have any questions?

Mr. Oriol, do you have any questions?

Mr. ORIOL. No.

Senator SMATHERS. Dr. Chinn, do you have questions?

Dr. CHINN. The only question I would like to ask Dr. Nolen is whether he feels preventive measures outside of the hospital might be more economically pursued or whether they should be toward prevention of illness and disability from disease as a means of economic safety. Whether, in your community for instance, this would be a practical approach rather than the utilization expense of the hospital?

Dr. NOLAN. I don't know if I can answer that question specifically because I don't know exactly what type of service you are suggesting. We instituted some of the things that have gone along with these new medical programs that are associated with Project Headstart and

that sort of thing. I am not sure that the statistics will bear out that the things that are found through these programs are numerous enough to warrant whatever the expenses incurred are going to be. I, of course, am in favor of preventive medicine and if it takes some sort of a plan to institute it then I agree that it might cut down expenses of the further, more intricate care that is demanded later on.

Senator SMATHERS. Let me ask you one question that has been suggested to me. Doctors are urging that direct billing be permitted under title XIX rather than vendor payments. Now, what is your feeling about that?

Dr. NOLEN. They were recommending direct billing rather than vendor payment?

Senator SMATHERS. Yes. You will recall earlier this morning when we had the Government witnesses here it was their feeling that doctors would oppose getting the billing, technical word vendor, coming through the Government to the hospitals for their payments, those doctors who wanted to get it directly were creating some additional cost and some difficulty. What is your comment about this?

Dr. NOLEN. I would say that we would all—I cannot say that. I would say in our community the doctors unanimously would prefer to bill the patient directly. We want to avoid as much redtape as we can, but from the practical point of view we don't bill them all directly. We pick and choose. We bill as many directly as we can and then take assignments on those where it is more practical and realistic to do so. But we would prefer to bill directly.

I would think this would be the general consensus in the medical profession. But from the practical point of view it does not work out.

Senator SMATHERS. All right, sir.

Dr. Nolen, thank you very much.

Without objection we will put Dr. Nolen's article in the record at this point.

Dr. NOLEN. Thank you.

Senator SMATHERS. Thank you very much.

(The article follows:)

ARE DOCTORS PROFITEERING ON MEDICARE?

(By William A. Nolen, M.D.)

No health-care program has ever strained the ethics of the medical profession as Medicare is doing. The temptation to chisel is enormous. Are doctors succumbing?

I can't speak for the medical profession as a whole, of course, but I'll admit that I try to take as much Medicare money from Uncle Sam as I possibly can. From what I've seen and heard, a lot of other doctors are doing the same. Maybe what we're doing is ethical, and maybe it's not. It depends on your point of view.

Let's consider the matter of fees. Before Medicare, I individualized the fee on every case. The old-timer who needed a colon resection might be charged anything from a token charge to $400, depending on his ability to pay. Four hundred was my "usual fee"—that is, I never went over it, even for the most wealthy. But if a patient was financially strapped, I'd cut my charges to the bone.

Those days are gone forever. Now, with Medicare patients, we doctors charge our "usual fee" for everything. And the consultations, catheterizations, cutdowns, and other procedures—things we often used to throw in for free—get tagged onto the bill. If the Government people will pay it, fine. If they won't, we can always discount it later. All this is technically ethical, of course. But it does show the way we're thinking.

What bothers me more than our new charging practices, however, is the way in which almost guaranteed payment-in-full is apt to color our medical judgment. For example, I know a 73-year-old woman who has been in and out of the office of every doctor in town for the last 10 years. She always has some complaint, most of the time purely functional. Till last July she was on welfare, and whoever happened to be taking care of her would, for next to no fee, give her the time and treatment she needed. But that wasn't much. She knew she wasn't really sick, and so did the doctor.

Now that she's on Medicare, how things have changed! She spends half her time in the hospital getting expensive diagnostic studies and thorough work-ups by a host of physicians and consultants. Is she really any sicker than she was? Of course not. It's just that now the doctor gets paid for his proctoscopy, fluoroscopy, or his consultations. And who knows? Maybe somebody will find something wrong with her. So the studies can, in the loosest sense, be medically justified. But the main reason she now gets more attention than she used to is that it's all practically free for her—and more lucrative for both the doctor and the hospital. Is it ethical? You tell me.

That woman doesn't happen to be one of the patients I've cashed in on, but I'll admit there have been some. I'm not at all certain, for example, that I'd have taken off one old gentleman's sebaceous cyst if he'd had to pay for it himself. I'd have probably told him not to worry about it, that the cyst would never hurt him. But since he's on Medicare, I wasn't at all reluctant to do the job when he asked me to. I didn't talk him into it, but I sure didn't discourage him.

I've noticed, too, that a lot of other men are doing more elective procedures on the oldsters since Medicare came in. Warts are getting burned, moles are being removed, and a few veins strippings of minimally dilated varices are getting onto the schedule. Some of these may help the patients substantially, but many of them aren't strictly necessary. If it weren't for Medicare, they probably wouldn't be done.

The fault, of course, is not completely ours. Now that the oldsters are on Medicare, they can demand that things be done for them—and they do. After all, haven't they got a *right* to Government-financed medical care? Didn't Uncle Sam say they could have their warts burned, their cysts removed, their veins stripped—and he'd pick up most of the tab? Then who are we doctors to deny them what the Great Society has bestowed on them? When you consider these pressures, it's not difficult to understand why some physicians give in and take the easy—and remunerative—way out.

Hemoglobin determinations, urinalyses, blood sugars, and the like are all increasing in frequency. It's possible to argue that more such tests should have been done in the past than were done, and I won't disagree. Still, I'm as certain as I can be that a lot of unnecessary checks are being run. I've seen them, and, very possibly, I've ordered some myself.

I say "very possibly" because this whole area is a nebulous one. It would take a utilization committee full of Clarence Darrows to prove that a hemoglobin, a urinalysis, a proctoscopy, or even an exploratory lap was completely unjustified. In medicine things just aren't that black and white. It's difficult for even the most conscientious doctor who orders a procedure to be certain that somewhere, deep down in his subconscious, his judgment isn't being influenced by the money he's going to make—maybe just a little.

Lest you think I'm being picayune, let me remind you that the degree of our cheating—if that's indeed what it is—has little bearing here. Those of us who order unnecessary hemoglobins because Uncle Sam is paying are not in a good position to criticize the few who perform unnecessary hysterectomies on Medicare patients. Remember the story attributed to George Bernard Shaw about the woman who agreed that she'd sell her favors for $100,000? When asked if she'd do it for $2, she answered, "What do you think I am?" His reply was: "Madam, we have already established that. We are now only quibbling over price."

We're all intelligent enough to know that Medicare isn't free. One of the main reasons we fought it so strenuously is that we know Government programs are inevitably wasteful and expensive. Eventually, through our taxes, we'll pay through the nose for this one. But an immediate result of Medicare is that it enables us to increase our incomes. When we're greedy and shortsighted, and succumb to the practices I've mentioned, we tempt fate. Injudicious behavior on our part may not only bring rigid Government control down on our necks but, more lamentably, may also destroy the ethical standards of medical practice we've fought so long and hard to maintain.

Senator SMATHERS. Mr. John W. Edelman and Mr. William R. Hutton, president and executive director, National Council of Senior Citizens, and Mr. Frank Wallick.

We are delighted to have you gentlemen here, as is always the case. You may proceed as you like.

STATEMENTS OF JOHN W. EDELMAN, PRESIDENT, AND WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS; AND FRANK WALLICK, LEGISLATIVE STAFF OF THE INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW

Mr. EDELMAN. Mr. Chairman, in case you have not met them already this is Frank Wallick of the legislative staff of the international union, United Automobile, Aerospace & Agricultural Implement Workers of America, UAW, who is testifying here today on behalf of Mr. Andrew Brown who is in charge of the retirees' section of his organization. On my left is Mr. William R. Hutton, executive director, National Council of Senior Citizens, who will in great measure carry the burden of this testimony. I will make a very brief statement.

I am John W. Edelman, president of the National Council of Senior Citizens, an organization comprising roughly 2 million members dedicated to building a better life for all the elderly in this country.

I mention in passing, sir, that I am also a "victim witness" in this instance. I have had two spells in the hospital as a patient under medicare program.

We of the National Council of Senior Citizens welcome the attention being focused on health needs of the elderly by the distinguished members of the subcommittee. We appreciate the wealth of knowledge and experience being brought to bear on this problem by the chairman, Senator Smathers.

Senator SMATHERS. Thank you very much.

May I say here that looking at you after you have had those two experiences in the hospital it is evident that you are getting quality medicine.

Mr. EDELMAN. Thank you, sir. I think that is exactly true.

As you must know, our organization was in the forefront of the legislative campaign for medicare and medicaid and our members are profoundly grateful to the Senators and Members of the House of Representatives responsible for enactment of this monumental legislation guaranteeing 19,300,000 who are over 65 hospital care up to 90 days for a spell of illness and 17,600,000 of this group who signed up for optional medicare doctor insurance payment of a major portion of their doctor and medical bills.

This has resulted in a tremendous upgrading of medical care available to the elderly. However, I must in all honesty remind the distinguished subcommittee members great numbers of elderly are being excluded from the benefits of medicare and medicaid. Those being excluded are the ones most in need of adequate health care.

There are no reliable estimates I know of as to the number of elderly thus excluded from medicare and medicaid benefits but the number may run into millions.

Widespread Poverty Among Elderly

Secretary John W. Gardner, of the U.S. Department of Health, Education, and Welfare, told the recent annual convention of the National Council of Senior Citizens in Washington that nearly 10 million, or nearly half those 65 or over, are poor.

They are poor, Mr. Chairman and distinguished members of the subcommittee, largely because they have to depend on inadequate social security benefits for their support.

Now, I ask the subcommittee members, can anyone getting social security averaging $84 a month—that is a meager $1,008 a year—find cash for the $40 payment required for hospital admission, the $50 downpayment required on doctor bills, the obligation to pay a fifth of remaining doctor bills, and the $20 payment required for outpatient diagnostic care under medicare?

We just simply think this is impossible for a great many of the persons eligible for medicare simply on the grounds of inadequate income.

Senator Smathers. It is obvious by your statement but I just wanted to connect this up with your previous statement that there is a large number who are not eligible to get the benefits of the medicare and medicaid programs.

Mr. Edelman. That is correct, sir.

Senator Smathers. Because of the deductible.

Mr. Edelman. That is our view.

Senator Smathers. Very well.

Mr. Edelman. For vast numbers of the elderly, a ride costing 50 cents for a trip downtown is a luxury they can scarcely afford. Where will they find the cash to meet these costly medicare deductibles?

Food or Health Care

Undoubtedly, many of the 1,700,000 elderly who refused to buy medicare's $3-a-month doctor insurance did so because they realize they cannot meet these high-priced deductibles. They had a grim choice between having something to eat and getting health care they might need but could not afford.

Just on this point, Mr. Chairman, could I mention that I got a letter the other day from a social security beneficiary in Philadelphia. She was telling me her only means of support is a social security monthly benefit of approximately, I think, $34 a month. And of this money she is now receiving, $3 of course is being deducted, so actually all her income is about $31 a month. She said she has been going to the doctor for some relief for a nervous condition and he has been prescribing to her certain pills, she said, which makes things worse. She writes to me—Mr. Chairman, this is a terrible tragedy—saying, "How can I get out of having to pay this $3 which I was told would benefit me so that I could use this $3 for food which I know would benefit me?"

I felt under obligation to write to her and explain what the law says about this situation. It will take her some little time, I believe this October, before she has an opportunity to withdraw from this program. I pointed out to her I thought it would be disastrous if she would render herself ineligible for these medical benefits.

True, medicaid, the health care program for the medically indigent, supplies cash for medicare deductibles in 28 States if—and that's a big

if—applicants submit to a means test. But what of the elderly in the 21 States that do not have medicaid?

Even in the States with medicaid, I am sure there are many elderly who proudly undergo great privation rather than submit to a means test. These are men and women who were most of them self-supporting until excluded from the labor force on account of age.

Upon leaving gainful employment, they were forced to join that other America, described by Michael Harrington, an America of poverty, deprivation, and disease.

A year's experience with medicare and medicaid shows that medicare and medicaid have bypassed a great many men and women they were designed to help.

What can be done?

Deductibles, Drugs Cause Problems

We of the National Council of Senior Citizens urge with all emphasis at our command a phasing out of the medicare deductibles. The way it is now, with deductibles and other restrictive medicare features, we offer the elderly modern health care with one hand and snatch it away with the other.

Even with the increase in social security now being considered, the medicare deductibles will remain a barrier to adequate health care for large numbers of older Americans.

Proper health care takes in vision, hearing and dentistry. Yet, medicare excludes eyeglasses, hearing aids and dental care. These items must be covered if we are really going to bring modern health care to the elderly poor.

The exorbitant prices often charged for drugs are another obstacle in the way of modern health care for the elderly. Drugs the elderly must buy—four out of five elderly have chronic ailments—should be brought under the medicare umbrella.

Who will pay for these improvements?

We of the National Council of Senior Citizens insist our prosperous land can and should pay for them out of general taxation, generally income taxes.

I am glad to note that the Health, Education, and Welfare Department has called a conference for June 26 and 27 in Washington to discuss these critical matters.

My colleague, Bill Hutton, executive director of the National Council of Senior Citizens, is close to the problems of rising health care costs. Daily, he and I see desperate letters from our members telling of their medicare problems. I would very much like to have him present his observations to the subcommittee. I thank you for the privilege of appearing before you.

Senator Smathers. Thank you, Mr. Edelman, for that splendid statement. We are happy that you are back feeling well and could make it. That is a fine statement.

Mr. Hutton, you may proceed.

STATEMENT BY MR. WILLIAM R. HUTTON

Mr. Hutton. Senator Smathers, members of the National Council of Senior Citizens do not spare themselves in recognizing that medi-

care and medicaid are doing more to break down the barriers to adequate medical care for older people than any other steps that have been taken in the history of American medicine and in the history of our social legislation.

But it is precisely because we believe that the organization and delivery of medical services to every American citizen may be changed dramatically by the impact of these programs that we are glad to submit the following observations.

Through its enactment of the Social Security Amendments of 1965 which included these important health programs, the U.S. Congress clearly recognized that the problems of medical care for the aged are more severe than for other age groups.

Though we are intensely grateful to Congress for the enactment of these programs, we have had plenty of opportunity during a full year of their operation to realize where they fall far short of the minimum that is needed to make good health a reality for many aged citizens.

Nevertheless, we want to emphasize that in our goal to seek a better life for all older Americans the National Council of Senior Citizens is extremely conscious of the national interest. This concept of seeking improvements for the elderly within the framework of the national interest is one, Mr. Chairman, which has brought recognition of our organization by the Members of this Congress as a responsible voice of the elderly people of America.

"Runaway Costs" of Services

We are desperately concerned about the health care needs of the elderly. We are just as desperately concerned with unnecessary, unrealistic, "runaway costs" which are forcing up the price of health care, not only to elderly people themselves, but for their sons and daughters and for their grandchildren.

Ever since the spring of 1965—when it became clear that medicare was going to be enacted—the National Council of Senior Citizens has been warning Congress that soaring hospital costs and spiraling doctor fees pose a dangerous threat to the program.

We believe quite sincerely that this is currently an economic threat and not a political one. Something must be done to halt the rate of health cost increases. We must work to control costs and improve efficiency without sacrificing the quality of care. While to some degree this calls for the understanding and cooperation of the people who will use the care, it calls more seriously we believe, for restraint and judgment by those doctors who are willfully and flagrantly raising their fees on the theory that "Uncle Sam can afford it" or who are inflating their fees because a patient happens to be privately insured.

It is understandable that some hospitals which are belatedly meeting staff demands for needed increased wages are having to meet higher costs. It is also clear that there are wasteful and extravagant practices in many of our health institutions. Inside and outside of Government there is a great need for built-in incentives to control costs.

Mr. Chairman, in your Senate statement on June 7 announcing these hearings, you asked a number of questions to stimulate discussion con-

cerning the organization of our medical services as they affect the elderly. I would like to group several of our observations under the topics prescribed by these questions.

Do many of our elderly face insuperable obstacles in obtaining needed health services?

I know that the committees of Congress appreciate the tremendous difficulties we experience in gathering accurate data on the invisible poor. As President Johnson pointed out in his message to Congress on social security, there are 5.3 million older Americans living in the squalor of poverty and obviously it is difficult, if not impossible, for many of them to meet the deductibles and coinsurance features of the medical law. The leaders of our over 2,000 affiliated clubs have told us they believe there are many older Americans in their communities who will not go to a doctor because of their lack of money.

Many aged sick would rather suffer in silence than admit they cannot produce the $40 for the first day of hospitalization, the initial $50 for doctor bills, or subsequent one-fifth of all doctor costs as coinsurance for medical insurance.

Only 29 States Have Medicaid

The people I am talking about, Mr. Chairman, include many proud Americans whose sweat and toil helped to make this country great. They don't wish to admit their failure by throwing themselves on the mercy of the welfare people and taking advantage of medicaid. It might be pointed out here, however, as it has been by Mr. Edelman, that only 29 or our 50 States have medicaid programs in operation. Elderly poor in 21 States are out of luck insofar as meeting the deductibles and coinsurance features of medicare are concerned even if they are prepared, in their desperation, to go the welfare route.

The truth is that the deductible and coinsurance features of the medicare program merely discriminate against the elderly poor who need the most help. Any hospital administrator will tell you that deductibles and coinsurance are not necessary to control utilization and they certainly will not control abuses. People with plenty of money never have much difficulty getting into a hospital.

Frankly, the National Council of Senior Citizens fought against the inclusion of deductibles in the original King-Anderson bill, and after 1 year of their operation in the medicare program we are even more convinced that we were right.

Our medicare program is a program of social insurance but the use of deductibles and coinsurance comes strictly from the practice and thinking in commercial casualty insurance. The basic concept of fire, auto, marine, et cetera, insurance is the pooling of risks to protect against loss from undesirable and often preventable accidents. The deductible is promoted as a guard against carelessness—or paying the consequences.

But in today's world everyone requires health services. Modern medicine embraces preventive care and health maintenance as essential elements. The casualty insurance concept simply does not fit in a medicare program established as an element of our social insurance system.

Now, Mr. Chairman, to answer another of your questions: Are rising medical costs causing special difficulties for the elderly?

Those elderly Americans who are fortunate enough to be able to pay taxes will, of course, have to meet their appropriate share of the Nation's precipitously rising health costs through the payment of these taxes.

But, under the coinsurance features of the medicare law, 20 percent of all doctor bills must be met by the elderly themselves. Nearly all doctors have raised their fees to aged patients—some have doubled or tripled their fees. Some of our elderly suffering in the most extreme cases are beginning to feel they are not much better off under part B of the program—voluntary supplementary insurance—than they were before medicare. They pay $36 a year in premiums, have a $50 coinsurance feature—and some doctors have doubled or tripled their fees.

Senator SMATHERS. Let me ask you a question right there. If, as you say, doctors' fees have gone up, do you think Congress is wise in eliminating the provision which allows taxpayers 65 years old and older to deduct all of their medical expenses irrespective of whether it exceeded the 3-percent limitation? Do you know what I am talking about?

Mr. HUTTON. Yes, I do, sir.

Frankly in our studies we believe that Congress probably made a wise decision. The number of elderly people who do have to pay taxes is much fewer than the mass of people who don't, and for the most good we feel that this is probably right.

Senator SMATHERS. I agree that most of the elderly——

Mr. HUTTON. Do not pay taxes.

Senator SMATHERS. They are in an income bracket where they are not too concerned with it. If physicians' costs continue to go higher, if hospital costs continue to go higher, if insurance finally gets to the limits of what it can cover, then should it not be as it once was, that people who are 65 years old or older should be able to deduct all their medical expenses?

Mr. HUTTON. I believe, Mr. Chairman, that hospital costs would have to go a great deal higher than they have even gone now to affect the majority of the elderly. It is only a very small percentage of the elderly who are affected by having to pay income taxes.

Senator SMATHERS. I tell you one reason I ask the question. I have personal knowledge of a situation of a lady who is 93 years old and has a fairly substantial income, $20,000 a year. She is an invalid. Every bit of that income is utilized in the payment of her nurse which she has to have with her full time, of doctors' bills and so on.

Now, when the Congress eliminated that total deduction, she now has to pay an additional $319 or $320 a year. With an income of that size there are certain things she cannot avail herself of, with the result that this woman is having to borrow the $300 to pay her tax.

Mr. HUTTON. Yes, sir, there are some sad cases.

Senator SMATHERS. I agree, generally speaking, that does not apply to the person that you are generally representing and that we are talking about, but I think the Congress made a mistake in doing that. I think if you are 65 years old and older you ought to be permitted to

deduct totally your medical expense because when you get to be that age even though you have some steady income, with the cost of things going as they are, even these people now in some respects have insufficient funds—although not to the extent of the great masses of the 19,300,000 elderly.

Increase in Premiums?

Mr. Hutton. Sir, there is one other aspect I would like to mention where these rising medical costs are threatening to cause additional cost for medicare. At his recent press conference in connection with the first anniversary of the introduction of medicare, Social Security Commissioner Robert M. Ball spoke of the possibility, starting January 1, 1968, of a substantial increase—perhaps 50 cents—in the present $3 monthly premium for the optional doctor insurance under medicare because of skyrocketing doctor fees.

Some doctors have excused their fee-grabbing by claiming they charged the impecunious elderly reduced fees before medicare and feel an obligation to charge them more now that the Government pays a major part of their doctor bills.

If this Robin Hood system of taxing rich patients for the benefit of the elderly poor was ever in general use by doctors it would seem that doctors, in all fairness, have an obligation now to lower their fees to the rich. Even though doctors no longer have elderly charity patients, we have yet, sir, to hear of one doctor who has lowered his fees to the rich, and we have surveyed our 2,000 clubs to find one.

Medical Economics, the chief journal devoted to doctors' incomes and financial practices, revealed in a national sample of 3,195 family doctors—general practitioners and internists—that since medicare began the median fee of general practitioners has jumped 25 percent for the key category of office visits—the patient's followup visits after the initial contact. The median fee of internists is up 40 percent.

A very interesting finding is that pediatricians' charges for office visits remained unchanged—the median figure was $5—during this period. Yet our population expansion is just as heavy among the very young as it is among our aged population.

Under the fee-for-service system the accepted principle is that fees should be "commensurate with the services rendered and the patient's ability to pay." Today, in millions of cases, the ability of the patient to pay has been reinforced, if not totally supplanted, by the resources of Federal and State treasuries or by Blue Cross-Blue Shield, or private insurance companies. This seems to have confused many of our doctors. They seem to want to charge what the Government can afford to pay, or what the insurance company can afford to pay.

The rising costs of health care are, of course, not merely limited to doctor fees. Walter J. McNerney, president of Blue Cross, has predicted the average cost of hospital care which he estimated at $54.05 nationally as of March 1967 might go to $69.79 a day by 1970. At these rates few older people could remain in the hospital 1 more day after their inpatient hospital benefits of 90 days run out.

Costs in extended-care facilities are rising and our members report that the costs in the custodial care nursing homes outside the system seem to be rising right along with them.

To answer another one of your questions we would like to say we believe much has been done on a geographical basis to provide health care institutions under the program. However, we are concerned that in many cases there has been a relaxation of the conditions of participation in some institutions. Introduction of the highly elastic concept of "substantial compliance" with conditions of participation gives cause for apprehension that the quality of care may be eroded in substandard and marginal facilities. I notice, sir, your colleague who was here earlier this morning, Senator Moss, has been doing extensive work in this field.

Before other committees of Congress the National Council of Senior Citizens has highlighted what it believes are much needed improvements in the medicare program so as to be able to deliver adequate health services to all older Americans. One of our major complaints is that while medicare takes good care of the aged suffering from acute illness and requiring hospitalization, there is little help available for millions of older Americans suffering from chronic diseases. We heard Mr. Alvin David say this morning that medicare covers only 40 percent of the health care costs of the elderly.

One of our complaints is that on the question of drugs, in this segment of our population among chronic diseases the drug industry——

Senator SMATHERS. Excuse me. The first witness we had, Mr. David, stated—and this was interesting to me; I had not heard it previously—that while doctors' fees had gone up 7.5 percent and hospital charges went up 16.4 percent, drug prices have not gone up.

Mr. HUTTON. Yes, sir. As a matter of fact, I would like to draw the attention of this committee to another subcommittee which has been conducting hearings chaired by Sen. Gaylord Nelson in which the National Council of Senior Citizens drew strong attention to the Bureau of Labor Statistics which conducted the gathering of statistics on the drug prices and brought out they had been using archaic examples of drugs which are not now in popular use. Consequently, the whole theory that drug prices had not gone up was shot to bits by the fact that today most of the prescriptions are compounded of new drugs, and Mr. Arthur Ross, the Commissioner, agreed that this was so. We took as our basis for these statements the claims made by the drug industry itself and this we will be very glad to submit to you, sir, should you require it.

Elderly people suffering from chronic ailments in a very real sense are captive to the drug industry because day in and day out they must take maintenance drugs for the treatment of chronic conditions which are an inevitable accompaniment to advancing age.

The high prices of prescription drugs constitute a problem of gigantic proportions. Frequently older people have to make a choice between needed drugs or food. At the present time there is no other country in the world whose prescription drug prices are as high as those in the United States. Congress must find a way to provide the cost of prescription drugs—at least on a generic basis—under the part B program dealing with supplemental insurance.

Senator SMATHERS. Let me ask you this. Could you supply us the charts and statistical information to support that statement that no

other country in the world has drug prices as high as those in the United States? I would like to have that.[8]

Mr. HUTTON. I'll be very glad to, sir.

Senator SMATHERS. You say you will?

Mr. HUTTON. Yes.

We believe, sir, that medicare will not adequately cover our older people until its provisions include wheelchairs; eyeglasses; hearing aids; all surgical and orthopedic appliances; and all eye, dental, and drug needs as prescribed by a physician.

There are shortages of trained personnel in the medical and medical-related professions in all fields and particularly severe in fields that serve the elderly. Our population is showing marked increases at both ends—as I said before, the very young and the very old. But after 50 years of struggle, baby care became a medical specialty and, in proportion, large numbers of each year's graduating crop of new doctors become pediatricians. At the beginning of this century there were only 3.1 million Americans age 65 or over. By 1980 we will have more than 25 million over 65. Not only is their number zooming but so is their proportion to the rest of the population. We believe it is high time that geriatrics also became a specialty of the medical profession.

One of the greatest hardships under the current medicare program arises from a doctor's refusal to accept an assignment of his medical bill. Social Security Commissioner Ball—and this was also mentioned this morning by Mr. David—estimates 57 percent of the doctors across the Nation accept assignments at least part of the time. In some States less than one in three doctors do.

It is often all a low-income senior can do to pay the entire amount of his doctor bill in cash so he can get a receipted itemized statement of services performed by the doctors. For the elderly, the majority living on shamefully inadequate incomes, it is a hardship to pay for major operations and treatment out of pocket and then wait weeks or months for medicare reimbursement.

Even though that delay is now being reduced, there are areas of the country—for example, in my State of Maryland it takes 35 days for reimbursement.

Senator SMATHERS. Is that an average figure?

Mr. HUTTON. No. An average today is about 21 days now as claimed by the Department of HEW. In certain States, I think the most outstanding is Iowa, where it is 50 days. In Maryland I know it is 35.

The National Council of Senior Citizens has asked Congress to simplify collection of medicare claims.

Congressman Al Ullman of Oregon, a member of the House Ways and Means Committee, has come up with a plan whereby the doctor would give his medicare patient an unreceipted statement of fees for service that conform to fees that are customary and reasonable. The medicare payment agency would be empowered to send a settlement to the patient for transmission to the doctor.

ALTERNATIVES ON BILLING

This would provide an alternative to the present billing options; namely, direct billing which allows the doctor to charge all the traffic

[8] See p. 225, app. 1.

will bear, and assignment which limits the doctor to customary and reasonable fees as determined by the payment agency. Now a third would be added in which the doctor would submit an itemized bill and the patients send that to the intermediaries and be reimbursed and pay the doctor. We think this is a great idea and will take care of any moral issues or fears which the doctors might have.

A resolution adopted at the National Council's recent convention calls for a system under which doctors send bills to medicare payment agencies as they presently do with Blue Shield plans or else allow the patient to collect on unreceipted bill as Congressman Ullman proposes. National Council members feel this will obviate the painful necessity of many seniors having to borrow to pay their doctor bills and then wait long weeks for reimbursement.

Apropos of that borrowing, Mr. Chairman, some of us were discussing last night an idea which might be worth while exploring and that is there apparently is about $4 million potentially available under the Economic Opportunity Act, section 206(b) on family emergency loans in which there is a 2 percent simple interest, although the person could not borrow more than $300 at any one time. It does seem to me that maybe we might explore that area to see if we can get that changed. Some of the people who really have not got the money to pay their doctor bills could borrow out of the Economic Opportunity Act at only 2 percent. That might be a help. It is very difficult for older people who are living on reduced income to be able to borrow money from other sources.

This in general concludes my statement. We do feel that there is a real need to take care of the holes in the medicare umbrella and we think there is a real need to take care of rising costs.

There were two other gentlemen who were to appear with us at this panel in addition to Mr. Wallick. They were unable to appear because of the change in schedule of this committee. If you wish, sir, I would highlight just one or two parts of the statements which these gentlemen have submitted and perhaps you will be good enough to include the entire statements in the record.

Senator SMATHERS. All right, sir. We will be happy to do it.

I want you to finish in 15 minutes, and I want to hear Mr. Wallick. The Dodd matter is being discussed on the Senate floor and I have to be over there.

Mr. HUTTON. I think it might perhaps be better if we heard Mr. Wallick's statement next.

Senator SMATHERS. Thank you, sir, for your statement. Good statement.

Mr. Wallick, you go ahead.

STATEMENT BY MR. FRANK WALLICK

Mr. WALLICK. Thank you very much, Mr. Chairman.

I want to express Mr. Brown's regret at not being able to appear. I am not an expert but I do want you to know the deep involvement of the impact of medicare upon older people.

We believe that medicare has been a tremendous boon to senior citizens. It has lifted much of the burden of health costs from them, and has greatly lessened their fear that a serious illness would reduce them to a pauper status. It has provided this protection with dignity, as a matter of right. However, I assume this committee is not so much

interested in hearing how much of a gain medicare has brought, as in knowing what problems still need attention.

The opinions presented here stem from the actual experiences of older people. Members of our department have talked about medicare with tens of thousands of senior citizens, especially through a network of medicare counseling centers.

When we became aware of the great confusion and problems existing among medicare subscribers, our union as a public service decided to establish counseling centers. On a pilot basis, 30 such centers were established in 23 cities across the country. The general public was informed through press and radio that counseling on medicare problems was available to them at no charge. The centers were manned on a volunteer basis by specially selected UAW retirees who were intensively trained for their task.

The first centers started in February 1967, and the latest was opened in May. As of June 2, 1967, 10,900 cases have been handled in these centers. Mr. Francis R. Moore, a retired auto worker who is serving as a medicare counselor, will later tell you firsthand about some of the cases he has handled.

In addition, we have prepared a sampling of cases which illustrate the kinds of problems people are having. Mindful of time limitations I shall not present them orally, but ask you to make them a part of the record at this point.

Senator SMATHERS. Without objection.

(The material referred to follows:)

CASES FROM THE FILES OF UAW MEDICARE COUNSELING CENTERS

1. A Chrysler retiree in California had a $1,159.49 medical bill for prostate and bladder surgery received in mid-July, 1966. Although the Medicare payment was made promptly, as of March 3, 1967, Blue Shield had not yet paid the 20% coinsurance amount. It was necessary for the Medicare Center to check with the complementary carrier responsible for this payment.

2. A G.M. retiree in LaGrange, Illinois paid his physician $200 for a hernia operation. He was reimbursed $120 by Medicare. Medicare Center had to advise the patient that his G.M.-paid health insurance paid the $80 complementary coverage. Retiree was unaware that he had this complementary coverage and had not filed for reimbursement from Metropolitan Life.

3. A Wisconsin retiree's (non-UAW) doctor refused assignment on a $410 bill for prostate surgery. The retiree (who has a monthly income of $240), asked that the Medicare Center attempt to persuade the doctor to assign the bill to the Medicare Agent, since the retiree would experience difficulty in paying this amount. The doctor was adamant in his refusal. The patient also produced a form he had received from his doctor stating that all contracts were between the patient and the Social Security Administration and that the doctor had no such contract with the federal government.

4. A (non-UAW) Milwaukee retiree with $92 per month income and Medicare-only coverage paid medical bills on November 12, 1966, following in-hospital prostate and heart treatment in October. The two bills totaled $556. As of February 21, 1967, the retiree had not been reimbursed by the Medicare Agent.

5. A Milwaukee housewife with a monthly income of $172, who was treated in a hospital for minor injury, was required to make a $20 deposit for in-hospital care, despite the fact she was covered by Medicare Part A. The hospital refused to refund the deposit until they received payment from Medicare. The hospitalization occurred in August, 1966; the hospital had not been paid by Medicare on February 23, 1967.

6. A "worried and harried old member" (Chrysler retiree) wrote from Hollywood, Florida to explain that he had not received payment from Blue Cross complementary coverage for the first $40 of his wife's in-hospital bill. Although his

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wife was hospitalized in September, Blue Cross had not made payment as of February 13th and the hospital had sent a fourth notice of payment which stated the bill would be turned over to an attorney for collection within 10 days.

7. A Newaygo, Michigan UAW retiree from Budd Company wrote to the UAW in May complaining of delay in Medicare and Complementary Coverage reimbursement. The retiree had borrowed $497 from a bank to meet medical expenses incurred in connection with a kidney operation in December 1966. Despite partial reimbursement, the retiree figures $63 is still due. He wrote both Social Security in Baltimore and the Medicare Agent, but received no reply to his several letters.

8. A Cincinnati physician who refused assignment nonetheless had his receptionist assist a patient in filing her Form 1490 for reimbursement. Paid bills between July and November 1966, totaled $565. Three months later, the patient complained to the Medicare Counselor that she had not yet been reimbursed. The Medicare Agent reported delay as being caused by going from a manual to a computer operation and promised a check within the next few days. Patient's anxiety was heightened by the fact that she had submitted two additional bills totaling $735 2 months previously and reimbursement had not yet been received. Total reimbursement outstanding: $1,300.

9. The son of a Chicago Park District retiree (deceased) came to the Medicare Center for assistance. Due to the refusal of three of his father's physicians to accept assignment of incurred bills totaling $716, the son required assistance in filing for reimbursement from Medicare.

10. A Grand Rapids retiree who had worked at Doehler Jarvis reported prompt reimbursement of his Medicare claim submitted in mid-October. However, on March 1, 1967, he had not as yet been reimbursed by his complementary carrier for the balance due him. The amount due is approximately $45.

Five Types of Problems

Mr. Wallick. One could group the 10,900 cases handled in our centers into five main types:

(1) Confusion about benefits. Many who came to see us did not fully and accurately understand the benefits under medicare. This is no reflection upon their mental ability because the law is extremely complicated. Deductibles and coinsurances are a major source of confusion. Another is the fact that hospital-based physicians are allowed to bill separately. For example, a medicare patient who has an X-ray while hospitalized could logically assume that it is a covered service since it is so stated in most publications. No wonder he is confused when subsequently he recieves a bill from a radiologist, especially since he never was introduced to the man and therefore the name means nothing to him. Understandably the patient assumes that an error has been made, or that some unknown physician is attempting to cheat both him and the Federal Government.

We know that the Social Security Administration has made a valiant effort to keep up with requests for information, both by individuals and senior-citizen organizations. Obviously, however, widespread confusion still exists. We have proposed simplifying amendments to the present law, which I will mention later. For now I suggest that it would be very helpful if the Social Security Administration could find the resources not only to answer requests, but to reach out to senior-citizen groups everywhere and also make greater use of the mass media.

Many medicare subscribers also have purchased complementary coverage, which gives them added protection but frequently leaves them even more confused about their benefits. Our observation is that the insurance companies could do a more effective job of educating their clients.

(2) Confusion about procedures for claiming reimbursements. This is the most common problem brought to us. My remarks on the previous point apply equally to this subject, and I shall not repeat them.

(3) Delay in receiving reimbursement. This is a common and very understandable complaint. The average retired person is not financially able to wait several months or more to be reimbursed. The situation is frequently aggravated because usually any benefit under complementary coverage will not be processed until after the medicare payment has been made.

(4) Overcharges. We have received some complaints by patients who paid a physician's fee and were reimbursed on a lesser scale because medicare considered the fee excessive. At times the overcharge has been in excess of $100, which obviously creates a real problem for the older person. We shall not attempt to say how widespread this problem is. Such data are undoubtedly available to this committee.

Aside from overcharges as such, however, there is no doubt that there has been a general increase in medical fees since medicare came into effect. The majority of older people we talk to report this. In a number of instances, for example, fees for office calls have risen by 100 percent or more.

(5) Refusal to accept assignment. The refusal of many physicians to assign their bills to medicare is without doubt the most critical problem. Indeed, one might say that this is at the root of the others I have talked about.

We had very few problems brought to us where the physician accepted assignment. Consider how things are changed when the doctor assigns his bills. If the patient had a question about benefits it would probably have been cleared up in the doctor's office. The patient would have no need to claim reimbursement. While this is an exceedingly simple procedure for a doctor's secretary it is overwhelming for many older persons. The elderly patient would not have to wait for reimbursement. It is true that the physician would have the wait, but he is in much better position to do so than the retiree. Besides, aside from medicare, doctors are accustomed to delays in payment, whether from an individual patient or an insurance company. The patient would have no anxiety about overcharge. Finally, the patient would be spared having to lay out the doctor's fee.

Direct Payment Problems

We have had innumerable cases in which the doctor's demand for direct payment caused hardship to the elderly patient. A number of examples have been submitted to you. We could have multiplied these manifold.

Testifying in behalf of our union, on March 22, 1967, before the Ways and Means Committee of the House of Representatives, President Walter P. Reuther called for an amendment which would limit payments by medicare only to those cases in which the physician accepts assignment. He made a number of other important proposals as well. Among these are:

Eliminate coinsurance and deductible requirements, extend hospital coverage to 365 days, add coverage for prescription drugs used

outside a hospital, liberalize requirements and extent of coverage for the extended-care benefit, and extend medicare coverage to all OASDHI beneficiaries regardless of age.

Thank you, Mr. Chairman.

Senator SMATHERS. Thank you, Mr. Wallick.

Any questions?

Mr. Hutton, did you want to add something?

Mr. HUTTON. I think perhaps I will just submit the statements. One, Senator, is from your own State of Florida, Mr. Cary M. Williams, who is with Suncoast Progress, Inc., in St. Petersburg, Fla. He is a distinguished former Social Security official now working with the Office of Economic Opportunity program.

Senator SMATHERS. We had him scheduled here as a witness. We were going to put that in the record and we were also going to put in the statement of Mr. Rodney M. Coe, Ph. D., Washington University, St. Louis, Mo.

Are those the two statements you had reference to?

Mr. HUTTON. Those are the two statements.

Senator SMATHERS. At this point we will again state that these witnesses were unavoidably detained, unable to appear. Without objection we are going to make their statements a part of the record; that is, Mr. Cary M. Williams and Mr. Rodney M. Coe who is the executive director of the Medical Care Research Center, St. Louis, Mo.

(The statements referred to follow:)

STATEMENT OF CARY M. WILLIAMS, SUNCOAST PROGRESS, INC., ST. PETERSBURG, FLA.

Medicare approaches the end of its first year of operation, a year marked by a wonderful improvement in the health care of our elderly citizens, and a year plagued by the usual "bugs" common to the initial stages of any program so far-reaching. Many of us associated with the administration of the Social Security program in its fledgling days well remember the difficulties encountered, the annual appraisals, and the many, many amendments necessary to keep abreast of the times. So will it be with Medicare.

I speak for the retirees of Pinellas County, Florida; of their appreciation for the blessings of the program, and of their frustrations over its shortcomings. According to the 1960 census, 31.5 percent of the population are over 65; and 58.7 percent of these folks have incomes of under $2000, 22.2 percent have incomes of under $1000. The majority have no family responsible for their well-being, and are far removed from their lifetime family doctor.

Our findings during the past year, in the course of personal interviews by our C.A.P. neighborhood workers, and by a recent "write-in" project, reveal that many of our elderly are unable to take advantage of the program because of their inability to finance the pre-payments required. Very few, if any, of the doctors in our area are willing to accept assignments; and patients are compelled to borrow the amount and to pay interest, often exorbitant, until their claim is settled. The position of the Florida Medical Association is that the patient should be allowed to send in his physician's statement and be reimbursed on that basis, in order that he might pay the physician without undue economic hardship.

The removal of the deductibles and full payment of all reasonable charges would enable many more of our elders to take advantage of the program. And, while this is not on the agenda of this hearing, let us consider the fact that a substantial raise in the Social Security benefits for beneficiaries in the lower brackets could make better medical care possible.

While some progress has been made, the "pipe-line" from the intermediaries to the patients still seems to be clogged. Medicare patients are bewildered by statements from hospitals listing unexplained and often duplicate charges, and by statements from the intermediaries. This adds to the worries and tensions and has an adverse therapeutic effect, hindering full recovery. The Social Security District Offices, in spite of the tremendous work load, have done an outstanding

job in explaining the provisions of the program and in the interpretation of various statements received by the patient.

As the Medicare program gains momentum, a serious shortage of para-medical personnel is appearing. This includes Nurses, Licensed Practical Nurses, Nurse's Aides, Physio-therapists, Laboratory Technicians, and more and more nurses for our nursing homes. This condition might be alleviated by stepping up the various programs administered by H.E.W. and the Dept of Labor. I refer to the M.D.T.A. training for Health Service Occupations, Public Health Training for Professional Education and Training, Nurse Training, Health Profession Educational Assistance, Student Loans, Scholarships, and Improvement Grants, Home Health Aides and other non-professional health service workers. As you are well aware, these programs depend on appropriations.

Post-Hospital Care

Post-hospital extended care and home health care play an important part in the road to recovery, and further implementation of these services would speed recovery of the patient and help to relieve crowded hospital conditions. In St. Petersburg, 4000 home health visits per month are made by the Visiting Nurses Association. Many people in Pinellas County either live alone or they live with a spouse who is almost as equally handicapped as the patient. A post-hospital cataract patient or one with a fractured hip needs assistance with personal care by the Home Health Aide. He also needs someone to do his grocery shopping, cook his meals and do personal laundry. These latter services are being excluded from the Home Health Aide Program until definite guidelines are set up as to what is reimbursable; i.e., "incidental household services which are essential to the patient's health care at home and necessary to prevent or postpone institutionalization." We could utilize the service of available low-income seniors for the more domestic of these home aid services. This would not only relieve the semiprofessional, but would add to the meager income of the aide.

One of the most serious of the deterrents to the success of the program in our area is the high cost of prescriptions. These folks just can't afford to pay even $10 or $15 a month for medication. I quote from one of the letters recently received, "for a whole year my husband had a doctor who constantly prescribed pills. Last November the pills were $12, which we could not afford, so we did not get them. He died February 16, 1967." As a result, many depend on patent medicines for relief. He goes to his favorite druggist and asks what he would suggest for his particular ailment. It is common practice in this area for a drug clerk to diagnose the ailment and prescribe the medication. This practice negates the visit to the doctor. By all means, the cost of prescription drugs should be covered by Medicare.

In our area there has been much discussion about the cost of medicines. The question arises, is it cheaper to buy the generic name or buy the trade name. Many physicians state that one can buy the product by the generic name and pay as much or more than he would pay for the same medication under the trade name. The true value of the product under the generic name can be only as good as the integrity of the firm producing and marketing it. In some cases absolutely worthless! Only the product of a quality-oriented firm can be relied upon to produce the desired, consistent physiological effects.

To sum up this all-too-brief presentation, Medicare can be made more effective if we can:

Eliminate the deductibles
Simplify the paper work
Furnish more in the way of home aid
Pay for prescriptions
Bring Social Security disability beneficiaries into the program
Train more physicians and para-medics

We are already experiencing the beneficial results of this wonderful humanitarian program in St. Petersburg, and our senior citizens petition you to make these suggested additions that will make it possible for full participation.

STATEMENT OF RODNEY M. COE, PH. D., WASHINGTON UNIVERSITY, ST. LOUIS

The purposes of this statement are to present some preliminary results and to describe the next steps of a research project to evaluate the effects of Medicare on the provision and utilization of community health resources. This project is

sponsored by the Midwest Council for Social Research in Aging and its host institution, Institute for Community Studies in Kansas City, Missouri (see Attachment A for a statement about the Midwest Council) and financially supported by U.S. Public Health Service Grant Number CD 00244.

DESCRIPTION OF THE RESEARCH PROJECT

With Medicare as its central focus, this research project, entitled "Changing Community Patterns—Health Care for Aging," is being conducted in two phases. The first is an interview survey of people aged sixty or over in a random sample of 2622 households in five midwestern communities. The second is an analysis of the ways in which these same five communities organize their health and medical care services for care of the aged. To measure the changes which take place, each of the phases is to be conducted twice; once when Medicare started and again in 1968.

The five communities were selected as "types" of cities varying by size and availability of health care resources. The metropolitan area chosen is Kansas City, Missouri which, like all large cities, has the full range of community health resources. Two cities of about 100,000 population which are alike in their essential characteristics, but differ in amount of health resources were selected These are Cedar Rapids, Iowa and Springfield, Missouri. Finally, two smaller cities of about 25,000 population which represent non-urban, medical trade centers were also chosen. These were Great Bend, Kansas and Waupaca, Wisconsin.

The household interview phase is designed to collect information concerning (1) *attitudes* of the older population toward the Medicare program, physicians, hospitals and nursing homes; (2) *perception* and understanding of the meaning of disease symptoms common among older people; (3) *experiences* with the Medicare program in terms of utilization of health resources and the costs of services received. The community analysis phase is designed to collect information about the ways in which organizations and groups in the selected communities organize themselves and coordinate their efforts to provide health and medical care services for the aged. The main targets for study in these communities are (1) *service facilities* such as hospitals, nursing homes and similar institutions; (2) *service organizations*, both public and private, such as welfare departments, Senior Citizens clubs, etc., but especially physicians in the local medical societies; and (3) *coordinating organizations* such as health and welfare councils or similar voluntary agencies. At the present time, the first household survey has been completed. The community analysis phase is not yet completed and no data are now available.

PRELIMINARY RESULTS OF THE HOUSEHOLD SURVEY

The first household survey was a very successful operation which yielded a large amount of data. I will attempt to summarize some results selected because I believe them to be most relevant to the purposes of this committee. A further elaboration of some of these results may be found in the attachments submitted with this statement (see Attachments B, C and D). The tentative findings presented here relate to (1) attitudes toward Medicare as a program; (2) attitudes toward medical care resources; (3) utilization of these resources before and after July 1, 1966; and (4) the costs of care received.

Attitudes toward medicare as a program

The responses to a question tapping general attitude toward Medicare as a program were overwhelmingly positive. The proportion of respondents in the different communities favoring Medicare ranged from two-thirds to nearly three-fourths. Actually, what is more impressive is the small proportion who did *not* approve of Medicare. These percentages ranged from 7% to 10%. The balance of the respondents, mostly those under age 65, were unable to clearly state their attitude.

The major source of this positive attitude lies in two, related opinions. More than 80% of all respondents agreed that "Medicare will improve the health care given to older people" and "most older people need Medicare." These respondents were much less certain that Medicare should be extended to people under age sixty-five (about 40% agreement) or that Medicare would lead to "socialized medicine" (about 30% agreement).

Attitudes toward health care resources

A series of questions were asked about three types of health resources; physicians, hospitals and nursing homes. In general, it may be said that most of these respondents hold positive attitudes toward physicians although respondents in the smaller communities are more favorable toward physicians than respondents in the larger communities. For the most part, they view physicians as being competent and exerting his best efforts regardless of their ability to pay for his services.

These respondents hold equally strong, positive attitudes toward hospitals at least in terms of quality of care. That is, respondents tended to agree that the hospital was the appropriate place for medical treatment and that a high quality of care could be obtained there. However, less than half the respondents agreed that hospital costs were appropriate for the care received and more than one-third flatly disagreed that hospital costs were fair.

Attitudes toward nursing homes were much less positive and, in fact, suggest that these respondents are quite suspicious about the quality of care received and about the cost of care rendered. The only consistently favorable response to nursing homes was that it was chosen over the home of a relative for incapacitated older people. Since these respondents have had considerable contact with physicians and hospitals, but virtually none with nursing homes. It is apparent that their expressed attitudes are based on experiences with the former two, but on a generally poor national reputation for the latter.

Utilization of health facilities

Three measures were used to estimate the utilization rates of hospitals, nursing homes and physicians. The measures were number of hospital admissions per 100 respondents per month; number of days of hospital care per respondent per month; and number of physician contacts per 100 patients per month. These measures were taken for the periods January 1 to June 30, 1966 and July 1 to October 31, 1966. Because less than 2% of the respondents had been in a nursing home, these data were not analyzed.

The tentative conclusions which may be drawn from comparison of these measures of utilization before and after July 1, 1966 when Medicare began are:

(1) no significant increase in number of hospital admissions,

(2) a generally small increase in the number of days of hospital care received,

(3) a significant increase in the number of physician contacts.

It seems doubtful, at this point, however, that much of the observed increase in utilization can be directly attributed to Medicare primarily because the percentage increase was as great for respondents under age 65 as for those over age sixty-five. Moreover, the total *volume* of utilization on these measures roughly approximates "normal" utilization as measured by other surveys, principally the National Health Survey. Since the volume remains relatively low, it is not surprising that most facilities, especially hospitals, do not report increases as large as expected prior to the start of Medicare.

Costs of services received

As in the case of utilization, respondents were asked a series of questions about their costs of medical care before and after Medicare. The questions related to whether they had had any medical bills not covered by some form of insurance, how much these were, who paid them and, as a result, did they put off any other purchases because of uninsured costs of medical care.

The tentative findings here indicate that one-half or more of the respondents in each community had had uninsured medical care costs during the period January 1 to June 30, 1966 and a sizable proportion had them after July 1. In every case, however, there was a *decline* in the percentage of respondents who said they had uninsured expenses after Medicare started. The decline was greater in the large cities (about 6%) than in the smaller ones (about 3%).

Despite the fact that the magnitude of the decline in uninsured costs was very small, it apparently benefitted most those respondents with the largest unpaid bills. The percentage of respondents owing $150 or more for uninsured bills showed the greatest decrease after July 1, 1966 while those owing $30 or less were not benefitted at all.

The source of payment for these uninsured bills was overwhelmingly the individual. Nine of every ten respondents, both before and after Medicare started, paid these costs out of their own pockets. The remainder was paid from other sources such as relatives, welfare agencies, etc., or it was not paid at all.

These out-of-pocket costs apparently had little influence on other spending habits. In the vast majority of cases, these respondents did not put off buying anything because of the costs of medical care. The percentage who did put off other purchases (including other medical treatments) declined slightly after July 1, 1966.

It is, of course, too early to make any generalizations about these data, but it would appear that the trends are in the direction of a successful program even if the magnitude of change is rather small.

PROVISION OF HEALTH SERVICES IN THE COMMUNITY

Since no data are yet available on the community analysis phase of this research project, the most I can do at this point is to describe what we hope to gain from such an analysis. Basically, this will be a study of (1) provision of various health services by community resources both before and after Medicare (mostly from records), (2) decision-making process in planning and coordinating the delivery of these services, including an evaluation of the role played by influential groups such as the local medical society, hospital associations, and voluntary agencies; and (3) the subsequent reorganization of health care services for the aged. Again the primary reference point will be Medicare although other programs presently operating and planned such as Medicaid will have to be considered also.

We have hypothesized that over the next few years the demand for health services by the aged will gradually and steadily increase although a "leveling off" should occur within roughly ten years. In response to this increasing demand, community resources will likely expand their facilities, both in terms of physical plants and scope of services. Expansion, however, takes time, money and personnel; thus, we predict that the *initial* response to increased demand will probably be a reallocation of present resources to meet immediate demands and at the expense of other presently offered services. For example, small, rural hospitals can provide essentially custodial services for elderly patients, but only at the cost of reduced provision of acute care services. Similarly, physicians who see an increasing number of older patients, necessarily will have to see fewer younger ones.

Because of the inability to readily expand their services now and because of the general shortage of trained medical personnel at all levels, we are hypothesizing that communities will be more or less compelled to engage in a coordinative effort to allocate their resources. In so doing, we expect (eventually) that there will likely be a substantial change in the organization of a community's health services.

The factors which will likely contribute to this "reorganization" are many and varied and, for the most part, are extensions of the processes which characterized the development of the 20th century medicine. Increased population size, rising standard of living, new drugs and medical techniques, new discoveries, etc., will promote increased longevity, emphasize management of chronic diseases, and further the specialization of the medical and paramedical professions. These, in turn, should subsequently require more personnel, increased "team effort" to provide for an extended concept of truly comprehensive care.

If, in fact, these things do occur, we would anticipate an increasing rate of growth of group practices, perhaps a further decline in the percentage of physicians in strictly private practice, the emergence of specially trained groups whose main task is to coordinate all these services.

These anticipated changes obviously involve some threat to present principles guiding health care delivery systems. Thus, initially we would anticipate some resistance to these changes. Potentially, physicians offer the most serious threat to successful development of the program not because they might refuse to cooperate or to treat patients whose care is subsidized. Rather the danger lies in physicians' attitudes toward aging as a process and related beliefs about medical management of long-term illnesses. The Medical Care Research Center is presently conducting a national survey on this topic. Results from the pilot study show clearly the relationship between the perception of aging as a "process of irreversible biological deterioration" and a tendency to recommend palliative or custodial care for the elderly. Thus, physicians may be reluctant to participate because they see no medical purpose to be served by extended health services.

Another source of resistance is, of course, the facilities themselves. In most communities there is still a spirit of competition for staff, for patients and

for community support. As a result, there is a very great reluctance on the part of these organizations to submit to the coordinative efforts of voluntary groups (even when they each have representation in that group).

Finally, but certainly not exhaustively, the patients themselves may not make full use of the facilities offered. For example, we have already noted a rather unfavorable attitude toward nursing homes—to be used only as a last resort. Reports from other studies clearly show that a host of socio-cultural, psychological and economic factors strongly influence a person's decision to use or not use some health resource. It seems evident that these changes will be slow in coming about, but, we feel, they must eventually occur.

RELATED ISSUES TO BE EXPLORED

As indicated in the preceding paragraphs, the major thrust of this research is on utilization and provision of community health resources. In the process, an opportunity arises to confront several related and important issues. In closing, I would like to make brief mention of only two of these. First is the effect of Medicare on the quality of medical care services for the elderly. This problem is viewed not in the sense of quality of technical services by a particular physician, but rather in the context of type of care rendered and increased scope of care. It seems reasonable that Medicare could lead a patient to seek a physician's care almost exclusively. That is, older people with health problems which they typically treat themselves, or consult with a spiritual healer or a chiropractor, may now consult with a physician who is eligible to receive payments for services rendered.

The rising demand for management of chronic problems may eventually lead to a reorientation of the medical profession in which chronic care is given equal status with acute care. If so, there should be a subsequent shift from a custodial orientation to a treatment orientation in dealing with patients with chronic disease problems.

It is also possible that increased contacts with physicians and more frequent treatment may actually improve the health status of the aged. Under these conditions, it is feasible that preventive medicine, especially preventive maintenance services for the aged will assume new importance—an importance at least equal to preventive services for communicable diseases.

Finally, the quality of care is affected also by the scope of service provided. We would expect there to be an extension of services under the concept of "comprehensive care." The management of chronic diseases calls for the specialized, technical competencies of several persons and in a variety of settings and as the need arises, it is likely that these services will be developed and expanded.

The second, related issue is more difficult to assess and it has to do with the basic philosophy or ideology underlying the provision of health services and modes for paying for them. Basically, we suppose that in the long run, the positive attributes of Medicare will outweigh its shortcomings and this should go a long way toward undermining the customary arguments about subsidized programs particularly those related to mode of payment. It does not seem too far-fetched to expect that ultimately all age groups will be fully covered by some form of insurance. Medicare (and Medicaid) represent initial steps in this direction.

Senator SMATHERS. Doctor, do you want to say something?

The American Medical Association has had Dr. Anderson here today as an observer and they were going to testify but they are otherwise occupied at the moment, and have offered to give their testimony at a later date.

Blue Cross Association, Mr. James Ensign, vice president, and Mr. Walter J. McNerney, president, have indicated that they will probably testify tomorrow.

If there is no other business to come before the subcommittee at this time, we stand in recess until tomorrow morning at 8:30 a.m.

(Whereupon, at 11:50 a.m., the subcommittee recessed, to reconvene at 8:30 a.m., Friday, June 23, 1967.)

COSTS AND DELIVERY OF HEALTH SERVICES TO OLDER AMERICANS

FRIDAY, JUNE 23, 1967

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

The subcommittee met at 8:40 a.m., pursuant to recess, in room 1318, Senate Office Building, Senator Walter F. Mondale presiding.

Present: Senators Mondale and Williams.

Committee staff members present: William E. Oriol, staff director; John Guy Miller, minority staff director; J. William Norman, professional staff member; and Patricia G. Slinkard, chief clerk.

Senator MONDALE. This morning we have an interesting panel on Organizational Deficiencies in Present Health Services. We are privileged to have Dr. George James, dean of Mount Sinai School of Medicine, New York City, and Dr. Milton I. Roemer, professor, School of Public Health, University of California, Los Angeles.

If you will both come up to the table, please.

Dr. James, you may start.

STATEMENTS OF GEORGE JAMES, M.D., DEAN, MOUNT SINAI SCHOOL OF MEDICINE, NEW YORK CITY, AND MILTON I. ROEMER, M.D., PROFESSOR, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA, LOS ANGELES

Senator MONDALE. I understand you got a 7 a.m. plane from New York City this morning. If you would like to use 5 minutes to attack the shuttle service, we would be delighted to have that a part of the record and I will add in my own comments.

Dr. JAMES. Thank you. It is sometimes easier to get to Washington from my office in Long Island than to the office in New York City.

Senator MONDALE. Without any doubt you may have seen Art Buchwald's column a few weeks ago where the newly developed SST had a race with the *Queen Mary* to see who could get to Paris first. The SST beat the *Queen Mary* by about 3 hours.

Go ahead.

Dr. JAMES. My name is Dr. George James. For the past 20 months I have been dean of a new developing medical school in New York City. For 25 years before that I have held various governmental public health positions in State and local health departments culminating in 3 years as commissioner of health of New York City. Recently I have been Chairman of the President's Task Force on Health and President of the National Health Council. I serve now as chairman of

the Review Committee for Regional Medical Programs and on one of the subcommittees of the National Advisory Committee on Health Manpower. This August I will be chairman of the National Conference on Public Health Training.

The health problems of the aged are among the most complex and difficult now facing the American people. The entire scope of disease can be visualized as a continuum composed of four stages. The first stage is concerned with risk factors which operate before disease begins. Ideally this is the best time to intervene and interrupt the beginning of the disease process. This is the time when we seek to modify health habits and adjust the environment to make our people less susceptible to the risk of disease.

The second stage is involved with that period during which the disease process has begun, but the patient as yet has no symptoms. By means of various detection tests we seek to discover the early manifestations of disease and interrupt their further development.

Much additional research and program development is required before we can say that we understand how to combat our present major killers and disablers. Useful hearings have been conducted by congressional committees which have highlighted those problems and suggested certain productive areas for attack.

The third stage of disease is the clinical period when the patient generally feels ill and demands medical care aimed at cure. This has always made up the bulk of medical care and has been the major focus of much of our recent medical care legislation.

The fourth stage is the chronic period. Here our patient can no longer expect cure, but rather hopes for a limitation on his disability. At best this means rehabilitation, but at least it means a readjustment of the patient and his environment so that he can maintain a maximum of self-sufficiency, family life, and human dignity for as long as possible. It is what has been called adding life to our years instead of the more biological goal of adding years to our life.

New York City Aging by 20,000 Yearly

The growth of our aged population, particularly in our rapidly expanding urban areas, is truly remarkable. New York City, with a fairly stable total population size, is aging by 20,000 persons per year. By 1970 we expect to have 1 million persons over the age of 65, making New York's aged the sixth largest city in the United States. A recent survey in New York City indicated that about 100,000 persons are fit candidates for rehabilitation for neuromuscular disease. Our present methods of caring for such people are ill-adapted to meeting this problem. We cannot continue to rely upon institutionalization and facility-bound services to meet these needs. We simply cannot afford either the time or money to build institutions for them. Nor are these institutional programs the answer, even if we could provide them.

Let me illustrate by describing for you one of my recent patients.

He is a man aged 76, who has the following pathological conditions: carcinoma of the larynx involving a tracheotomy and oesophageal speech, hypertrophy of the prostate with some pyelonephritis, diverti-

culosis, a hiatus hernia, a cataract of the left eye, chronic bronchitis, varicose veins, arterio-sclerotic heart disease with a healed anterior wall cardiac infarct, and, finally, diabetes mellitus. Now, if you ask this man what is his chief complaint, he will tell you quickly enough that it is his wife.

His wife is 75 years of age; she had a thyroidectomy but, unfortunately, the recurrent laryngeal nerve was cut. She cannot shout at him, but she nevertheless can scold him rather effectively in a whisper. She has a tracheotomy with a lot of excoriation around the neck, and she is rather miserable, but they are miserably happy together as elderly people often are.

One Patient—Ten Clinics

Now, if this man would come to a major teaching hospital, this is perhaps what would happen to him. For his cancer of the larynx and related conditions, he would visit the ear-nose-throat clinic and the cancer clinic; the hiatus hernia would be seen in the surgical clinic; the cataract in the eye clinic; bronchitis, chest clinic; hypertrophy of prostate, GU clinic; vericose veins, vascular clinic; the heart condition, heart clinic; the diverticulosis and hiatus hernia, medical clinic; diabetes mellitus, metabolism or diabetes clinic—10 clinics in all. This man is much too sick to go to 10 clinics. How long would he last as an ambulatory patient waiting in the waiting rooms of one clinic after the other, of 10 specialty clinics in a teaching hospital?

Actually, he is a noncooperative patient, and that was an advantage because he didn't go to the clinics.

I can tell you what happened to him: he went to none of the clinics because the traditional pattern of medical care which was available to this medically indigent old man, living with his wife in a public housing project, was not one which could help him. It would have incapacitated him. Suppose he had tried to go to the 10 clinics. One can readily predict what would have happened. He would have become exhausted and sooner or later would no doubt have become so weak in one of the clinics that he would have required an emergency admission. and then, how long would the average hospital allow him to occupy a hospital bed? It would not be very long before he would be referred to a nursing home. Once he entered a nursing home it seems fairly obvious that he would never leave, and his wife, too, would have to be admitted fairly soon to a nursing home. Because of the way we do things in our culture, they would probably be put in separate nursing homes at a cost of about $10 each per day.

This episode I have just related occurred 4 years ago. This man is still living with his wife, and they are still miserably happy together. He now attends a hospital clinic about once every 2 weeks. The bulk of his medical care—and it is quite a bulk—is received in a small clinic, a branch of the general hospital outpatient department which was opened within the housing project where he lives. This man is receiving fourth-stage medicine, the kind of medical care so many patients like him need and which so few hospitals have become equipped to render close to the patient's home.

Mental Problems of Aging

Let us consider the mental problems of these old people. If you take a man in the prime of life, deprive him of his wife, his hearing and vision, his job, his contemporaries and confine him to his home month after month and year after year, you would not be surprised if he developed some strange personality traits. Yet this is frequently what happens to our senior citizens with hearing and sight diminished, his friends departed and his arthritis severely limiting his mobility. It is not unusual that he avoids medical care because it is too taxing to his physical resources and that he withdraws from society into an unrealistic shell of his own drab world.

Senator Mondale. Would you yield at this point? We had testimony from Dr. Ostfeld, University of Chicago, indicating that many senior citizens do not present themselves for an examination of symptoms but may disclose serious health conditions because, fearing the worst, they pretend the symptoms do not exist. If they have a bad cold, they might present themselves but if they have something that sounds like a bad heart or something serious that they are disinclined to do it. Do you think this is a phenomenon that is rather widely found among our senior citizens?

Dr. James. Yes. The studies which have been done in which populations of older people have been offered free disease detection examination services generally show that only about a half of the population will come, and even the best of them are able to recruit only two-thirds. The small clinic we opened for this man I have just described, even though it is right within the housing project, has only recruited half of the elderly people in that institution as clients, even though every effort is made to recruit them.

Senator Mondale. In other words, the others living in the same public housing project as the person about whom you are testifying who have available to them this new type of chronic patient clinic won't show up?

Dr. James. That is right. Every effort is made to recruit them. They are advised at all the affairs which this housing project holds for its older people. The clinic is well described. There are many satisfied patients living in the same development, but still they do not come. I think the answer is fairly obvious. As you pointed out, the threat of illness is such an overwhelming threat to what little security they have, particularly if they live alone, they find it difficult to act on their symptoms.

The sociologists have done some interesting studies in which they showed the steps one goes through in deciding to visit a physician. You wake up in the morning and your stomach bothers you. You tell your wife, and she says, "See a doctor." Later she asks you, "How do you feel?" "Well, I don't feel so well." This acting out and discussion with another person plays a major role in getting an individual to seek medical attention. A person who lives alone and is denied this opportunity is much less apt to act on this symptom. This is the reason in addition to the tremendous threat to a person's whole life that a serious illness should be looked into.

Senator Mondale. What about in this case, you have what you might call a chronic clinic, a one-stop chronic clinic conveniently lo-

cated for the occupants of this public housing development and you say only about half of them show up despite every effort to persuade them. Have there been any efforts to go to their unit?

Dr. JAMES. Yes. A great deal of work is being done to try to bring these people in, and I think that it will eventually be handled in one of two ways. One, to get the patient used to coming for medical care as a routine instead of waiting until he feels sick. Let this be a health maintenance program to keep them well, rather than only an emergency service after illness strikes. This presents much less of a threat and can be presented in a warm, friendly, supporting way.

Second, you have to develop the kind of services that will backstop them if their security is threatened. Very intensive home care services, homemaker services, make him feel that he has a family that will look after his social needs as well as his stomach or gallbladder if that is what is afflicting him.

In New York City we have a million and a half people that live alone; many of these are young but many of them are old. We have couples that moved into public housing projects at the age of 60 and now 20 years later only one is left. Often the husband who does not even know how to boil an egg and lives alone with a neighbor supplying him with food. If that neighbor gets sick and goes to the hospital, suddenly people discover this poor old man is living without anything.

SOCIAL PROBLEMS RELATED TO DISEASE

There are many social problems which are closely related to disease and are part of the care of these people. As a matter of fact, the physician is often the least important person in the total medical care of what I call four-stage medicine or chronic care of the aged. Very few of these conditions are cureable, but there are problems of adjustment of a man and his environment which require quite a team of people.

What I am going to tell now is highly pertinent. Recently an exciting program to combat this vicious cycle has been developed by the Henry Street Settlement in New York. Here about 100 senior citizens banded together to help their colleagues. Showing unusual patience and empathy, they started a friendly visitors program in which they periodically visited old people in their homes. Often their first efforts were rebuffed. Only after making dozens of visits were doors opened, conversations and friendships begun, and new recruits enlisted into the ranks of the friendly visitors. The rehabilitation thus became double, with both the patient and the visitor finding a new meaning to life.

Old people do not generally want to sing in glee clubs or do basket weaving. They can recognize such busy work for what it is, and they do not usually do it well. But here they have a mission which they have the time and ability to perform in a way which is vastly superior to that of our so-called professional manpower. The potential of this untapped resource is enormous.

HOME CARE DEFICIENCIES

A report recently prepared by the Public Health Service indicates that there are only 70 medically directed home care programs now in operation in the United States, and these serve only 5,500 persons. I

might add that one-third of them are in New York City. Truly this is fantastic considering the enormous numbers of persons who are either homebound or understandably lacking in the ability or motivation to seek high-quality medical care, no matter how much we offer to pay for it. One patient of ours consistently refused to attend the cardiac clinic for a severe heart ailment. Careful study of his total problem revealed that his feet hurt. After receiving corrective attention to his painful corns, he was so grateful he walked, despite his diseased heart, 3 miles to the cardiac clinic as a favor to the nurse who spent so much time trying to gain his cooperation.

The answer to the problem of medical care for our aged is to reorganize our services around the patient and his needs, rather than to insist that he spend what few energies and motivations he has in a futile round robin of visits to various specialty services. Ideally, all people should go for medical care not because they fall ill and feel sick, but because as people they should receive a routine checkup for all stages of many different diseases. At Senator Neuberger's hearings last year, I deplored the fact that Americans take far better care of their automobiles than of themselves. Automobiles are usually sent for a spring and fall checkup. Perhaps some day we may see the wisdom of doing as much for ourselves.

Cornell-New York Program

Happily today we are seeing the development of a significant number of demonstration programs aimed at giving medical care to people and their families on such a comprehensive basis. One of the first of these to be done on a major scale was the Cornell-New York Hospital comprehensive care program. One thousand welfare families were invited in for medical care as whole families as soon as they were added to the public assistance lists. Incidentally, inviting them in as families is a means of breaking down their resistance to coming. Of course, these are the more fortunate older people who have a family.

The same team of physicians attempted to follow the family as outpatients, inpatients, in the nursing home, and in their own homes. Certainly the specialist was used, but the specialist always referred his findings to the general medical team. Data on the program are being collected, cost information is being studied, and very interesting results are being discovered. For example, they are finding that only rarely will an individual ask for home visits, even though the treatment team is willing to go to the home. Part of this is because the patient is not quite sure he will see the doctor whom he knows, and he is sure that he will see him if he comes to the clinic.

The other reason is that there is not as much need to have home calls, because the patient has had his diseases detected and under treatment before the symptoms have appeared. It is also of interest that an enormous amount of very significant disease has been discovered from this population. One sidelight which reveals something of this program is that for the first time New York Hospital has had to print signs in Spanish for its waiting room. They have a group of patients they never had before.

In New York City we also have the Gouverneur program where the staffs of several city departments are starting a program with Beth

Israel Hospital. As you know, a new hospital building is being erected and all agencies will try to cover the total health needs of the area's total population. There is also St. Vincent's Hospital with a program for its welfare patients which is now expanding to include the rest of the family. What we are dealing with here in the efforts of these and other hospitals is the adaptation phenomenon. They are trying out various methods in order to learn how to approach total family care and how to treat all stages in the natural history of disease.

The Great Need—Closer Contact

The first step in one of these programs could be anything which will bring an institution or a service into closer contact with a group of patients which has not been seen before. These patients may actually be the hospital's own patients, but that particular institution may never have looked at them before in relation to many of their total health needs. Ideally, a hospital should pick a population group, as Beth Israel is now doing in the Lower East Side. This will be "their" population for the total practice of medical care. The hospital plans to try to meet all the medical care problems in that area to the best of its ability, utilizing all the modalities of private practice, clinics, chronic care, health center services, and home care.

Senator Mondale. How is Beth Israel financed?

Dr. James. This program has been going on now for several years. It was begun with their own funds. They received a significant grant from the Office of Economic Opportunity, and now, of course, with medicaid in New York State it can be amply supported that way.

Senator Mondale. Are they using medicaid for this now?

Dr. James. Yes; but they still have a large OEO grant.

Senator Mondale. Medicaid and OEO?

Dr. James. They have a large OEO program which will last for a few more years.

Senator Mondale. What about the earlier program to which you made reference?

Dr. James. The Cornell-New York Hospital?

Senator Mondale. Yes.

Dr. James. New York City is unique in having its own little "NIH," for health programs, called the health research council. Mayor Lindsay has continued the program whereby a dollar per capita is appropriated. It is 50 percent reimbursable by the State health department. It is dedicated to the support of worthwhile research in biology and medicine in New York City, and one of the priorities has been medical care. So this Cornell project was supported by a 5-year grant. Actually, several million dollars was invested in this program and it has been the prototype for many others which are developing in New York now.

Senator Mondale. Would this program we are now discussing be fundable under medicaid?

Dr. James. It is fundable under medicaid not as a program, but it is fundable in the sense that the doctors could be paid for giving the treatments. Therefore, by putting together all the doctors' fees, we could obtain support from the program. It would be highly desirable for there to be better support than there is for such demonstrations,

although some support is available from OEO, from National Institutes of Health, from the Public Health Service granting mechanisms. I am sure we could use more.

The big problem with demonstrations is that if you put enough money up, you can do nearly anything. It is not difficult if you want to spent $5,000 a patient to give sparkling medical care. The kinds of demonstrations we need are the ones that can develop and grow without that kind of unusual support.

Senator MONDALE. Yet if you undertake an optimum program and do a good job of appraisal—that might be the best way of starting the perfect program to do a good job appraisal—you come down to a more sophisticated level that you could fund.

Dr. JAMES. That is right.

Senator MONDALE. I think one of the problems in these kinds of programs is that you never really do a good job and then properly appraise it so we can show what can be done if we do our best.

Dr. JAMES. Dr. Charles Goodrich, who did the Cornell study, is now in my institution and is developing our entire outpatient ambulatory service on the basis of medical practice units with pediatricians as consultants. We are going to take all of the people who walk into the clinic and treat them as private patients, with 1,500 families per doctor. He, therefore, is building on this Cornell experience. He, incidentally, is documenting this and it is going to be published between hard covers. The results of the program were thoroughly evaluated and the costs clearly delineated.

So he is going to be able to take the best of this demonstration and support it through medicaid. It will be no more expensive than running a poor set of clinics as my 76-year-old man was subjected to. It will be even cheaper and more effective with home care and backup services.

There will also be linkages for medical supervision with nursing homes, so that it will be possible to follow the patient in the nursing home. At the same time, this will permit the hospital to have a better basis for discharging certain categories of patients from the parent institution to nursing homes, and also bringing them back to the hospital when necessary.

MEDICARE ONLY A BEGINNING

In conclusion, let me emphasize that we are only on the threshold of an attack upon the complex problems of medical care for the aged. Medicare and medicaid are largely aimed at the removal of financial barriers to care—there are many high fences still to be removed. As a matter of fact, strictly speaking, medicare and medicaid are not medical care programs but income maintenance ones. There are many aspects of medical care, including attention to the high quality to which they have not even gotten close.

The hospital emergency room has too long been the inept resource used for chronic care of disease; the traditional proprietary nursing home has too long been a dismal answer to crying medical and emotional needs which have gone unheeded. The key demonstrations for improvements have been performed and several major enterprises are well under way. Much more must be done to improve their efficiency

and effectiveness. We desperately need packages of care we can afford. One thing, however, is certain. At the current rates of increase of our aged and their concomitant higher incidence of chronic disease, these problems cannot be ignored.

Senator MONDALE. Dr. Ostfeld testified the other day that most of the killers of aging are diseases that result from bad and long-term habits: oversmoking, overdrinking, overweight—habits that should have been corrected earlier in life. One of the things I have been toying around with here is a proposal which I have not worked out yet but call for preretirement counseling at some point in life, say age 40, where we would actually encourage a couple to take some time off to consider the life that remains ahead, their own careers, whether they want to do something different or whether, as Secretary Gardner put it, they are already psychologically retired and bored and maybe they ought to do something else. Look at their retirement financial problems and get them under control. With regard to health, have a checkup at that time and have a doctor tell them the truth about their habits and their health and what they ought to do if they want a long-term, improved health picture.

Does that make sense to you?

Dr. JAMES. Yes, that is an excellent idea. One should begin with what I call the first-stage problems, these things that make an individual more or less at risk of developing disease at any time. The retirement counseling program would be an excellent way to begin with this group. Of course, it would be even better if we had people coming to us as part of families all through their lives receiving this type of counseling.

Actually, if you look at the diseases which we have controlled in this country, like polio, diptheria, measles, smallpox and so on, almost all of them have been diseases we have attacked in the first stage and not by using clinical medicine, waiting for the patient to have a symptom. We have made some progress in controlling these diseases after symptoms occur but it looks like only when we can develop some method of attacking them before they start can we really make a major impact upon them.

Obviously, if the patient comes to you with symptoms, we have to do the best we can. If he comes to us after he has the chronic incurable disease, we still do the best we can. But it is far better to accent just what you suggested, types of activities which reach into their lives and try to keep them healthy.

Senator MONDALE. You are dealing with health problems as distinct from financial arrangements, new careers, and some of the other things that might be explored at some midpoint.

Dr. JAMES. Very good.

Senator MONDALE. What is the likelihood after you have diagnosed a 40-year-old person and he is smoking too much and drinking too much that these things will happen when he gets older, bad habits? What happens? Doctors do this all the time.

Dr. JAMES. First of all, it would be better if he stopped than continued. Even if he has had a 20-year experience of bad habits, it is better if he stopped. Our success in getting people to change their habits is rather poor, but there is a challenge. Our success in curing

coronary heart disease is equally poor, if not poorer. That does not mean that we stop trying; we have to keep working with them.

Of course, as far as smoking goes, if we can keep pressure on the system we might come up with some other answers. For example, a safe cigarette would fit into a person's existing motivation rather than the more difficult, alternate task of attempting to change that motivation. We are not going to get these answers unless pressure is continued.

Suspicions of the Elderly

Senator Mondale. I am always impressed by the deep suspicion that one encounters among the elderly. What you talk about pops up almost all the time. The elderly are suspicious that if they go to someone other than a doctor they will not get to see the doctor. Half of them will not go to this very convenient chronic clinic which is provided because of one fear or another. There apparently is a deeply suspicious, fearful psychology among our elderly in this country. It pervades almost everything that they do.

Dr. James. That is true. That is why ideally if we could get families to come in when they are well for routine checkups, the physician and the surroundings and the health team become friends. Medical care becomes a predictable situation.

Senator Mondale. But you have to overcome this barrier of suspicion. It takes a while for these friendly visitors just to get their confidence. People come in to talk to them. We think this is the first thing lonely people want but they are suspicious.

I remember one time when I was campaigning and somebody told me it would be a good idea to go down to a senior citizens project and shake hands. They were playing cards and they said, "Get out of here, we don't want to see you people; we are sick of you politicians." I think I lost the town.

Bill, do you want to go into that medicare question?

Mr. Oriol. I have several questions but perhaps you want to hear from Professor Roemer.

Senator Mondale. If that would be all right, we will hear from Dr. Roemer and then we will have questions afterward.

Dr. Roemer, we are very glad to have you.

STATEMENT BY DR. MILTON I. ROEMER

Dr. Roemer. Thank you, Mr. Chairman. I feel honored to be invited to make some comments to this Special Senate Committee on Aging on this question of the costs and delivery of health services to older Americans.

Since 1936 when, while still a medical student, I undertook studies on the social aspects of medicine—earning a master's degree in sociology in 1940, the same year as receiving the M.D.—I have been exploring the problems of delivering the fruits of medical science to meet the needs of people. For 14 of these intervening years I have worked in public health tasks at local, State, National, and international levels and for 12 of them I have taught at universities—Yale, Cornell, and now at the University of California.

The vast achievements of medical science are well known, but the failures and gaps in delivering these benefits for persons, old and young, who need them, are less well understood.

Medical service delivery is, in a sense, a more complicated task than scientific medical diagnosis and therapy. The latter, technical tasks, require great knowledge and skill, but once a logical decision is made, the various measures of surgical or pharmaceutical or other types of medical management can be readily prescribed. The actual delivery of those services to large human populations, however, requires coping with enormously complex social, psychological, economic, political, and cultural forces. There are vast pressures of tradition and numerous vested interests that can obstruct the implemention of logical decisions.

Delivery of medical services to the aged is made difficult by all the same problems that face any other age group, compounded by further problems of the older years. In these years, the burden of sickness is far greater, the individual's financial resources to meet it are less, and the physical procurement of needed medical care is impeded by numerous problems of transportation and understanding.

The enactment of the medicare amendments to the Social Security Act in 1965 has been a great step forward in reducing the financial handicaps of the aged with respect to certain sectors of medical care. In a sense, however, this law has only tended to give the aged a certain parity of health insurance coverage with the young and self-supporting population. Before this important law, only about 50 percent of the aged had any hospitalization insurance, they had less of other types, and most of that was meager in benefits; now close to 100 percent are covered and the benefits are much more liberal.

The effective delivery of medical service, however, requires more than underpinning of the bills, and this is especially true of the aged. It requires an organization of the technical services that meets the complex demands of science and needs of sick and disabled people. It requires medical care that is comprehensive in scope, continuous over time, physically accessible, scientific in quality, and humanistic in spirit.

Horse-and-Buggy Level for Services

While we have made a great deal of progress over the last 30 years in the United States in financing medical services, for both young and old, our social machinery for delivering those services has remained almost at a horse-and-buggy level. Perhaps it is a team of horses, rather than an old gray mare, that deliver the product, but medical care organization has hardly caught up to the motor-car era, let alone the jet plane.

The crucial fact is that most of the expanded economic support for health service has been applied to a framework of medical and dental practice in isolated individual offices and a patch quilt of hospitals, drugstores, and laboratories which are characterized by extravagance, inefficiency, and frustration for the patient and provider alike. Half the Nation's general hospitals are of under 100 beds—a size much too small to render optimal scientific services soundly and economically. Eighty-five percent of clinical physicians and 95 percent of dentists hold forth as solo practitioners, despite the enormous development of specialization demanding professional teamwork.

Thousands of small, independent drugstores dispense a bewildering array of drugs at very high prices, inflated by the cost of a fantastic

volume of competitive advertising, robust manufacturing profits, and an elaborate network of middlemen between producer and consumer.

Dental treatment absorbs the scarce and expensive time of highly trained professionals, doing tedious tasks that could be readily assigned to technicians under supervision.

Preventive medicine is widely preached but seldom practiced, while geriatric rehabilitation is a fiction in the thousands of small proprietary nursing homes that accommodate the vast majority of chronically ill and aged patients whose numbers are increasing daily.

Though this is a grim capsule sketch, Mr. Chairman, it could be easily documented with reams of facts and figures. While American medical science at its best is capable of wonders in reducing disability and saving lives, these wonders are applied far less than they could be. Our age-adjusted mortality rates in the United States are higher than those of many other countries of lesser wealth and, at that, spending lower proportions of their gross national product on health care. The difference lies in the way we spend our health dollars. Our social machinery has simply not caught up with our scientific capacity.

Piecemeal Efforts at Reform

The history of social and legislative action to correct these organizational anachronisms is one of piecemeal efforts. Special laws have been passed to help a worker who has been injured on the job, but they don't help him if he gets injured or sick off the job. The crippled child can be helped if his diagnosis happens to be on the approved list in the State where he lives and if he is poor enough. A veteran may get first-class medical care for a military-service-connected disability, and sometimes for other disabilities, but if a physical handicap barred a man from military service in the first place, he is, of course, outside this ball park.

There are literally hundreds of other specialized piecemeal programs for selected categories of American citizens or selected types of medical diagnosis. On top of these governmental programs is a vast jungle of medical care plans and agencies, supported by voluntary insurance, donations or industrial expenditures.

If one adds up all the dollars spent by these organized health service programs, through hundreds of administrative channels—both governmental and voluntary—and relates them to the total dollars spent on health in the Nation, one finds an important trend. In 1965, of the $38,500 million spent on health, about 55 percent was passing through some organized fiscal channel, and this was a large increase from the 20 percent so spent in 1930. With medicare and other new programs of the last 2 years, this social sector of health expenditures is now probably about 60 percent of the total.

In recent years everyone has become acutely aware of the rising costs and prices of medical care. Since the medicare enactment in July 1965, medical prices have taken a steep spurt upward, as this guaranteed support led hospital nurses and other employees to seek long-overdue wage increases, and as the increased demand on a fixed supply of physicians led—following the usual economic laws—to fee elevations. The point is, however, that medical costs have been rising steadily

for many years, but it is the increasing social assumption of those costs that has now made them so very visible and has catalyzed public concern.

Senator MONDALE. This morning in the Washington Post there is an article by Marquis Childs on this very issue of skyrocketing cost. Would you object to having that article included in the record?

Dr. ROEMER. It sounds very appropriate.

Senator MONDALE. If you have no objection, let us put it in the record at this point.

Dr. ROEMER. Of course.

(The article referred to follows:)

[From the Washington Post, June 23, 1967]

THE RISING COSTS OF MEDICAL CARE

(By Marquis Childs)

At least a half-dozen high-level conferences, both Government and private, are taking aim at the rapidly rising cost of medical care. The struggle to keep up with inflationary costs is nowhere more acute than with the hospital and the doctor's bill. A study prepared for the National Conference on Medical Costs next week shows that in 1966 the price of physicians' services increased 7.8 percent. In the last half of 1966 daily hospital charges rose 11.5 percent. The Medical Care Index went up 6.6 percent which was just double the percentage for last year's over-all explosive cost-of-living jump.

None of this is surprising to experts who follow the trends. They point out that the old order is giving way to revolutionary change with medical care in the forefront.

July 1 will mark the first anniversary of Medicare, a program covering 18,000,000 Americans over the age of 65. Medicaid is being developed in many states to provide medical help for low-income families. In a nation so long resistant to any Government participation in medicine, with many professionals denouncing "socialized medicine," this is indeed a revolution. And as in all revolutions the penalties at times seem to exceed the rewards.

What is more, the revolution is just beginning as the Johnson Administration takes a stern look at the facts of medical care in this country. Sargent Shriver, that affluent apostle of revolution, is attacking through his War on Poverty the shocking failure of the poor to benefit from America's high level of medical care. At a recent conference he came up with startling statements about what this failure means—60 percent of poor children receive no medical care and never see a dentist; the chance of a child dying before the age of one is 50 percent higher for the poor, the chance of dying before 35 four times greater.

As one line of attack six health centers have been established with the goal of making medicine accessible to the poor in city ghettos. Six more are on the way. Shriver is enlisting under his banner the American Medical Association and other organizations that might once have fought such an experiment.

But as the demand for medical care increases the pressure on the supply of services inevitably forces up the cost. The supply of doctors, and in particular general practitioners and pediatricians, is woefully short—a reminder that for years the AMA opposed expansion of medical education. The Vietnam war takes about 5,000 doctors a year for a two-year stint. To meet the demand, according to the study prepared for next week's conference, doctors are seeing more patients.

One consequence of the pressure on inflation, as reflected in the steep rise in the cost of medical service, is in the wages of hospital workers. They have always been among the low paid, existing on marginal salaries in institutions that confused charitable intent with business administration.

That is now beginning to change as full employment—or comparatively full employment—opens other opportunities even for the unskilled and the semi-skilled. The new minimum wage law, which covers hospital employes for the first time, provides that they must be paid a minimum of $1 an hour starting in 1967, $1.15 in 1968 and $1.30 in 1969. Hospital workers have rebelled against low wages, with nurses leading the way in strikes in a number of instances.

"If hospital staff per patient continues to increase at recent rates, the total wage bill per patient day seems likely to increase from $27 in 1965 to about $38

in 1970 or 7 percent a year." the report on medical prices states, pointing out that one result of the wage squeeze is to increase the number of people who will share the work at marginal pay.

While the start of Medicare is often blamed for the rise in medical costs, the study finds that this is not true, at least insofar as the recent acceleration of the rate of increase in doctor's fees is concerned. Increased use of hospital space could even result in economies of operation and more effective use of available beds.

In presenting the report which will be the starting point for the conference John Gardner, Secretary of Health, Education, and Welfare, suggested a number of ways in which medical resources can be employed to greater advantage. The old patterns, Gardner was saying, simply will not suffice if the demand for more and better medical service is to be met at a reasonable cost. Concerned men and women throughout the country are seeking new and constructive channels for the forces of change at work in medicine and in almost every other area of American life.

Dr. ROEMER. The overall costs of health care have been rising faster than our gross national product. In 1930 all health expenditures claimed under 4 percent of our GNP. Now it is over 6 percent—a 50 percent higher share. Much of this rising cost is due to a greatly increased rate of utilization of health services by the people, surely a good thing. Another part of the rise has been due to improvements in the content and quality of care—improvements which would have meant much greater cost escalation, if it had not been for some automation of hospital service and increased use of auxiliary health personnel.

But a portion of the rising costs and the rising share of GNP required for health care has been due to the backward inefficiency and needless complexity of our health care system, noted briefly before. These wasteful inefficiencies, furthermore, must be measured more by their human toll than their drain of dollars.

THE STORY OF ONE PATIENT

May I take the time of a distinguished committee of the U.S. Senate to tell of one aged patient who, like most old people, suffered from multiple diagnoses? He had a serious eye problem—actually two diseases: glaucoma and keratitis—for which he received care at a nearby medical center, in the department of ophthalmology. His personal doctor, a good internist, however, had diagnosed a mild diabetes, and for this periodic visits were necessary to an office 8 miles away. Painful corns and bunions, impairing the ability to walk, were not within the speciality of the personal doctor, so these required periodic visits to a podiatrist at an office 6 miles in another direction. Dental care, in an effort to save the few remaining teeth, so that dentures would fit more firmly and food could be more properly chewed, required numerous visits to a dentist at still another location.

Then a bladder problem developed and prostatic disease was suspected. At about the same period, the patient showed lethargy and confusion, suggesting a mild cerebrovascular accident. The personal doctor made a home call and the decision was to hospitalize. A bed was not immediately available—except in a small proprietary hospital which the family refused—and it was not till 10 days later that he could be admitted to a good voluntary general hospital 15 miles away. After X-rays, cystoscopy, and other examinations there, his treatment

was stabilized. In the workup, it was discovered that a drug the ophthalmologist had been prescribing for many months was causing serious side effects, which had been missed by the internist since these two specialists had never communicated with each other. The patient was then admitted to a sanatorium, selected for its closeness to the family home, so that visits from the patient's children would be possible daily.

This was one of the "better" nursing homes—it was certainly expensive enough at $32 a day paid by medicare—but this was evidently not costly enough to support a proper staff. After a few days, because of lack of proper surveillance, this aged patient was found roaming on the street. When this happened a second time, the commercial proprietor decided to discharge the patient as "too difficult to care for." It took 5 weeks of nursing care at home, with daily problems of incontinence of urine and feces, before a bed in another nursing home became available.

The latter facility proved to be better managed and the patient improved. After only 2 weeks, however, he was getting up from a chair one day, when he fell and fractured his left hip. This required an orthopedic surgeon, readmission to the hospital, and preparation for a major operation. But then complications to the diabetes set in, because of the traumatic shock of the fracture. A delay of over 24 hours in reporting a critical laboratory test nearly cost the patient's life at this time. Had the hospital been adequately staffed, this delay would not have occurred. A skillful operation, with a pinning of the broken bone, was done. Special-duty nurses costing $111 per day—over and above the medicare coverage of the hospital bill—had to be hired because of the shortage of regular hospital nurses.

I have not recounted the other details of multiple drug prescriptions, special services of an appliance shop to adjust the bed at home, the physical therapy required for a knee injury, and much more. This patient was my widowed father, who lived with my wife and me for 9 years after his retirement from 51 years of medical practice. My abbreviated account of his medical care problems applies only to the last year, or it would be much longer. Accounts like this could be told thousands of times over, each day in the United States, and would doubtless be more complex and disturbing for a family less well informed about the jungle of medical care delivery.

I was notified by telephone when I arrived in Washington late last night that my father had just died.

The problems in this, and thousands of similar cases, it may be noted, are not primarily financial. That side of it was handled. The problems for this and similar patients were and are a consequence of the crazy quilt of a fragmented nonsystem of health service delivery in our country. This was a case, incidentally, in a high-income section of a great metropolitan city; consider the comparable problems in a rural area or a blighted urban slum.

Innovations Underway

Yet, many important innovations have been developing in the organization of American health service in recent years. In numerous small ways, integration of the manifold specialties and paramedical

skills is being achieved. While each of these is only a minor stream in the larger flood, we do see group practice clinics, expanded hospital outpatient departments, neighborhood health centers for the poor, emerging regional hospital networks, liaisons between nursing homes and hospitals, and other intelligent arrangements that give us a glimpse of a better future.

We have heard from Dr. James this morning of the interesting developments in integration of health services in New York City.

Without taking the time to review all these significant recent developments, may I request the privilege of attaching as an appendix to these remarks a paper on this subject of "New Patterns of Organization for Providing Health Services" [9] which I presented not long ago at the New York Academy of Medicine.

Senator MONDALE. Without objection it will appear in the appendix.

Dr. ROEMER. Because of these hopeful signs of change, we can begin to see the shape of a new pattern of health service for the American people—young and old, rich and poor—in the years ahead. With appropriate leadership in the Federal Government and effective partnership between public and private resources, I think we can expect to achieve this picture in a generation from now:

COMPREHENSIVE HEALTH CENTERS

In each neighborhood there would be a comprehensive health center staffed by a team of general physicians, specialists, nurses, technicians, and aids. Everyone—not just the veteran or the pauper or the crippled child—would be served by a "primary physician," as the Millis report of the American Medical Association has recently defined him. Specialists would be called on for help as necessary. The mentally disturbed would be treated as well as the physically disabled. Dental care would also be provided, with reasonable use of dental technicians for the many simpler mechanical tasks. Laboratory and X-ray procedures would be done in the center, and drugs dispensed by the staff pharmacist. Preventive health examinations and screening tests for hidden disease would be done routinely with the aid of modern equipment and auxiliary staff.

Hospitalization, when necessary, would be provided at a good general facility of perhaps 300- to 500-bed capacity, where the full range of technical modalities could be offered. Institutional care of the mentally ill or the chronic sick would be given in special wings of the hospital or in affiliated units nearby. Several of the neighborhood health centers would be satellites to each such hospital, and their professional staffs would receive periodic continuing education in the hospital. Depending on the density and ecology of the population, the hospital would be professionally and administratively tied to other institutions in a regional network; at its hub would be a great medical center, where basic education of the health professions and medical research would be actively pursued.

The quality of health service would be subject to continuous surveillance, not just in the hospitals but throughout the system. Major surgery or other serious procedures would, of course, only be done by

[9] See p. 236.

qualified specialists. Cultists would have no place, nor would patent, self-prescribed medications. Physicians or public health nurses would make home calls, as necessary, but no time would be wasted in a doctor's travel to five, or six separate hospitals—as the current lack of system compels him to do. The patient would be treated as a whole person, monitored by a unified medical record which would move with him to a new health center if he changed his home. Whether he was a veteran or an injured worker or a welfare recipient or a parochial school child, whether his illness was infectious or mental or traumatic or neoplastic—he would be treated by the unified system, starting in a nearby neighborhood health center and branching to other resources as necessary.

Economic Support

The economic support for all this would be derived from the social devices of insurance and public revenues that we have seen evolving over the last 30 years or more. The underlying resources of personnel, equipment, facilities, and knowledge would be produced likewise by social planning and investment, both governmental and voluntary, as they are now at an increasing tempo. The personnel would be rewarded for their labor according to equitable principles of skill, seniority, and responsibility, and their contributions would also be recognized by appropriate social status. But the receipt of services by an individual would not depend on the amount or source of the money paid, nor on the diagnostic category of his disease, nor his social pedigree. It would be a right of his being an American.

This picture, Mr. Chairman, is not utopian. It is easily attainable within our resources, and, while I do not say it will reduce expenditures, it will permit health achievements at a far lesser cost than a policy of unplanned drift.

The new legislation on "comprehensive health planning" is, in my view, an important step in the right direction. Like the medicare law and the heart-cancer-stroke legislation, it is only a beginning. Positive stimulation is needed for promotion of group medical practice and neighborhood health centers—not just in the slums—on a very wide scale. Far more medical and allied personnel must be trained. The endless programs defined by category of person or category of disease must be replaced by health service organization based simply on geographic regionalization.

If these changes evolve, the health needs of older Americans, as well as everyone else, will be met at a level of which our Nation could be proud and of which we are certainly capable. I thank you very much.

Senator Mondale. Thank you, Dr. Roemer. Needless to say, we all join in expressing our condolences on the passing of your father and we are grateful to you for proceeding with your testimony despite that tragedy.

I thought it was interesting that the two examples, the example of your father and the one that Dr. James cited, were so similar and the conclusions that one must draw about a better organization of our services were very similar and parallel each other very closely.

Unfortunately I have to excuse myself because I have to be over at another committee.

Just one quick question and then I must go. Without objection I am going to ask the staff to continue the questions because I do want to be sure while you are here to get the benefit of your thinking.

What is the reaction of the medical profession to these proposals to organize medicare and some of these other problems to which you make reference on this kind of systematic overall basis?

Is this being received with great enthusiasm by AMA?

Dr. ROEMER. I think the reaction is mixed, Mr. Chairman. There are sectors of the medical profession that are very responsive to these ideas; for example, physicians who on their own initiative organize group practice clinics, like the Mayo organization, the Oschner Clinic and so on, establishing first-rate teams of specialists.

There are physicians in the universities, in medical schools and great teaching centers, who see things this way. There are physicians who devote themselves to the study of these problems, like Dr. James here and other academic people, who share these views.

Senator MONDALE. Yes, but you are giving us examples——

Dr. ROEMER. There are rank-and-file private practitioners who resist these ideas as they have resisted in the past voluntary health insurance, public health programs, better organization of the staffs of the hospitals, et cetera. But as these changes evolve, the interesting fact is that physicians adjust to the demand and cooperate with them.

For example, the kind of medical staff organization in the average general hospital in the United States today which was called for by the Joint Commission on the Accreditation of Hospitals was regarded as bureaucratic and totalitarian by physicians 25 years ago, but today is widely accepted.

The day-to-day care of patients in hospitals has tremendously improved just by the reason of the more systematic organization of the medical staffs.

Senator MONDALE. Of course, what you are proposing to do here goes far beyond the properly existing hospital. I would like to have Dr. James' reaction to that same question, the reaction of the medical profession.

Isn't it always true that the staffs of the medical schools and advanced clinics like Mayo Clinic are more liberal and willing to accept these sorts of things?

Dr. ROEMER. The reason I mentioned hospitals, Mr. Chairman, is that there was the same resistance to the tightening up the organization of hospitals in the past, and my proposal is to apply the same kind of genius to take care of the ambulatory patient in his neighborhood.

Dr. JAMES. I think what Dr. Roemer says is correct. There is nothing that is incompatible between the things we have been saying and the private practice in medicine.

As a matter of fact I was in Honolulu not too long ago and I was surprised to find that over 50 percent of the physicians in Hawaii operate under group practices, and group practice lends itself very readily to this kind of total approach.

Moreover the American Academy of General Practice has become keenly interested in this type of approach and are eager to develop more in the way of becoming true family physicians.

The hospitals have taken leadership because they do have huge numbers of patients coming to their fragmented clinics.

Since they have this clientele to start with, by using the same funds and better organizing of their services, they can develop a family practice for this population very readily.

I think the private sector would object if the only way that the problem could be handled were by hospitals and by some kind of a Government organization, but the pattern is readily translated into the private sector.

Senator MONDALE. There is a story in the morning New York Times I will ask to be included in the record which quotes Dr. Milton Rouse of Dallas, president of the American Medical Association, who expressed concern at the increasing involvement of our National Government in the health field.

(The article follows:)

[From the New York Times, Wednesday, June 21, 1967]

DOCTORS URGED TO COMBAT GOVERNMENT PLANNING—NEW A.M.A. HEAD ASKS STEPS TO FULFILL LOCAL NEEDS—CONVENTION EXHORTED TO BAR "THREAT" OF CENTRALIZATION

(By Donald Janson)

ATLANTIC CITY, June 20—Dr. Milford O. Rouse, new president of the American Medical Association, urged doctors today to step up efforts to curb government planning in the field of medicine.

In an inaugural address to the 116th annual convention of the association, the 64-year-old Dallas gastroenterologist said that the "threat" to the private practice of medicine had not stopped with Medicare and Medicaid.

"Judging by events of the last two years," he told some 1,000 physicians at Haddon Hall, "we must increase the effectiveness of our opposition."

About 9,000 physicians are registered at the convention.

Dr. Rouse said the Government was now "making its moves into areas where, to its own satisfaction at least, it is able to demonstrate unfilled needs for health care or health care planning." He urged that organized medicine meet the "crisis" by filling any vacuums it found in communitywide health planning before the Government did.

Dr. Rouse said in an interview that his own Dallas County Medical Society, for example, was taking the initiative in investigating the need for new community health services, such as neighborhood health centers.

As for himself, he said, he still refuses to take patients who insist that their bills be assigned to a Medicare fiscal agent. Many Medicare patients, he said, "have no need for government help." He said more and more doctors were insisting upon direct billing.

Dr. Rouse said in his speech that "capitalism" was so seriously endangered by people who want "an all-powerful central government" that doctors must "concentrate more attention on the single obligation to protect the American way of life."

He said the profession was "faced with the concept of health care as a right rather than a privilege" and with "many additional social concepts" distressing to doctors.

He named some of these as "price and wage fixing," "emphasis on a nonprofit approach to medicine," "problems of free choice," "increasing coercion," "special attacks in the drug field," and "emphasis on the academic and institutional environment."

Dr. Rouse is considered much more conservative than the outgoing president of the A.M.A., Dr. Charles L. Hudson of Cleveland. He has characterized himself as an "independent conservative" and "a Democrat whose party has left him."

He has served three years as Speaker of the A.M.A.'s policymaking House of Delegates. He is a past president of the Texas Medical Association and the Southern Medical Association. He has been active in the ultraconservative As-

sociation of American Physicians and Surgeons. He is a former director of the Life Line Foundation of H. L. Hunt, Texas oil billionaire.

The 242-member House of Delegates unanimously adopted a statement earlier today saying there was no conflict between medical ethics and the loyalty oath administered to officers of the armed forces.

The statement was adopted as a rejection of the contention of Dr. Howard B. Levy that the physician's Hippocratic Oath might conflict with orders from military superiors.

Captain Levy, 30-year-old Brooklyn dermatologist, was convicted by a military court June 3 of willful disobedience of orders in refusing to train Special Forces medical aides to treat skin diseases in Vietnam, a war he called "a diabolical evil." He was sentenced to three years in prison at hard labor and dismissed from the Army.

Senator MONDALE. Does that kind of attitude create a healthy environent for your proposals?

Dr. ROEMER. I think, Mr. Chairman, there has been a distorted view of the role of government by the private profession. The private physician is inextricably involved with government—Federal, State, and local—in treating several million medicare beneficiaries right now, a program that has worked out remarkably well despite its complexities.

He is involved with the government every day. This does not impede his freedom to make a decision on a diagnosis, to do what is good for the patient. In fact, it helps him to do what is good for the patient.

Senator MONDALE. I don't think we are getting anywhere on this particular argument because I am going to have to excuse myself. Thank you very much.

Dr. ROEMER. Yes, sir.

Mr. ORIOL. I have just a few questions. Both of you have described changes you would like to see for experiments already underway and you called for reorganization of existing services.

The first question is, Where does this reorganization begin? Is the Comprehensive Health Planning Act comprehensive enough to help create the kind of change you would like to see, or would you think that somehow community resources have to be organized and started?

How do you go about reorganizing and getting the kind of changes you would like to have?

How To Effect Change

Dr. JAMES. First of all, with medicaid there are problems which we did not have before, Secondly, there are a number of places in the country where there are people who feel as Dr. Roemer and I feel and are doing something about it, and this is growing rapidly.

Thirdly, there are funds available for special projects such as Office of Economic Opportunity funds, the Public Health Service and some of the health services research funds of the National Institutes of Health.

I also believe it would be very good if the health services research center which has been planned for the Public Health Service gets underway so that it can provide additional stimulation and evaluation in many of these programs.

The question you are asking, I suppose, is what could be done by whom to stimulate more activity in this field. Now that we have money, although we could always use more, I suppose the holding of

hearings such as this, anything which would call attention to the problems, would be highly important.

We were able to get fluoridation of the water supply in New York City by calling attention to the severe problems posed by dental care.

We can perhaps get some action against cigarette smoking some day by calling attention in no uncertain terms to the tremendous hazards of lung cancer.

The problems and cases such as Dr. Roemer and I have described today have not been made generally evident to the public. The public has felt that if there is a clinic, it is available; the individual is supposed to go there, and if he goes there he will get care.

A study done by Dr. Trusell in New York with the Teamsters Union clientele showed that 40 percent of the medical care received by the population was grossly poor care and 95 percent of the people were well satisfied with them.

So we have to make these facts evident, we have to get people to be dissatisfied with the way things are and then they will demand better methods of doing it, and the methods are available.

Now we do not have a sufficient manpower supply in this country of people dedicated to developing these improved programs.

These people have to be trained. Those centers which are capable of doing this kind of program have to be in a position to train others. There should be much ferment along these lines over and above what there now is.

If you are suggesting possible ways for the Federal Government to take some leadership, I would suggest that the supported demonstrations, the development of training programs for others into what these demonstrations can accomplish, the support of the health services research center of the Public Health Service would all be excellent steps.

Above all, methods should be developed to make the American people aware of the conditions as they are now and that there are corrective measures which can be taken.

Mr. ORIOL. Dr. Roemer, you mentioned the Comprehensive Health Planning Act. As I understand it, this act will funnel funds to States so that the State can plan properly for its own needs.

Do you think that this will encourage the type of development you are talking about?

Dr. ROEMER. I think it will, Mr. Oriol, because it will help to make visible the problems of fragmentation and inefficiency that we have both discussed. It will also help to produce data which will educate the public as Dr. James has just suggested.

RISING COSTS TO FORCE CHANGE

It seems to me that the problem of rising costs is going to be one of the strongest educational instruments to clarify that our system of providing health care is not as efficient and effective as it could be.

Throughout the whole history of medical care developments in the world, the problem of rising costs has stimulated improved patterns of organization.

In addition to the suggestions that Dr. James has made, I would agree with those and add one or two others. I think the Federal Gov-

ernment can promote integration of specialty services for ambulatory patients—that is, for patients not in the hospital—by subsidy of group medical practice.

Now this is a private mechanism, the idea of group medical practice, but it can be facilitated by grants or even loans of money for the tasks of organization of group practice clinics and for the organization of prepayment systems to go with them. I think much could be done also by subsidizing or encouraging hospitals through grants to develop outpatient services on a more comprehensive basis.

Such grants could promote what Dr. James described in New York at the Beth Israel Hospital on a much wider scale. There is a very interesting development in the hospital field, what some people have called the "explosion" of emergency room services.

Here is a remarkable increase in the use of hospital emergency rooms by ordinary people, not just the poor.

Mr. ORIOL. Would this be especially true of the elderly?

Dr. ROEMER. Yes. A high proportion of the emergency-room patients are the elderly but the point is that these are not organized clinics. There are a lot of people who come to the hospital today whenever they are sick, not just for hemorrhages or other emergencies but for almost anything, day or night.

There has been an enormous increase in this demand, which I think reflects the problem of unmet need for general medical care in the population.

THE KAISER-PERMANENTE PLAN

We have some other models that I think are worth looking at, especially the prepaid group practice plans like the large one in my State, the Kaiser-Permanente Health Plan. Here is a health program with over 1 million members who are getting comprehensive medical care through health centers and hospitals tied to them on a prepaid basis.

This model I think can be greatly extended if it is assisted through promotion by the Federal Government. I think the State comprehensive planning activities will help to make visible this kind of approach to the problems of medical care for the aged and the young.

Mr. ORIOL. I take it you were encouraged last year when Congress passed legislation to give assistance for construction of group health practice facilities. Do you see any other ways in which incentives could be provided?

Dr. ROEMER. I think that was an important first step. In addition to aid in construction, assistance in the organization of group practice would be valuable, through provision of consultation services and even loans to provide for organization of medical staffs.

For example, the Kaiser-Permanente Health Plan was started by a far-seeing industrialist who had to put hundreds of thousands of dollars into the idea before the first patient was seen.

The Health Insurance Plan of Greater New York is doing a magnificent job, and yet it required something like half a million dollars or more just to get the plan started in 1947, before the first patient saw the first doctor.

A lot of organizational efforts are needed along the way. This money has been provided in the past by philanthropic foundations, by indus-

trial people, and so on, but if it is to be done on a massive scale I think it needs governmental assistance.

Dr. JAMES. Mr. Oriol, there is an important principle here that I think is worth mentioning. When the Government gets involved in medicare and medicaid, it tends to accent quantity of service of a uniform quality instead of putting the premium on quality.

The net effect is that a physician will make more money if he sees more patients. Another effect is that with the deductible features of medicare and medicaid, people are told to get good and sick before they see the doctor, sick enough to spend $40 or $50 of your own money and then we will pick up what is left.

Mr. ORIOL. Let me interrupt. I have a statement from a doctor at Sinai Hospital.[10] And he comments on that point. He says it seems inconceivable that one could approach the problem of elderly people who have much greater than normal health service needs and considerably less than average incomes.

Then he cites barriers to their receipt of care. I refer of course to the deductibles under part A and part B. Is that true?

Dr. JAMES. That is quite true. The general principle is that would it not be nice if the Federal Government could so administer its medical program so that the premium is put on high quality so that if a group would organize a group practice with home care programs, complete continuous care, family care, care for all stages of disease, it could get a higher reimbursement rate.

Actually if a group is going to do this, its costs will rise and it loses money, so the premium is put on getting the cheapest form of care and seeing the most patients in the shortest period of time. This is the way you can get the greatest reimbursement. If the Federal Government would only make it profitable to give high quality comprehensive care, this would lead groups to organize group practices. When they develop those kinds of programs they will get better reimbursement.

This is the general plan behind the regional medical programs. If an area wishes to develop a better program with higher quality care, they can get more money.

This principle is also back of the National Institutes of Health research program. You can get premiums put on excellence, on quality. Medicare and medicaid is just the opposite. Here the emphasis is put on quantity.

THREE-DAY REQUIREMENT QUESTIONED

Mr. ORIOL. I wanted to ask two questions of both of you on that point. We had some discussion here yesterday on the requirements under medicare that a person spend 3 days at a hospital before that person can be assigned to an extended care facility.

The question came up about whether the physician seeing a patient, knowing that that patient really needed let's say a month or two in an extended care facility and did not really need that 3 days in the hospital, that even though there it violates the principle that medicare is really a health insurance program, couldn't that physician sign a certificate in here saying that in his estimate that person should go to the extended care?

[10] See p. 278, app. 2. Letter from Dr. Frank F. Furstenberg, Medical Director.

What is your reaction? Do you think that poses grave difficulties for medicare?

Dr. JAMES. I would be heartily in favor of such a principle. However, there is a point here that is worth mentioning. Many of the regulations of that nature are aimed at preventing financial abuse of the system because if an individual can be admitted directly to an extended care facility, without first being seen in a hospital for a couple of days, the implication is that perhaps he really is not sick enough to require this expensive care.

I think what this means is we must have better supervision of the medical care program.

Mr. ORIOL. Suppose a person were sent to the hospital for a comprehensive medical examination and then if that comprehensive examination so showed that person could then go to the extended care facility.

Dr. JAMES. I would be in favor of sound methods of evaluating the medical care of the patient rather than the counting up of the number of days he has been in the hospital for eligibility.

Mr. ORIOL. I think it was said by Dr. Roemer that most of our hospitals are under 65 beds?

Dr. ROEMER. Under 100 beds.

Mr. ORIOL. Are these hospitals capable of giving the swift comprehensive check up we were just discussing?

Dr. ROEMER. I agree with Dr. James that this may be a difficult way to get a diagnostic workup of the patient before he is admitted to the extended care facility.

It is kind of an admission of the inadequacy of our out-of-hospital services that the law requires in-patient admission for 3 days, which can be a very wasteful matter.

Many of the smaller hospitals can do a proper workup, yes. I could not give an exact percentage. Many of them could not give as good a workup as an outpatient service in a larger hospital or as a good group-practice clinic. I think the important consideration in medicare is to require a diagnostic workup of the patient, with perhaps specified standards being written in as a condition for nursing home admission.

Mr. ORIOL. You think this would save a lot of money and serve the individual better?

Dr. ROEMER. It would serve the individual better and probably then it would save money in the long run, yes. Some of the 3-day-hospital admissions now are essentially abuses; the management of the patient did not really require hospital admission.

Mr. ORIOL. Dr. James——

Mr. MILLER. Mr. Oriol, before you leave this point I would like to direct a question or two to Dr. Roemer on this matter.

Do you have any lack of confidence in the ability of the individual physician to certify a person for extended care? Is your position, as might be inferred from your statement about the complicated workup, suggesting that the individual physician is not competent to certify a patient?

Dr. ROEMER. No, I think many individual physicians would be able to do a proper diagnostic workup in a private office.

Mr. MILLER. You say many physicians. Does this imply that the bulk of them are not able to?

Dr. ROEMER. I would not give a percentage figure. There are many individual physicians who simply don't have the resources, the equipment, the technicians, the X-ray machinery, et cetera, in a private office to do this but——

Mr. MILLER. Excuse me. Do these men have the capacity to recommend hospital care for a patient? Do they?

Dr. ROEMER. Yes.

Mr. MILLER. But they do not have the capacity and professional ability to make such decisions with reference to long-term care? A nonhospital institution?

Dr. ROEMER. I said they lacked the resources, the equipment, the technical staff to do a proper diagnostic workup in a private office.

Mr. MILLER. Then you would say——

Dr. ROEMER. Some of them, that is.

Mr. MILLER. What percentage of the physicians are incapable of making a proper diagnosis of the patient, because this is the crux of the point you are making it seems to me.

Dr. JAMES. I think the problem is not quite that way. When a patient is admitted to a hospital, there are a lot of pressures to get him out of the hospital.

First of all, costs are tremendous; second, there is pressure from other physicians to get their patients in the hospital, so that the tendency is to keep patients from overstaying their need in a hospital. This is not quite true about the extended care.

Mr. MILLER. Thinking about the competence of the physician——

Dr. JAMES. Once you are admitted to an extended care facility, you can spend the rest of your life there, and the pressures are not as great to get out of there. This problem may, therefore, be purely a matter of fiscal controls to keep extra money from being spent and not a problem relating to the competence of the doctor.

Mr. MILLER. That relates to another question as to whether this is the purpose. My understanding of HEW's interpretation of what extended care means is an extension of hospital care presumably involving some degree of acute problem or serious medical situation that initially requires hospital care. As the Medicare Act is set up the purpose of the extended care, as being interpreted in many quarters, is to provide additional care. This is a possible argument for prior hospitalization if this is what it is.

But I have been a little disturbed about the question of the competence of the individual physician to determine the need of that patient for long-term care.

Dr. ROEMER. I won't argue with HEW's interpretation but it seems more reasonable to think of extended care as something that does not necessarily stem from a hospital but from the need for extended care service to the patient.

Now the initial illness may have occurred while the patient is at home, and if a proper diagnosis and decision on therapy can be made while he is living at his own home and is served by a private physician, I believe he should be permitted to enter directly into an extended care facility.

The resources of private physicians for that proper workup varies. I cannot give a percentage figure. I have visited many private physician's offices where I would say a proper workup could not be done.

There are others where probably a very good job could be done. In general, we have seen this great development of hospital outpatient departments, with all the technicians and equipment and auxiliary personnel and so on, simply because the complexities of science are such that it is beyond the financial capacity and the organizational capacity of single individual physicians to provide for these resources.

In general I believe a better workup can be done in any case through a group practice clinic or——

Mr. ORIOL. Simply because of the amount of equipment and number of specialists on hand, is that it?

Dr. ROEMER. Yes.

Mr. ORIOL. Mr. Miller, if you will yield for a minute, Senator Moss has been invited to pay special attention to some of the questions that might arise at this hearing that relate to long-term care. Mr. Frantz is here representing him. I wonder if you have any questions at this point.

Mr. FRANTZ. Yes, I have a couple of questions.

I would like to refer to a comment in Dr. James' statement describing the Beth Israel program. You say at one point that there will be "linkage for medical supervision with nursing homes."

Do you refer to medical supervision of the nursing home program or the individual patient? In other words, sir, does this bring medical surveillance to the nursing home itself?

HOSPITAL—EXTENDED CARE FACILITIES

Dr. JAMES. The hospitals are being urged to develop extended care of nursing home type facilities. There are also a number of proprietary nursing homes which have been working out agreements with general hospitals so that the medical care in these institutions will be under the supervision of the teaching hospital and the patients will go from the hospital to the nursing home, and if they need rehospitalization they will come back to the hospital.

So, by tying in the ambulatory program, the inhospital program, the nursing home program, and the home care program, you are able to embrace the entire scope of medical care.

Mr. FRANTZ. Would you say that what is being done here represents a model at all as to what should be done with nursing supervision in general?

Dr. JAMES. Very definitely yes. There is a move in many States to get voluntary hospitals to go into the nursing home business and encourage them to do this, because in so doing they can literally extend their medical care program over a wider area.

Where there are now proprietary nursing homes, they are being urged to team up with teaching hospital institutions to provide this service. Much more of this should be done. The individual patient and his needs should be paramount, not the given facility in which he may be located.

Ideally, these should all be tied together—same physicians, same general concern over the patient and his needs instead of having a whole new look every time you send him to a new doctor or a new facility.

Mr. FRANTZ. Well, in the pattern of delivery of health services in the future as you visualize it, or perhaps visualizing it as it should be, what is your view of the future of the free standing proprietary nursing home?

Does it have a role in this pattern?

Dr. JAMES. I would say that in the view of the future the status of a free standing anything is in question. All of these units should be tied in together, focusing around the patient and his needs, and not letting the patient filter his way through a large number of different types of services and facilities to try to select what he thinks he needs.

Demand is not the answer to medical care if we are to meet the problems of disease before disease occurs, the risk factors, the early problems of detection.

We must motivate people to go for medical care as a routine when they feel well and then find out the risk factors they should modify, detect the diseases which are detectable, treat them for clinical diseases that occur and start them on necessary rehabilitation programs through the home, the hospital, and the nursing home.

Mr. FRANTZ. Just one more question.

In view of that do you think that we have a shortage of nursing homes in this country? Every day we hear that we need many more nursing homes and we are urged to have programs to build them, and so on. Do we need more nursing homes?

Dr. JAMES. Let me try to answer your question by approaching it a little differently. We have a tremendous number of people who need extended care facilities.

If many of their conditions had been approached at an earlier stage, they would not now be in the position they are.

If we had imaginative home care programs and excellent ambulatory programs, we would need much less in the way of institutions. With the aged population in New York City growing at an alarming rate, we cannot build institutions fast enough; we have neither the time nor the money to build them to meet this type of problem.

ALTERNATES NEEDED

We have got to come up with alternates, and the alternates are effective. We do need more home care facilities; I would hope they would be closer to the hospital instead of the free standing nursing homes. We also need much more in the other way of services to replace institutional care, better home care programs and better ambulatory programs.

The old man I described for you would certainly have ended up in a nursing home and his wife in a nursing home and we might spend $20 a day caring for them, where in their own apartment it would cost $2 or $3. Here they get better service, are much healthier, have more dignity, and are far more self sufficient.

It is cheaper, it is better, and it is more socially desired.

Mr. ORIOL. Dr. James, on home health care I was startled by the limited number you described. What are the big obstacles and don't we need more of that for medicare?

Dr. JAMES. Well, this particular man described for you lives in the Queensbridge housing project in New York City, which is a public

housing project of about 10,000 or 12,000 people. There are about 1,500 aged people in this housing project. Since it was a public project, the hospital working with the city housing authority opened this clinic.

The city housing authority was delighted with it, and so as a matter of fact was Secretary Weaver when he visited it. The Public Housing Authority has asked that every time it puts up a public housing project it demands—not wants but demands—that there be such a clinic in it.

So, a demonstration is beginning to take root and other such clinics are being developed. All new housing projects are going to make actual physical provision for such a clinic.

Mr. ORIOL. How are private housing developments doing?

Dr. JAMES. We are going to develop our own program in our own institutions. Satellite family practice units will be provided so that not only will we have them in our hospital but we will scatter them throughout east Harlem and central Harlem. We will have these clinics for the people in that area.

A group practice with several centers is a similar type approach. Individual physicians can team up and form groups to do this. There are innumerable ways to develop the supporting services.

Our medical center is talking now about teaming up with the health insurance plan, which is a group practice, and working out something with them.

There are all kinds of developments in this field which should be furthered.

Mr. ORIOL. I would like to note for the record that we have another New York Times article here. At the same time that Dr. Rouse was giving his viewpoint a Dr. Kerr White, professor of medical care at Johns Hopkins University, was testifying before the House committee warning that we might be on a path toward chaos in monolithic national health service unless we make changes in basic organization of our services.

I would like without objection to put this into the record and ask in writing for further discussion from our two witnesses.

(The document referred to follows—statement resumes on p. 102.)

[From the New York Times, Friday, June 23, 1967]

U.S. HEALTH CARE TERMED CHAOTIC—DOCTOR WARNS THE HOUSE OF MONOLITHIC SERVICE PERIL

(By Harold M. Schmeck, Jr.)

WASHINGTON, June 22—Health care in the United States might be on a path toward chaos and the eventual emergence of a monolithic national health service, a specialist told a House committee hearing today.

Dr. Kerr L. White, professor of medical care and hospitals at Johns Hopkins University, Baltimore, said changes were inevitable in the organization of medical care, but that the real question was the direction of change.

Dr. White said public dissatisfaction was mounting with deficiencies in the present system.

One possible outcome is a series of major breakdowns, chaos and, ultimately, the emergence of a vast national system, said Dr. White.

Such a system would be deplorable, he warned, because it would have a built-in rigidity, would hamper all change and improvement.

The preferable alternative, he said, is to encourage innovation, experimentation and evaluation of present health care methods. This requires research, but such research is seriously lacking, the doctor noted.

He testified before the House Committee on Interstate and Foreign Commerce, which is considering a law that would encourage health care research.

"In 1967, the total annual expenditures or costs, depending on your point of view, of the health services industry, will be about $45-billion," he said, "less than one-tenth of 1 per cent will be spent on examining the effectiveness and efficiency with which these vast resources are being used in the interests of the patients and potential customers."

To illustrate the kind of research he had in mind and its potential importance, Dr. White cited several studies.

One study, made several years ago in Britain, compared patient fatality rates in hospitals associated with medical schools or other teaching programs and nonteaching hospitals.

Comparison, disease by disease, showed twice as many deaths per 100 hospital admissions in the nonteaching hospitals.

Another study—by scientists at Yale about three years ago—showed that 20 per cent of patients admitted consecutively to one general hospital had bad reactions from drugs, diagnostic or other exploratory procedures. About 7 percent of the patients suffering the reactions died from them.

This kind of study should be repeated at many hospitals, Dr. White said, to see if it is a general experience.

Still another study, by a research team in Chicago, showed that moving an elderly person unexpectedly from one nursing home to another raised the death rate to twice what it would have been had the shift not been made.

In another British study, 19 general practioners in Wales kept notes on the drugs they prescribed during a two-month period. When making a prescription each doctor noted whether he thought the drug was definitely or probably effective for the disease in question or whether it was just possibly useful, or given primarily for its good psychological effect on the patient.

The study showed that only one-third of all the drugs were given because the doctors thought they would definitely, or probably, be useful.

All drugs carry some risk, Dr. White said. The moral of the story in this study, he said, is that doctors often give drugs where there is no clear need for them.

(Subsequent to the hearing, Senator Smathers wrote to Dr. White for additional views. The reply follows:)

THE JOHNS HOPKINS UNIVERSITY,
SCHOOL OF HYGIENE AND PUBLIC HEALTH,
Baltimore, Md., July 17, 1967.

HON. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Washington, D.C.

DEAR SENATOR SMATHERS: Thank you for your letter of July 7, I fully endorse the statements by Dr. George James, Professor Milton Roemer, and Dr. George Silver.

I enclose a copy of my testimony given before the House Committee on Interstate and Foreign Commerce as you requested.

In closing, I would urge your Committee to look with favor on any and all efforts which would encourage innovation, experimentation, and evaluation of our health services and our medical care delivery systems. In addition, I would encourage any efforts towards the systematization of health services into coordinated arrangements for delivering a full spectrum of services.

I hope these comments will be helpful. If I can be of any further assistance, please let me know.

Yours sincerely,

KERR L. WHITE, M.D., *Professor.*

[Enclosures.]

STATEMENT OF KERR L. WHITE, M.D., PROFESSOR OF MEDICAL CARE AND HOSPITALS, THE JOHNS HOPKINS UNIVERSITY

Mr. Chairman, Members of the Committee, I welcome this opportunity to appear before you in support of HR 6418, and in particular of Section 304, pertaining to "Research and Development Relating to Health Facilities and Services".

In addition to practicing internal medicine for a number of years, I have had a long-standing interest and commitment to health services research. More recently I have been responsible for a research and training program in Health Services Administration and Medical Care Research. For about eight years I was a member of the Health Services Research Study Section of the Public Health Service and for four years (1962–66) I was Chairman of that group. Among our activities was the sponsorship of a two volume series of scholarly papers on the present scientific state of Health Services Research both in this country and abroad.[11] The field is well-described in these papers. The needs and opportunities are defined, the methods delineated and the unsolved problems frankly presented. Clearly Health Services Research is a viable field; widely recognized in the United States and other countries.

This morning, I do not intend to dwell on the absurd position of the health services industry in the United States with respect to research and development. In 1967 the total annual expenditures or costs, depending on your point of view, of the health services industry, will be about 45 billion dollars. Less than one tenth of one percent will be spent on examining the effectiveness and efficiency with which these vast resources are being used in the interests of the patients and potential consumers. I doubt if there is any otehr industry, or even any other service system approaching this magnitude, which spends such a trivial part of its resources on research, development, and evaluation. The Bill before you is a small effort to remedy this imbalance. Although the economic arguments may be persuasive from the viewpoints of improving the efficiency with which health services are delivered, and of obtaining better value for the funds expended, there are, I believe, more cogent reasons for supporting HR 6418.

The arrangements for delivering needed medical care in this country are, I believe, less than optimal, in the light of our organizational, technological and scientific capabilities. Public dissatisfaction is mounting, and as some have predicted, reduction of financial barriers to medical care can only compound the organizational problems. The latter are infinitely more complex than the financial problems. Changes in the organizational arrangements for providing medical care are inevitable; the real question is the direction of change. One possibility is that we shall experience a series of major breakdowns in our health services system, and that, as a result, we will gradually move towards a monolithic national health service. I personally would deplore this; not because I am so worried about how doctors are to be paid, but because it would be so difficult to modify any vast national system. Built in rigidities would inevitably make the rapid introduction of desirable change based on new knowledge exceedingly difficult. The other alternative, and the one in keeping with our traditions of pluralism, diversity and healthy competition, is to positively encourage innovation, experimentation and evaluation of present and future arrangements for delivering scientific medicine through diverse health services arrangements and systems. In order to develop and evaluate these new methods of delivering medical care, I believe it is essential to encourage a tradition of research in health services which will emulate our accomplishments in biomedical or laboratory research. The present Bill is designed to encourage and stimulate this tradition.

There is no one "best" method for delivering medical care. I doubt if there ever will be or should be, in this country or elsewhere. Hopefully, there will be a continuing improvement in the arrangements for delivering medical care which is based on research and development. To undertake this work, we need to encourage health departments, hopsitals, professional associations, private entrepreneurs, voluntary agencies, group practices, universities, industries, research institutes and others with the capability and competence to undertake research in this field. My experience with the Health Services Research Study Section and my university responsibilities have persuaded me that there is rapidly growing interest in this field and, what is much more important, a substantial number of talented individuals who would like to undertake health services research. In addition to physicians, dentists, nurses and other health professionals, there are operations engineers, systems analysts, behavioral scientists, economists and others prepared to apply the methods of epidemiology, operations research, systems analysis and the social survey to the problems of

[11] Mainland, D., *Health Services Research,* Milbank Memorial Fund Quarterly, 44: Nos. 3 and 4, pt. 2, 1966.

delivering optimal health services to all the people. Surely one percent of the total expenditure of the health services industry would not be an excessive amount to invest in this endeavor? This would amount to $450,000,000 annually. The appropriations proposed to you, for the next four years, do not approach this sum.

Let me now give you some concrete examples of health services research that have been completed. You are entitled to know what has been done, in addition to hearing suggestions about what can, should or might be done if you approve HR 6418.

One study has shown that the case/fatality rates, i.e. the number of patients dying per 100 admitted to hospitals, for a number of common diagnoses, are about twice as high in non-teaching hospitals as they are in teaching hospitals.

A second study found that about 20% of consecutive patients admitted to a general hospital experienced an adverse reaction to a drug, treatment or investigative procedure. About 7% of these patients died from these reactions.

A third study showed that age-specific mortality rates for aged persons moved unexpectedly from one nursing home, to which they were accustomed, to another home, were twice as great as they would have been had the transfers not taken place.

A fourth study showed a direct and rather strong association between the length of patients' hospital stay for five common conditions, with the rate of nursing turnover in the hospitals studied. The higher the labor turnover among the nurses, the longer the patients stayed in the hospital.

In a fifth study of referral patterns to a university clinic, it was found that for only 40% of the referrals was there evidence in the medical records of any written communication from the referring physician which gave any medical information, even so much as the referring physician's diagnosis, or the area in which he thought the patient's problem lay.

In a sixth study, a group of general practitioners participated in an analysis of their own prescribing habits. They found that only about one third of their prescriptions were for drugs which they believed had a known specific or probably beneficial effect on the conditions for which they were being prescribed.

In a seventh study, samples of patients in two similar hospitals were studied to ascertain the amount and kind of nursing care needed by the patients. It was found in different parts of the country that for at least one third of the patients, doctors and nurses differed substantially with respect to the kind of nursing care needed by specific patients.

Finally, studies using identical methods in three different areas, each with different ratios of doctors, nurses and hospital beds available to the population, showed that four out of five persons experiencing "great discomfort" in the previous two weeks, from one or more of twelve common conditions, had not consulted a doctor about them during that period.

These are all brief examples of health services research bearing on the effectiveness of medical care and on the problems of organizing health services so that contemporary scientific knowledge can be delivered promptly to the people who need it and can benefit from it. Much of our biomedical research will be of little avail until we can make useful preventive, therapeutic and rehabilitative knowledge generated in the laboratory accessible to all the people. In essence, health services research is designed to reduce the gap between medical science and medical service.

To summarize, I have advanced three reasons why I believe we should rapidly increase our national effort in health services research. There is first the "economic" argument. Our arrangements for delivering health services should be more efficient. The experience of other industries and service systems suggests that to spend 45 billion dollars a year without spending at least 1% on research, development, and evaluation may be wasteful.

There is the "organizational" argument. If we are to avoid chaos, if not collapse, in our present health services system, and if we are to move from what one observer has called a "cottage industry" to diverse responsible systems for delivering medical care, we should encourage innovation, experimentation, evaluation and healthy competition. To accomplish this we need to develop a tradition of competence and excellence in health services research which is the equal of our record in biomedical research.

Thirdly, and I believe most importantly, there is the "humanitarian" argument. It is through health services research that we can make health services them-

selves more effective. It is through prompt delivery of useful scientific knowledge that we have the greatest expectation of helping people at the earliest stages in the natural history of disease. Where we cannot cure disease, we can at least diminish disability and alleviate discomfort. That is what medical care is all about.

Thank you for allowing me to testify on behalf of HR 6418; I urge you to take favorable action.

Mr. MILLER. Mr. Oriol, taking a slightly different track on your question regarding home health services I have a question.

In your statement, Dr. James, on page 7 you make the observation that the Public Health Service showed approximately 70 medically directed home health care programs. Information available on the medicare program would indicate that a vastly larger number of home health care programs have been certified.

I would be interested if you have any comment on this.

Dr. JAMES. Yes. The Public Health Service report was only concerned with those home care programs which are medically directed. Every visiting nurse service in the country has home care services and there are others in county health departments that have been certified for home care to medicaid patients. A medically directed home care service means that there are physicians and physicians' services available to go to the home under medical direction.

This is an integrated complete home care program.

Mr. ORIOL. Mr. Norman do you have a question?

Mr. NORMAN. Yes.

Dr. James and Dr. Roemer, both of you have discussed the desirability of group medical practice and Federal action to stimulate more group medical practice.

Is your recommendation of this type of delivery of health services based upon the economy of this method of providing health services or on the quality of services that can be provided or some other reason supporting group medical practice?

GROUP PRACTICE ADVANCES

Dr. ROEMER. The evidence is that both of those achievements are possible.

Mr. NORMAN. You can provide better medical service at less cost by group practice?

Dr. ROEMER. Yes. It so happens that the President's Advisory Commission on Health Manpower made a contract with my university to undertake a study of this nationally with respect to the very question you ask, the effects of group practice on quality and on economy.

The best evidence we could gather based on studies made over the last 30 years suggests that the teamwork idea found in group practice reduces the costs per unit of service and increases the quality of care in general.

Now, to back this up with facts and figures would take a long time, but this was our basic finding.

Mr. ORIOL. Dr. Roemer, you have been working on a study of just this, have you?

Dr. ROEMER. Yes.

Mr. ORIOL. Will the findings or excerpts be available for our record?

Dr. ROEMER. This is now in the hands of the National Commission on Health Manpower.

I trust the report—we submitted a report of several hundred pages—will be made public.

Dr. JAMES. I would like to comment on this matter of cost because it is a very difficult item to play with. If you wait until people come for medical care, and if you make medical care difficult enough for them to receive as it was difficult for the old man that I described, then costs are low. On the other hand, if you invite people in routinely for medical care, even if they are not feeling sick and you uncover a large number of conditions and give the proper care for them, the costs may well go up.

If you look at costs in a "cross section right-here-now concept" this is true. But if you look in terms of the tremendous cost of putting the old man and his wife in a nursing home for 5 or 10 years and the tremendous cost of repeated hospitalizations, if you look at the problem over a long term, you get a different idea.

So one cannot be too quick about assessing the cost. If in New York City I test 100,000 adults, I will find a thousand with diabetes, and the cost of treating those 1,000 heretofore unknown cases of diabetes is appreciable.

If I had waited until they got sick enough to go to a doctor for symptoms, then I would have saved the money in between, but what about the huge amounts of money it is going to cost from now on?

Mr. NORMAN. Is it going to cost much more money in the long run?

Dr. JAMES. I believe so, although enough careful studies have not been done. The advantage of picking up diseases early is incontrovertible. If you want to say we cannot as a nation afford to be healthy, this is a strong statement.

Mr. NORMAN. Pursuing a little further this line of questioning about group medical practice, one of our subcommittees of this committee, our Subcommittee on Employment and Retirement Incomes, has recommended very strongly that professional service corporations be recognized by the Treasury Department and that the Internal Revenue Code be amended to clarify the right of doctors to incorporate and to receive the tax advantages of incorporation.

Do you think this might be an appropriate means of stimulating group medical practice? That is to say by statute that if they will group themselves together in an approved fashion, that they can organize corporations and be recognized as such for tax purposes?

Dr. ROEMER. This is a very complex legal question on which I don't presume to be an expert. There are, however, a good many States that prohibit the incorporation of doctors.

Mr. NORMAN. I know but this would be only if the State permits incorporation.

Dr. ROEMER. I was about to say that that prohibition has actually——

Mr. NORMAN. More and more States are permitting professionals to incorporate.

Dr. ROEMER. Yes. The history of these prohibitions, I think, is a case of a justification having existed some years ago that ceases to exist now. There was an objection to a large corporation, such as a mining company, hiring doctors and perhaps even profiteering on the doctor's work, and this was one of the reasons that the laws in many States banned the corporate practice of medicine as it was called.

Well, the situation has changed and when we think of incorporation of a group practice clinic or, for example, the hiring of doctors by a hospital, pathologists or radiologists, this has a totally different meaning in the context of the corporation law.

So I would tend to think that any Federal law which would permit incorporation of medical practice with appropriate controls would probably promote group practice organization.

Mr. NORMAN. Just one followup question. Then you would say that permitting doctors to incorporate for Federal tax purposes would probably further this highly desirable objective of stimulating group medical practice and that it would be an appropriate means of doing so?

Dr. ROEMER. I am not aware of all the detailed implications, but my first reaction would be yes, that it would be helpful.

Mr. NORMAN. Do you have an opinion on that, Dr. James?

Dr. JAMES. I am in favor of anything that would stimulate group practices as long as it means we stimulate the ones we are proud of. I am just not competent to judge the economics and legal aspects of the solution you suggest.

Mr. NORMAN. Thank you very much, Gentlemen.

Mr. ORIOL. If I could interrupt we have a statement from Walter J. McNerney, president of the Blue Cross Association. I don't believe there is a Blue Cross Association representative here.

His statement will be put into the record but it includes a section on the need for organized medical practice, either a group practice plan or, as this is, methods.

That will be inserted in the record and will send a copy to you for whatever comment you make.

(The statement referred to follows—testimony resumes on p. 107.)

STATEMENT OF WALTER J. McNERNEY, PRESIDENT, BLUE CROSS ASSOCIATION

Mr. Chairman, it is a privilege to offer this testimony to the Subcommitte on Health of the Elderly of the Senate Special Committee on Aging, discussing the delivery of health services to older Americans. Blue Cross has a strong and continuing interest in this subject, having written over five million contracts for senior citizens before the advent of Medicare, and now being so actively involved as an intermediary under Medicare as well as a carrier for complementary coverage.

In the capacity of intermediary and carrier, in regard to elderly persons, and, in fact, to all age groups of the population, we have a strong interest in seeing that health services are effectively rendered at a reasonable cost. Health care costs are rising at a rate which is measurably greater than the increase in wages and earnings. If this disparity were to continue at the present rate, the ability of several groups in our population to afford care would be jeopardized. Those elderly persons with relatively fixed incomes would have to be classified among these groups.

Because the health economy lacks a number of the checks and balances of a free market, it is necessary for all of us involved in the health field to formulate incentives and develop sensitive controls which effectively allocate resources into the most productive channels. Many important controls exist today, in the form of self-imposed professional controls, fiscal or legal controls. Some of these are wide-spread, others must become more wide-spread to be effective. Still others are yet to be fashioned.

Two major challenges are: 1) To affect favorably the cost of health services without jeopardy to quality, and 2) to merge or adjust some of the various controls so that they are mutually reinforcing rather than overlapping or contradictory.

The first suggests the need for added benchmarks on quality to assure the public that as costs are affected, quality will remain high. The second suggests that we need to have a more conscious relationship among standards and other controls such as that, for example, between State agency certification of hospitals under Medicare and accreditation by the Joint Commission on Accreditation of Hospitals.

THE EXPANDING ROLE OF HEALTH PREPAYMENT

In its early years, health prepayment focused to a great extent on making medical services available to people who otherwise would not be able to purchase them, and correspondingly making it possible for providers of care to render service by insuring a stable financial basis. These objectives are still valid. However, if there has been a major change in the role of health prepayment plans, it is that they must increasingly accept a responsibility to participate in affecting the way service is rendered. That is to say they must participate in the development of visible instruments in the health care system which demonstrate to the public that health care dollars are being effectively spent.

With this in mind those of us who are involved in health prepayment have given and are continuing to give increasing attention to such programs as the following:

(1) Participation in areawide planning. Most Blue Cross Plans participate in this important community-wide activity. A few Blue Cross Plans have experimented with relating participating status of institutions to their status in an areawide plan.

(2) Accreditation and licensure. Among some Blue Cross Plans reference is made to these as a condition for full participating status as a Blue Cross member hospital. In nursing home coverage Plans are considering voluntary accreditation and Medicare certification as important criteria.

(3) Utilization review. Inside and outside Medicare there is growing insistence on the need for the hospital to monitor its use from an economic as well as a clinical point of view and a growing determination by Plans to provide data and other assists to make this possible.

(4) Claims administration. The claims review process provides information that makes it possible to develop parameters of use to select cases falling outside these parameters for discussion with physicians and other providers of care.

(5) Reimbursement. Ways are being sought to make the payment in itself an incentive for more efficient care. This can come about through spirited negotiations on the cost formula or built-in incentives of an economic nature. Let me say here that I feel that such devices as deductibles and co-payment, intended to serve as consumer-related incentives for appropriate use of services, have very little application in the payment of health care expenses. They are particularly inappropriate among the elderly, where their potential effectiveness in deterring overuse is overweighed by their potential promotion of underuse. These are devices which should be reserved in prepayment for the small repetitive expenses where the cost of administration could otherwise become excessive.

(6) Breadth of benefits. Yearly, the range of benefits available to all segments of the population is growing significantly. This growth increasingly serves to protect individuals, among them elderly persons, against financial hazards of illness. Also, broader benefit patterns that include coverage for services outside the hospital take the pressure off the physician to concern himself with his patient's personal financial situation before prescribing desirable although expensive services. Therefore, such patterns act as an encouragement to early diagnosis and treatment at the same time providing alternatives and other reasonable approaches to post acute care.

Here, I should like to take special note of drugs. They are a considerable expense to the average older pension. Fortunately, they are now beginning to be covered under Title XIX programs where such exist. What is needed immediately is more activity in the drug benefit area in the private sector. Here again, however, we must face up to the problem of control. What about the pros and cons of generic vs. brand name drugs? Can exploitations of various kinds be dealt with effectively? There are many hard decisions to be made. Most importantly, however, we should make the benefits available, and then address ourselves on a continuing basis to the issue of professional, fiscal or legal controls in the public interest.

ORGANIZATION OF HEALTH SERVICES

While it is important that prepayment agencies continue to pursue these objectives and to enlarge their role, other areas must also be taken into consideration. There remain some problems outside the scope of what I have discussed thus far that need the attention of our health statesmen and our legislative bodies. Too many health care facilities dealing with chronic illness are anachronistic and geographically remote. There is a significant need to update the capacities of nursing homes, certain chronic disease hospitals and rehabilitation institutes, and to relate them more effectively to the general hospital and the balance of the health community. Whereas the purchasing power of private prepayment and government programs is reaching out in these directions, special appropriations are needed to stimulate the proper capital growth of the structures required. The total result is important on a community-wide basis. If we are to achieve the proper relationship of private practice to hospitals, to health departments, to post-acute care, etc., there must be in each State an overall planning mechanism concerned with program and facilities. Thus the sensitive implementation of PL 89–749, with proper roles and representation for community health services and organizations, becomes important.

A major need is for prepayment agencies among others to evaluate various organizational forms of rendering health services. At the present time, there exists a wide band of practices in the provision of personal health services. For example, one finds physicians practicing in a solo capacity; others in solo practice but sharing joint office facilities; still others sharing income as well as office facilities; some groups constituting a hospital staff such as at Henry Ford Hospital in Detroit; and others in groups some of which are related and others not directly related to a hospital.

Further, one finds a wide range of payment mechanisms employed in paying for physicians' services. Some of the various patterns mentioned above receive payments on a traditional fee for service basis. Some are paid through a prepayment mechanism tied directly to the group of physicians and their services such as HIP in New York, and some represent combinations or variations of each.

There are those who feel that a comprehensive prepaid group practice pattern is highly productive and effective. Others feel that more informal organization and more traditional methods of financing are desirable. In all probability, some practitioners will always prefer one type of practice to another. Some may be better suited to one type of organization than to another. However, in a decade when the need for productivity is so compelling, it is extremely desirable to weigh the advantages and disadvantages of various prototypes. What are, in fact, the use, cost and professional strengths and weaknesses of various organizational patterns of medical practice? If there are quantitative or qualitative advantages to any given form, the public has a right to know about it. I have called previously for objective studies of the situation by leading associations such as the American Medical Association and the American Hospital Association. I call for them again. Further, I think any laws which artificially prohibit associated practice on the part of physicians, wherever it may be along the scale, should be struck down unless they can be directly related to either moral or ethical considerations inimicable to the best interests of the public.

At the moment, we are in a position where the whole topic of associated action by physicians is overcharged emotionally. This bears in turn upon a lack of definitive information. With costs and delivery of health services now a matter of major public policy, such information is essential if we are to avoid precipitous actions or pursuit of avenues which could lead to underfinancing or undercare.

PROGRAMS FOR THE ELDERLY

Specifically in regard to the elderly, I feel that Medicare is performing a great service. Title XIX programs, as they develop, stand to add considerably more assistance. With complementary coverage in the private sector for those with adequate purchasing power, the capacity of Titles XVIII and XIX, properly administered and implemented, can solve most of the major financing problems of older persons. We must change Public Law 89–97 on the basis of experience. I have testified elsewhere regarding the need to simplify the benefit structure under Title XVIII and various administrative considerations under Title XIX, and I feel these changes will take place—if not this year, next. Many carriers

are offering highly useful benefits on a complementary basis and the enrollment has been impressive. For example, under Blue Cross, we have already enrolled almost 90% of the number of senior citizens that were enrolled before Medicare began. However, we see again some grandiose claims made by a minority of carriers regarding benefits which are not as substantive at the time of illness as one may have believed.

Finally, I think that we find the elderly in a better situation than before July 1, 1966. In fact, encouragingly so. We need, however, to push forward along the lines I described if we are to avoid losing the gains made for them as well as for the rest of the population.

Mr. MILLER. I have one question of Dr. Roemer related to this question of group practice and the need for Federal subsidy through grants for the establishment of group practices.

Is there any evidence of serious inability of physicians who desire to enter together in a group practice to obtain loans and financing?

Dr. ROEMER. There is evidence of an extremely slow growth of multispecialty group practice. I have seen data from the American Medical Association which give the latest counts on group practices organized throughout the country, since the last previous national survey which was in 1959.

The trend of the last 8 years has been one in which a great many partnership groups of doctors in the same specialty have been formed—for example, three or four radiologists coming together or two or three obstetricians coming together. This has occurred at an impressive rate.

This is convenient for the doctor, but it makes little advantage for the patient. The multispecialty groups have hardly grown at all, as a rate, over the last 8 years and this would suggest that some assistance might accelerate the growth of multispecialty groups.

Mr. MILLER. My question, however, is directed to the need for such assistance taking the form of loans or grants to the physicians. It would appear to me that a group of physicians would be regarded by most lending institutions and other private sources of money as a preferred risk.

Dr. ROEMER. Yes; I think that is true. I did not say the loans or grants should go to the physicians. I said they should go to assist in the organization of group practice and prepayment.

Mr. MILLER. The combination?

Dr. ROEMER. The combination, I think, is most important, but even perhaps group practice alone could be facilitated by the availability of an administrative person to help in working out the very thorny details of bringing together a group of specialists under one roof. There are problems of professional relationships, of real estate, equipment, and so on. This has become almost a technical specialty, the task of administering and organizing a group practice organization.

Mr. MILLER. With relation to the prepayment aspect I would gather your point might be a little different from that of Mr. McNerney in view of Mr. McNerney's role for the Blue Cross and Blue Shield type of prepayment approach.

Dr. ROEMER. I have not seen the statement but I believe the combination of prepayment with group practice provides still greater advantages than group practice alone.

Dr. JAMES. Actually, these groups work in some areas, with Blue Cross, the health plan in New York. Kaiser, of course, has its own hospital program.

You see, prepayment is extremely important for many things I have tried to say because it permits people to come for care before they have serious symptoms. It is a treatment program for the total individual at all times and encourages his coming for the so-called preventive type services.

Mr. MILLER. Would it not then perhaps be more proper to voice the recommendations as a recommendation for subsidized loans or grants to group practice prepayment plans?

Dr. JAMES. It would be a higher priority. Perhaps group practice without prepayment might be an interesting evolutionary step along the way.

Mr. ORIOL. We now have about seven cities or eight cities that again have group practice, isn't that then about the total?

Dr. JAMES. Very few.

Dr. ROEMER. I recall a situation in a county of West Virginia some 20 years ago where a group of physicians attempted to organize a private group practice. This was not with prepayment, simply a group practice.

The difficulties were tremendous. There was objection by the other physicians in the community. There were difficulties in acquiring a building. There were difficulties in recruiting physicians, and so on. The mere tasks of organizing this group practice, which, after some years, did take shape, could have been aided by the services of a person who could work on these problems. Physicians are busy. They don't have the time and they don't know many of the details of business management. It is this kind of service that I think can be of assistance.

Mr. MILLER. What was the focal point of the organization of this particular group?

Dr. ROEMER. A surgeon and a pediatrician and a few others who wanted to get together to organize a clinic. I recall a similar development in my hometown in New Jersey.

PUBLIC INTEREST IN GROUP PRACTICE

There are simply technical problems along the way. If we regard the rendering of medical care as something with great public interest, something that affects the welfare of people, I think it quite reasonable to invest public money in improving quality through group practice, just as we invest in improving medical education or improving the quality of hospitals.

Mr. MILLER. The inability to get a building and similar technical difficulties, however, does not relate to their inability to have obtained money, if the other problems are resolved. This, I think, is essential to the question I am directing.

Dr. ROEMER. You may be right. It is not just a question of money; it is a question of technical expertise. I would not want to imply, however, that the nonprepaid group practice is as important as the prepaid type.

It seems to me that prepaid group practice has numerous additional advantages, and that certainly requires organizational assistance.

Mr. ORIOL. With two such knowledgeable witnesses it is tempting to keep up the questioning. I am looking at the clock. We now have an hour and a half before we must cut short this hearing.

I would like to note for the record that several written questions will be submitted to the two witnesses. For example, Dr. James, you mentioned the growing numbers of older people in the central city area.

Father Cervantes has in his testimony a reference to the central city burden. The question that we will put to both of you is, how can we get the kind of special attention that such areas require?

Another question, perhaps I can get a word of comment from Dr. Roemer now, you refer to a vast jungle of medical care plans and agencies. Now this was when you were talking about the kind of organization you see for the future.

I take it that you don't mean that we scrap existing private agencies. I am impressed with the Project Well-Being in Detroit and how a private agency with Federal help and assistance from all over the community organized an effort.[12]

Dr. ROEMER. Yes, I think it is a task of articulation among the agencies. We have roughly 100,000 voluntary health agencies in the United States, according to Dr. Hamlin's study a few years ago from the Harvard School of Public Health. There is great duplication among them; there is extravagant use of administrative funds, and so on.

In the health insurance field there are well over 1,000 separate organizations. If the energies and dedication of these people could be mobilized and coordinated, I think we would get a much better product for our dollar.

Mr. ORIOL. Another question which will be asked is whether medicare and medicaid are encouraging or perhaps putting obstacles in the path of the reorganization you would like to see.

Dr. ROEMER. It seems to me that the design of the medicare legislation is rather effective at this stage in building its program into the existing structure; that is, the existing insurance programs, especially Blue Cross and Blue Shield, have been incorporated into the operation of the system so that their skills have not been lost, but have been mobilized.

The provision of financial support for hospitals and extended care facilities and home health agencies has certainly been a boost to their availability and the improvement of their quality.

Dr. JAMES. I believe very strongly that where Government funds are used to support medical care, the Government has a responsibility to insure that these funds will be used to improve the quality of that care.

Mr. ORIOL. Again, I would like to thank you.

Dr. Roemer I would like to mention that Senator Williams of New Jersey hoped to be here to say "hello" to an old constituent. He is on his way and will be here shortly.

Thank you again for your testimony.

I would like now to call Father Lucius F. Cervantes, S.J., Ph. D., professor of sociology, St. Louis (Mo.) University, and assistant to the mayor of St. Louis.

I would like to note for the record that we have a letter here from the mayor of St. Louis and it will be put into the record at this point.

(The letter follows:)

[12] See pp. 135–138 for additional discussion.

OFFICE OF THE MAYOR,
CITY OF SAINT LOUIS, MO.,
June 13, 1967.

HON. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Washington, D.C.

DEAR SENATOR SMATHERS: I welcome the opportunity to be of some assistance in obtaining professional testimony for your Subcommittee on Health of the Elderly, Senate Special Committee on Aging. I recognize your eminent endeavor as one of the critical thrusts of the War on Poverty and as one of the firm bases of the Great Society.

The Health Legislation of 1965 established through our democratic processes that the opportunity for quality health services for every citizen of the United States, irrespective of age or race or economic condition, as a matter of right has become a matter of conscious social policy.

As the Mayor of one of our nation's central cities, I was acutely aware that older Americans were not obtaining the type of health service that our country's genius and prosperity should be able to afford. I am likewise very much aware that despite the great advances made in the provision of quality health services through Title XVIII and XIX of the Social Security Act, that our goals in this area are by no means attained. There are persistent problems in obtaining adequate health services for the disadvantaged who are increasingly concentrated in the center cities of our metropolitan areas.

I am happy to have been able to cooperate with the Special Committee on Aging's staff director, Mr. William E. Oriol, in obtaining local resource persons who would be knowledgeable in the field of your investigation. Our common goal of assuring an equal opportunity for all citizens to obtain a high quality of comprehensive health care has been a bridge of mutual interest and cooperation.

Sincerely yours,

A. J. CERVANTES, *Mayor.*

Mr. ORIOL. I also would like to note that Father Cervantes has within just two and a half or fewer weeks given us a comprehensive and very helpful collection of statements from knowledgeable people in St. Louis and that, too, is here today.

Are you going to give excerpts from all of the statements?

STATEMENT OF REV. LUCIUS F. CERVANTES, S.J., PH. D., PROFESSOR OF SOCIOLOGY, ST. LOUIS (MO.) UNIVERSITY, AND ASSISTANT TO THE MAYOR OF ST. LOUIS

Reverend CERVANTES. I could, Mr. Oriol. I do have another statement here, too, and it is from Dr. William Danforth, chancellor for medical affairs at Washington University in St. Louis.

Let me say that I will be very brief. I know that your time is limited.

Mr. ORIOL. Father, we have an hour and a half and we have one more witness, so perhaps we could parcel out 45 minutes to each witness and not cut it too short. You have a wealth of material to work with.

Reverend CERVANTES. I would summarize immediately a key point. It is the question of the central city overburden. More specifically in all of the literature that I have read on health problems, practically nothing was stated about the selective concentration of the disadvantaged, including the elderly, in the central city and the selected deconcentration of the affluent into the suburbs.

Mr. ORIOL. Father, may I interrupt at that point to tell you, you were not here when Dr. James made this statement and I think it bears on what you are saying here. New York City, with a fairly stable

total population size, is aging by 20,000 persons a year. By 1970, we expect to have 1 million persons over the age of 65, making New York's aged the sixth largest city in the United States, just the aged population. I thought you would be interested in that point.

Reverend CERVANTES. This is just half of my point, though. It seems to me you have stated, Mr. Oriol, quite correctly and quite pertinently that we do have a growing escalating population of the aged.

However, this is just half of my point. My total point is that not only are the aged concentrating in the central cities but the central cities are incapable of supporting them. Central cities are not capable of supplying even the basic services for their citizens.

In the city of St. Louis, and I think it is rather representative of the country, there are already 15 percent of the population over 65; whereas, in St. Louis County, there are only 6 percent over 65. The affluent county has less than half the percentage of elderly than do the bankrupt central cities which are no longer capable of supporting the growing masses of disadvantaged which are being concentrated there.

May I draw the attention of this subcommittee to the study of TEMPO, General Electric Co.'s center for advanced studies, which found that the Nation's cities face the staggering revenue gap of $262 billion during the next 10 years. The study likewise points out that without any Federal tax increase the Federal Government during the next 10 years will have a revenue increase of one-third of a trillion dollars.

Within the next 10 years not only will 10 of the larger central cities be predominantly Negro—and this dramatizes our problem by putting into it the element of race—with the surrounding suburbs a white noose of the affluent, but likewise the central cities are going to have a revenue gap of $262 billion.

So when Senator Smathers comments to the group here, "I am going over and confer about the space program which has a yearly budget of approximately $6 billion"; or when Mayor Cavanagh at the U.S. Conference of Mayors mentioned that "in the 3-year period ending next June, we will have spent 13 times more on the space program than for all of the programs managed by HUD"; or you read that without scarcely debate or dissent a $70 billion defense budget is readily passed but only with the greatest of difficulty is $12 million provided in the model cities program for planning grants for the rejuvenation of the central cities, we can readily see that there is an intolerable priority lag in this country's recognition of the crisis of our central cities.

So what I am saying is this: that, even though $2 billion a month is being spent on Vietnam and many people say that, "Well, after the war is over we will try to get a great deal of that money into the central cities," still $2 billion a month would not take care of the grave needs of the central cities of our metropolitan areas.

URBAN INCIDENCE OF ELDERLY

To try to state this more succinctly and more to the point of health care for the elderly, in the city there is more than twice the incidence of elderly than in the county. Furthermore, those elderly who are in the suburbs or in the county are better able to take care of themselves

financially, to obtain the health care needs that they have than the growing number of elderly within the central city.

Since one out of three of those over 65 years of age in the United States have an income of $1,000 or less, and since the impoverished elderly are by central tendency gravitating toward the central cities we come to our key question: "Has medicare under its present limitations been advantageous or disadvantageous for the elderly poor within the central city?"

I would like to include in this testimony statements from various knowledgeable individuals in St. Louis bearing upon this question. At this time I would also like to make several comments upon these statements.

On page 1 we have the testimony of Elmer M. Johnson, the associate director of the Metropolitan St. Louis Hospital Planning Commission. He is speaking of home health service agencies. His statement gives rise to the following thought.

It costs about $50 per day for hospital care, $20 per day for nursing home care, and $3 per day for home health care. U.S. citizens would not be getting their money's worth of health care for the elderly if they are paying $50 per day for hospital care or $20 per day for nursing home care for a person who could readily be taken care of for $3 per day with home health service care.

But the disadvantaged and the city governments have to take advantage of what is available to them. At present the home health care services are not available to them through medicare. Consequently they take the higher cost health services.

Mr. Johnson's specific suggestion is to add home health services to the present list of five health services that are available under the medicare legislation.

Intermediate Care Needed

We next come to a related topic developed by Dr. Bernard Friedman, a medical director and superintendent of one of our St. Louis hospitals. He is speaking of intermediate care. Many patients, he observes, do not need the intensive care of a general hospital but require general care greater than is available in a nursing home or in their home. For these patients Dr. Friedman suggests intermediate care.

I would like to read part of his material that refers to the fact that the type of care needed by many elderly patients is not strictly medical care but social care.

He states:

> The problems that occur over and over again are social conditions that prevent the transfer of the patient back to the home or apartment from which he came. A third floor apartment of a patient who is short of breath because of emphysema, a toilet in the basement of a patient who has already fallen once and broken her hip going down stairs, a patient whose neighbor has in the past done her shopping and looked in daily but is now moving to another location—these are the kinds of problems that may actually make the difference between sending a patient home or to a nursing home. There is no question in my mind but that there are thousands of patients in nursing homes who have been transferred there not because they need to be in a nursing home, but because of the social problems involved in the patient living on the outside.
>
> Two patients can reach the same levels of self-care with the same diagnosis. One can be discharged to a family eager and waiting to have him back, another cannot be discharged because the home circumstances are unfavorable.

You will notice this theme of "social" rather than strictly "medical" care is a frequent theme in the testimony from St. Louis. For instance it is elsewhere remarked that there are 13,000 individuals who are in mental health institutions in Missouri. A great percentage of these could be returned to their homes if the social conditions and care were adequate.

> The extension of home health services, home care, and such services as meals on wheels would help tremendously in keeping the elderly, chronically ill patients in their home. In working with these elderly people we find that an adequate social service staff both in the hospital and for out-of-hospital care is indispensible. At our intermediate care division all efforts are made to prevent permanent institutionalization.

He concludes:

> On the other hand, a significant number of patients that we still send to domiciliary care institutions or nursing homes could be discharged home if some of the social problems of home care could be solved.

I know that this committee and subcommittee are working on this problem, but nevertheless it gives support to your overall emphasis of the social needs of the elderly as far as health care is concerned.

The next paper is from Dr. Morris Alex. Dr. Morris Alex stresses my previous thesis of the central city overburden in contradistinction to the suburban underburden in relation to the provision of quality health service for the elderly when he states—"in the city of St. Louis in 1960, 12.3 percent of the total population was 65 and over. By 1970 it is estimated that it will reach 15.3 percent. By the same token, it is estimated that in St. Louis County the percentage will be 6.4 percent."

He goes on to develop the fact that in the State of Missouri more than 100,000 are on old-age assistance, that 13 percent of these elderly are located in the city whereas only 2.7 were in the county. This observation reverts to our same thesis of the completely different type of tax base and of services available in the city and in the county.

The next paper is from St. Louis' director of health and hospitals, Dr. Herbert R. Domke. One of his insightful observations is a corollary to our basis thesis that the central cities are bankrupt. I might point out in passing that, in 1900, 51 percent of the total Government taxes in the United States were collected by and accrued to the municipalities. Today the municipalities' share of all taxes is not 51 percent but less than 15 percent.

Obstacles to New Programs

Dr. Domke points out that because of their straightened financial condition the central cities are no longer capable of independently initiating new programs. They don't have the money. They must follow the Federal leads in order to get more adequate financing through the Federal Government. They must forego their own initiative, and their own creative programs to abandon themselves to Federal grantsmanship.

Let me just give you an idea of what our health and hospital system is in St. Louis.

The following dramatized but adequately accurate account is taken from one of our local papers from this present week:

PATIENTS WAIT FOR HOURS FOR HOSPITAL TREATMENT

(By Jim Floyd, Globe-Democrat Staff Writer, June 20, 1967)

While two doctors struggled heroically with a massive case load at the City Hospital emergency room Monday night, more than 100 sick and injured St. Louisans waited long hours for treatment.

The case load at the emergency room for Monday up to 10 p.m. was 312. For all day Sunday it had been 273. On previous days the total case load had been 252 and 254.

While the doctors handled emergency and police cases the rest of the people waited . . . and waited.

"It's the heat that brings many out," a hospital clerk much too cynical for her years said.

But the emergency room is a producer of cynicism.

"They take the drunks and hoodlums first," a woman supporting a badly swollen ankle complained, "they don't want to hold up the police."

She said she had been waiting for 6 hours.

"I need the hospital," one elderly woman said. "It's terrible. It's dirty. The service is miserable. But it's all I have."

One woman brought her sick cousin into the hospital at 6:30 p.m. She was still waiting at 10 p.m.

"I complained so much they finally took his temperature," she said. "I don't know when they'll get around to doing anything else for him."

Another woman, Mrs. Evelyn Glenn, 1604 South 14th St., hadn't been waiting "too long." She brought her daughter Alice into the hospital at 8:30 p.m. At 10 p.m., they were still waiting.

Alice had stuck something in her foot and it had become infected.

A member of the Chouteau-Ruskin Gateway Center Committee for Better Municipal Services, Mrs. Glenn pointed around her to the people strapped to stretchers, propped up on benches and sleeping in the waiting room.

"Something's got to be done," she said. "We've been talking to Mayor Cervantes trying to get better hospitals and better emergency care. If more people could see this maybe they'd start listening to us."

It so happens that the city of St. Louis is already spending $25 million—one-fourth of its limited budget—on its health services. It so happens that the administration and staff of this hospital system are unusually competent and dedicated. But it is also true that St. Louis as other cities should be spending far more to provide quality health services to their disadvantaged and medically indigent citizens. Municipal health services have deteriorated and this inadequacy of service is characteristic of the total spectrum of city services for the simple reason that the cities are all but bankrupt. We must bear in mind that the cities during the coming decade will have a revenue gap of $262 billion. The quality of city life in the United States will continue to deteriorate until Congress faces up to the fact that our central cities are just as fine targets for $6 billion per year programs as is the moon and that the slums of our major cities are in many cases in a worse condition than were the cities of Europe when we established the Marshall plan for their recovery.

Speaking of ravaged cities in need of a Marshall plan for the cities of the United States let me give you the example of Cleveland. Not so long ago the New York Times News Service (April 8, 1967) carried the story of the "last firms leaving ghetto in Cleveland." My point is not that firms are leaving the ghettos in our central cities. They have to. They can't get insurance. But my point is that in Cleveland—a harbinger of what is yet to come to other central cities—the insurance companies are hesitating to supply insurance and consequently economic viability to any firm within the central city. Let me

quote this report at length so that there will be no doubt in your mind as to the radical seriousness of the crisis of the central cities:

> Since last summer's outbreaks segregation has increased and tensions are building anew. The insurance industry sees unusual risks here. The Home Mutual Insurance Co., of Binghamton, N.Y., wrote to its local agent that "quite frankly, we are concerned at the racial situation in Cleveland and feel that quite probably the next blowup will not be confined to any particular area," it was learned.
>
> The company's agent, William E. Wilson, wrote to Mayor Ralph S. Locher that all insurance carriers were "extremely cautious about writing any type of insurance within city limits * * *." (St. Louis Post-Dispatch, Apr. 9, 1967, p. 4 K.)

Does the economic community wish to seal off its central cities and segregated ghettos to let them disintegrate in their own racial frustrated confusion? This is already happening in the Houghs and Harlems and Watts and core cities throughout the country. There is a central city crisis in the United States.

But, you might ask, what does this have to do with quality medical care? And the answer is that health services for the elderly is just one small facet of the total urban social situation. A city is a social system of interrelated dynamic components. Health care, employment, housing, transportation, tax structure, education—all are interrelated and interdependent. If ghettos spread, housing disintegrates, crime becomes rampant, insurance companies withdraw coverage, industries withdraw, hardcore unemployment and welfarism become a way of life, and city administrations economically castrate and impotent, there can be no question of quality health services or quality municipal services of any type.

Municipal Budgets Drained

But let me return to the paper of our highly competent director of health and hospitals, Dr. Domke. Commenting upon the practical consequences of the inadequate budgets available to directors of municipal health and hospital systems.

Since municipal health service budgets are so inadequate the directors must devote a dysfunctional amount of their time and energy to "grantsmanship" in order to render their local health service systems eligible for Federal grants. This means that the interests and commitments of the Federal Government in health services must become the interests and commitments of the local directors of health and hospitals. Dr. Domke points out that health service is a continuum starting with preventive medicine, continuing through hospital care of acute and chronic disease, and stretching through rehabilitative services. Traditionally the Federal Government has concentrated on assisting local governments with the most expensive portion of this continuum: the provision of the brick and mortar aspects of hospitals. Local hospital and health directors have consequently had to concentrate their limited resources in innovative efforts in hospital buildings. Their creative energies have not been channeled into the extremely important areas of preventative medicine, rehabilitation, home care services, etc. Dr. Domke's very substantial suggestion is that some way must be elaborated to release the local and Federal health interests to include the total spectrum of quality health services rather than the truncated segment hitherto embraced.

The Unfinished American Revolution and the American Proposition

In my formal presentation submitted before this informal and spontaneous discussion before this subcommittee I made the point that this subcommittee was engaged in finishing the unfinished American Revolution and in furthering the proof of the American proposition. The American Revolution is an unfinished revolution because it set out to provide, implement, and operationalize the revolutionary idea that all men are created equal, that they are endowed by their Creator with certain unalienable rights and that among them are the right to life, liberty, and the pursuit of happiness. Health and health care for all and not just for the wealthy, the upper class, and the power structure is an obvious corollary of the American Revolution.

This subcommittee strives to implement one facet of the American proposition. It was Abraham Lincoln who stated that our forefathers dedicated this country to the proposition that all men are created equal.

A proposition in philosophy is a statement that is to be proved; in mathematics a proposition is an operation to be worked; in sociology, a proposition is a hypothesis which is to be tested and you hope it will be found to be a positive proposition, an approved proposition.

One of the reasons why it is a gratifying honor to testify before this subcommittee is that you are continuing the work of the unfinished American Revolution and you are striving to prove the American proposition.

The Central City Overburden

We may summarize our materials on the impossibility under present circumstances for the central cities to provide adequate services for their disadvantaged citizens by the following statements:

A. The central cities have become the depot of the disadvantaged from farm and the South;

B. Middle-class population and industry have fled to the suburbs;

C. During the next 10 years the cities will have a revenue gap of $262 billion; and

D. At present one out of four of the children of the slum areas need substantial medical assistance and are not receiving it; one out of two of teenagers need substantial medical assistance and are not receiving it; three out of four of those over 65 need substantial medical assistance and are not receiving it. These data are educated guesses derived from various knowledgeable sources and are not hard data.

Consensus of Testimony From St. Louis

There is a consensus of opinion from those that I have canvassed in St. Louis area that—

A. The Federal health legislation of the past 3 years has been a tremendous boon to the overall health needs of the central city; and

B. That there must be some modification of the coinsurance and deductible principles lest the disadvantaged for whom the legisla-

tion was primarily intended suffer rather than prosper from this enlightened legislation.

Role of the Federal Government

In our formal testimony we finally addressed ourselves to the role of the Federal Government in its dealings with the local governments. The danger of Federal assistance is the danger of a Federal takeover and the consequent deadening of local initiative, interest, commitment, and control.

The first point that we made was in reference to the shibboleth "socialized medicine." This opprobrious term was used by the adversaries of medicare and medicaid in their unsuccessful fight to obstruct the passage of health service legislation. By "socialized medicine", as in England, is meant the ownership of the installations and the hiring of the personnel. But medicare and medicaid own no hospitals and hire no personnel for the practice of medicine. Whatever they are they are not socialized medicine. They are forms of insurance and not forms of medical practice.

We then went on to ask more specifically what the relationship of local government and the Federal Government should be. Three years ago on the occasion of his famous Great Society speech at Ann Arbor, President Johnson used the term: "Creative federalism." On seven occasions since then he has had recourse to this term. More recently the phrase "creative federalism" has been supplemented by the phrase "balanced federalism." These are pregnant phrases and bear investigation.

"Federalism" means complementarity between a limited central power and other powers that are essentially independent of it. "Creative" federalism accents the theme that local initiative and creativity will be held at a premium. In the long American dialog over states' rights and the question of individual liberty versus Government domination, it has been tacitly assumed that the total amount of power is constant and, therefore, any increase in Federal power diminishes the power of the States or participating agencies such as hospitals.

Creative federalism starts from the contrary belief that total power—private and public, individual and organizational—is escalating very rapidly. As the range of conscious choices widens, it is necessary to recognize vast increases of Federal Government power that do not encroach upon or diminish any other power. Simultaneously, the power of States and local governments will increase; and the power of individuals will increase.

The Federal administration is following the lead of modern business. The Great Society is being built not on the models of central determination of all solutions in Washington, but on the concept of maximum feasible participation of all elements of society and of many centers of decision. Today there is no premium placed upon obsequiousness and inertness at the local level.

On the contrary, only those programs and proposals are being funded on a local level that manifest creativity, originality, initiative, comprehensiveness, and a soundness never before demanded on a local level. The old argument of Government intervention being one

more instance of creeping socialism and womb-to-tomb welfarism is losing its relevance.

The new emphasis is upon "problem solving" and this is at a local level.

Let us take the case of medicare. When medicare was first debated in the thirties and forties, the accent was upon what the young owed to the unfortunate and what the Federal Government could do by giving a single monolithic plan excogitated in Washington.

Today this emphasis has changed. Medicare and medicaid are put forward as devices to deal with a problem with solutions derived from local cooperative initiative, funding, and administration. So likewise with the programs to improve education, rebuild the cities, clean up rivers, beautify highways, reduce air pollution, decrease unemployment, minimize discrimination, and fight the great war on poverty.

We welcome the fact that the new role for Washington is not that of "big brother," but "junior partner." The "monolithic" is out and "polycentric" is in. The old-fashioned business paradigm of the "captain of industry" and the industrial absolutist has yielded to the corporation "team approach."

There is a conscious, unceasing effort to insure that any given decision will be made at the most appropriate place—high or low, in Washington or out—and on the basis of the best information. Programs and projects are not being funded and social blueprints are not being approved unless there has been local initiative and, as much as possible, local consensus.

So I think we can summarize what I have tried to state in three points.

1. I am gratified to have been asked to testify before this subcommittee since I feel that the provision of health services especially for the aged and disadvantaged is of primary importance in the forwarding of the unfinished American revolution's guarantee of life, liberty, and the pursuit of happiness;

2. The central cities' overburden must be recognized and compensated;

3. The Federal Government's accent upon "creative" or "balanced" federalism is appreciated, and should be promoted.

Mr. ORIOL. Father Cervantes, I would like to thank you for a magnificent summary and a magnificent total presentation. As you know, these are survey hearings. We wanted to get basic themes that we will develop further and I think you have given us several themes that will certainly be discussed often here.

To come to one of your chief points, the central city overburden, I think, in effect you are saying that we have a tendency for people most in need of health services to congregate in the area least capable financially of giving that.

Reverend CERVANTES. Exactly.

Mr. ORIOL. You have very high concentration of elderly in St. Louis, I believe it is above the national average, or is this true for central city areas throughout the Nation? Would you have that information?

Reverend CERVANTES. I think that our 15 percent is slightly higher than is true of the other central cities. There is a constant pattern,

however, of a dense concentration of the disadvantaged—young and old—in the central city, and a concentration of the affluent and a smaller proportion of the elderly in the suburbs. The elderly in the suburbs are better able to afford quality health service irrespective of the suburban broader tax base.

Mr. ORIOL. The Comprehensive Health Act, which got off to a start last year, would work through States. Do you think that central cities will be benefited as much as they should be through this program?

Reverend CERVANTES. Anything that is run through the States, I feel, has the bias of the out-State or noncentral city people. Traditionally, as our 49 capitols not being in our central cities indicates, the power structure of our country has tended to pit the rural population against the urban populace. The Supreme Court's decision demanding reapportionment has instituted a new axis, a new alinement of power: the suburbanites and the rural population now tend to be alined against the central city and the increased demands of the growing proletariat of the central cities.

Mr. ORIOL. Do you happen to know whether, at the National Conference on Health Costs, which begins next week, great attention will be placed on the central city overburden?

Reverend CERVANTES. I do not know. I would hope so, but frankly I have not seen this developed any place.

Mr. ORIOL. That is why I asked. I think this is an area of inquiry that should be followed.

Reverend CERVANTES. Right.

Mr. ORIOL. I have other questions, but I will ask Mr. Miller if he has any.

Mr. MILLER. No.

Mr. ORIOL. Mr. Norman?

Mr. NORMAN. No questions.

Mr. ORIOL. Some other questions will be submitted in writing. I remember back at the conference at which this presentation was discussed, we got into a conversation of, as Dr. Domke called it, grantsmanship and the amount of time it takes from staff at a municipal level. We actually got to the point where he was wondering out loud whether instead of devoting his time to making the application, he should be out working with the limited resources he has to give more direct help to the people who needed help.

Could you develop that a little bit more?

EXPENSES OF "GRANTSMANSHIP"

Reverend CERVANTES. Paul Zimmerer, who is the head of the Committee for Economic and Cultural Development of Chicago, maintains that the city of Chicago cannot ask for anything less than a grant of between $100,000 and $200,000 because of the amount of time that is required to make the application.

The Real Estate Research, Inc., which has undertaken any number of research studies for the Economic Development Administration here in Washington, recently submitted a proposal for the city of St. Louis to develop a municipal business development agency.

The young man who prepared it, a man by the name of David Wuenscher, showed me the proposal. He had been working on it for

some months. He said, "How much do you think this has cost to prepare?" I said, "I would guess about $3,000." He replied, "No, it would be closer to $25,000." It takes a tremendous amount of time, energy, and money to apply for grants.

So, to come immediately to your point, would it be better for an administrator of health and hospitals rather than dedicating so much of his time in grantsmanship, to dedicate himself more completely to the administration of his health system with the resources he has at hand? I would say if you are talking about small grants, yes; but if you are talking about large grants, no, because the central cities simply must obtain supplementary funds from the Federal Government.

Although we have not talked about it throughout our discussion, there is a question of restructuring the tax system in the United States and the restructuring of the jurisdictional boundaries so that each political jurisdiction has an adequate tax base that can support the services that need be given.

I think that each one of the administrators ought to enlist the services of a professional proposal writer. The obtaining of a professional writer of proposals will again present an all but insuperable financial problem for the central cities. A professional writer is about as difficult to obtain under civil service salary limitations as is a psychiatrist. We have empty child psychiatric facilities in St. Louis because it is impossible to obtain the full-time services of a psychiatrist under the civil service system which does not allow anyone—even a psychiatrist—to earn more than the mayor's $25,000 salary and no psychiatrist will work full time for this "paltry" salary.

Mr. ORIOL. In Mr. Johnson's statement he recommended stimulating the establishment of the national accreditation for home health service agencies which involves review of patient records by a team of competent specialists, and so forth.

Unless you would like to comment on it here, we will submit a request for further information on that proposal. It sounds interesting and something that we should consider.

Reverend CERVANTES. You will notice likewise, Mr. Oriol, that every one of the individual comments from St. Louis has been most enthusiastic for the Federal assistance in the area of health. We all encourage a reappraisal of the coinsurance and deductible features. We encourage you to hold fast to the requirements demanding fuller participation of State governments in doing their part in supplying quality health service for the disadvantaged in their States which are centralizing in the core sections of our metropolitan areas.

Mr. ORIOL. Any more questions?

Thank you again.

We appreciate your coming here, and your complete statement and other information you have submitted will be placed in the record.

(The statement and information follow—testimony resumes on p. 135.)

STATEMENT OF LUCIUS F. CERVANTES, S.J., PH. D., DIRECTOR, SOCIAL RESEARCH CENTER, ST. LOUIS UNIVERSITY; RESEARCH DIRECTOR, MAYOR'S OFFICE, CITY OF ST. LOUIS

Senator Smathers and members of the Subcommittee, I consider it a distinct privilege to have been invited to testify before the Senate Subcommittee on

Health of the Elderly. The work of your distinguished subcommittee is dedicated to the provision of quality health services to Older Americans, irrespective of race or economic condition. Cooperating with your subcommittee in the conservation of life and the pursuit of happiness for all Americans is cooperating with the fulfillment of the American proposition and the unfinished revolution which is the United States. Permit me a prefatory digression.

A. THE AMERICAN PROPOSITION AND THE UNFINISHED REVOLUTION

When it is stated, as immortally done by Abraham Lincoln, that the new nation which our Fathers brought forth on this continent was dedicated to a "proposition," the propriety of the term is pertinent. In philosophy a proposition is that statement of a truth to be demonstrated. In mathematics a proposition is the statement of an operation to be performed. The founders of our country dedicated the nation to a proposition in both of these senses. Our belief that all men are created equal, that they are endowed by their Creator with certain unalienable rights and that among these are the right to life, liberty and the pursuit of happiness must be demonstrated in our legislative enactments and operationally performed within the historical contingencies of our times. When Congress pursues the unfinished American revolution by affirming that all elderly Americans shall have a *right* to the health care that the medical genius of this country can provide and when this Subcommittee seeks out strategies whereby this right can be more equitably implemented irrespective of age or race or economic condition you are demonstrating the American proposition.

The meaning of recent federal legislation in the area of health services bears reemphasis. In a clear breakthrough against the opinion that quality health service is a private commodity to be provided according to income capabilities, Congress has asserted through Titles XVIII and XIX of the Social Security Act that quality health service is a right of every citizen of the United States, is a legitimate concern of public policy, and that enabling legislation will be invoked when this right to quality health service is jeopardized or rendered inoperative.

When President Johnson announced the Medical Assistance Program he stated: "We are learning to think of good health not as a privilege for the few, but as a basic right for all." Such do I take to be the philosophical underpinnings and American tradition of this subcommittee's quest to assure quality health services to older Americans.

B. THE CENTRAL CITY OVERBURDEN

My first specific observation in reference to "Costs and Delivery of Health Services to Older Americans" is to point out what may be termed the "Central City Overburden."

A great deal of attention has rightly been paid to such facts as the following:

Hospital costs between 1960 and 1965 rose 6 per cent per year but last year they experienced a startling rise of 16.5 per cent;

Five years ago a day of hospital care cost $36.38, today it averages $57.93 and in five years from now the cost will be $96.38 a day; (*U.S. News and World Report* May 22, 1967 p. 77)

Physicians' fees increased only two or three percent a year from 1960 through 1965; they rose 7.8 percent in 1966;

More than a third of those age 65 and over earn less than $1000 per year and the median annual income of unattached individuals of this same senior citizen age is less than $1,250; (Leon H. Keyserling, "Progress or Poverty," *Conference on Economic Progress* quoted in John G. Field, "The Diversified Community," *Community Development*, Vol I, No. 4, p. 22)

Older Americans' slight incomes are not expanding commensurate with the economy;

An elderly person can be much worse off with Medicare as it now stands than he was before without it.

Where before Medicare he might have managed, for example, to stretch his $60 monthly Social Security and $37 state old-age assistance checks to cover rent, food, clothing, and incidentals he is no longer able to do it because he now has deducted $3 a month under Title XVIII plus $50 deductible and finds that he must pay $86 per year and then 20 per cent of the health service balance when previously he was paying half that for his total doctor's bill. As the supplementary testimony from Howard C. Ohlendorf, Chairman of the Planning Committee on Aging, Health and Welfare Council of Metropolitan St. Louis, states:

"With the advent of Medicare, older individuals qualifying under the program, who previously used the out-patient clinic services provided at (the St. Louis) City Hospitals, are now billed the full fee for a clinic visit, whereas prior to Medicare, they were billed approximately one-eighth of this amount. This is very frustrating to many of them who are living on reduced or fixed incomes and cannot afford to pay this fee." (It should be pointed out that the welfare payments in Missouri are quite inadequate and, as yet, we do not have Medicaid).

All of these facts are pertinent and important. Very important. But what is scarcely recognized in the health service literature is that the impecunious older Americans are increasingly coming to be located in the central cities of our metropolitan areas. And it is these central cities which are increasingly incapable of providing the escalating demands of the poverty-stricken for the needs of health, housing, education, employment, security, transportation, and the dozen other basic services. The City of St. Louis is typical of the central cities of the United States in that 15 percent of its population is age 65 or over whereas in the affluent county there are but 6 percent age 65 or over. The central cities overburden consists in the fact that it is increasingly becoming the depressed corrals and tax-shy repositories of the aged, the unskilled, the disadvantaged children and the dispossessed minorities. During the past fifty years the suburbs have increasingly become the refuge of the affluent seeking to avoid the problem peoples of the central cities. The resulting central city overburden is now reaching crisis proportions.

May I draw the attention of this Subcommittee to the study of TEMPO, General Electric Company's Center for Advanced Studies, which found that the nation's cities face the staggering revenue gap of $262 Billion during the next ten years. The study likewise points out that without any federal tax increase the federal government during the next ten years will have a revenue increase of ⅓ of a trillion dollars. ("Revenue Sharing," *Nation's Cities*, April, 1967, p. 7ff.)

Our point of citing the "central city overburden" is to indicate that the disadvantaged elderly are selectively being concentrated in the central cities which are becoming progressively bankrupt so that the older Americans are afforded little or no hope, without federal assistance, for quality health services.

C. EXAMPLES

I had hoped to be able to present to this Subcommittee a profile of health needs within the City of St. Louis that could be directly attributable to lack of government funding. I had set for myself an impossible task for the data are simply not available. I have managed, however, to obtain the following suggestive examples which I feel are pertinent.

Comparative data from 19 of the largest cities in the United States shows that in 1964 the City of St. Louis ranked as follows (rank #1 means that the city is the worst of the 19 largest cities): infant mortality rate, first; accident rate, second; heart disease, second; maternal death rate, third; influenza and pneumonia, third; tuberculosis, fifth; and cancer, fifth. Saint Louis has ranked first in total death rate among the 19 largest American cities in four of the past five years.

There are 13,000 patients in the Missouri state mental hospitals. One Thousand of these patients need not be there, but because of inadequate personnel to prepare them to leave and inadequate family and social structures to receive the patients when they should be prepared to leave, this lost legion of 1,000 is doomed to die within the darkened confines of institutional incarceration. Older Americans are disproportionately represented. The Health and Welfare Council of Metropolitan St. Louis estimates in regard to mental health services that "less than half of the individuals who need the service receive it." (*Seventy-Nine Services*, February, 1963, p. 35)

The closest estimate I could obtain as to what percentage of the disadvantaged were not receiving seriously needed medical assistance is the following: disadvantaged children: 25 per cent; disadvantaged youths: 50 per cent; disadvantaged older Americans: 75 per cent. I do not present these estimates as scientific evidence; I present them as educated estimates. The genesis of the first estimate of the incidence of failure to obtain seriously needed medical service among children is from a Dr. Anne Bannon. Through a federal grant of $205,000, some 2,000 children enrolled in Head Start underwent a series of medical tests under the general direction of Dr. Bannon. The results indicated that one out of every four of the disadvantaged pre-school children were in need of substantial medical assistance. Systemic infections from infected teeth, iron defi-

ciency, cardiac lesions, are examples of the serious uncared for health problems. Draft board rejections for reasons of health among poverty neighborhood draftees are the source of the 50 per cent estimate of uncared for serious uncared for health problems among disadvantaged youths. As for the health service needs of the older Americans I call attention to the observation that among the disadvantaged the co-insurance and deductible components of Medicare have frequently in face of resultant cost increases made the obtaining of health services more difficult.

D. THE ROLE OF FEDERAL GOVERNMENT

Granted that the impecunious older Americans are tending to becoming centralized in the impecunious central cities which in turn are becoming regressively incapable of providing even basic services—medical or other—what should be the role of the federal government? Granted that broadly speaking the federal government has the bulk of this country's taxes and the central cities have the bulk of the country's problems, what direction are we to expect the relationship between the municipal and federal government will take?

Let me make several preliminary remarks:

(1) The central cities are deeply gratified that Congress and the federal executive administration have decided through the revolutionary health service legislation of the last several years that the criterion of the reception of quality medical assistance shall be the *need* of the citizen rather than his economic capabilities.

(2) The federal government's aid to older citizens through Medicare is not "socialized medicine." This spectre when raised against Medicare and Medicaid is a fraud. In England there is socialized medicine because the government acquires the hospitals and hires the medical staff. But in the United States, titles XVIII and XIX acquires no hospitals, hires no physicians to practice medicine, treats no patients, strives to conserve and support the existing voluntary agencies, and merely performs a function that was not being and seemingly could not be performed on a lower institutional level. Medicare is an insurance and not a medical treatment plan.

(3) The interposition of a fiscal intermediary for the Federal government in the Medicare act has worked well. The St. Louis Blue Cross, for instance, serves as the fiscal intermediary for the Federal Government in an 84-county service area paying $35 million to hospitals and related agencies in the 10-month period from July 1 through April 30 as well as $41.5 million to hospitals for member care. Mr. Elzey M. Roberts, Jr., chairman of the St. Louis Blue Cross pointed out to the board earlier this month that the major problems of transition to the medicare era have been overcome through the co-operation of the hospitals, the medical profession and the public. We in St. Louis are gratified that the Under Secretary of Health, Education and Welfare, Mr. Wilbur J. Cohen was able to state: "Thirty years ago people who wanted reform couldn't even have a dialogue with the medical profession. . . . Now there is a breath of fresh air, and even though there isn't always total agreement all the time, we have a completely open dialogue."

Granted that responsible individuals do not speak of the federal insurance plans in the area of health services as "socialized medicine" I do wish to draw attention to the suggestion that government support can be bought at too high a price. "Big brother's" price is too high if this "help" leads to the deadening of local initiative and the burying of local creativity in a grave lined with triplicate forms, computer tape and spindled data processing cards.

Three years ago at Ann Arbor President Johnson delivered his famous Great Society speech. On that occasion, and many times since, the President has used the phrase "creative federalism." Federalism means a relationship, cooperative and competitive, between a limited central power and other powers that are essentially independent of it. "Creative" federalism accents the theme that local initiative and creativity will be held at a premium. In the long American dialogue over states' rights and the question of individual liberty versus government domination it has been tacitly assumed that the total amount of power is constant and, therefore, any increase in federal power diminishes the power of the states or participating agencies such as hospitals. Creative federalism starts from the contrary belief that total power—private and public, individual and organizational—is escalating very rapidly. As the range of conscious choices widens, it is necessary to recognize vast increases of federal government power that do not encroach upon or diminish any other power. Simultaneously, the

power of states and local governments will increase; and the power of individuals will increase.

The federal administration is following the lead of modern business. The Great Society is being built not on the model of central determination of all solutions in Washington, but on the concept of maximum feasible participation of all elements of society and of many centers of decision. Today there is no premium placed upon obsequiousness and inertness at the local level. On the contrary, only those programs and proposals are being funded on a local level that manifest creativity, originality, initiative, comprehensiveness, and a soundness never before demanded on a local level. The old argument of government intervention being one more instance of creeping socialism and womb-to-tomb welfarism is losing its relevance.

The new emphasis is upon "problem solving" and this at a local level.

Let us take the case of Medicare. When Medicare was first debated in the Thirties and Forties the accent was upon what the young owed to the old and what the fortunate owed to the unfortunate and what the federal government could do by giving a single monolithic plan excogitated in Washington.

Today this emphasis has changed. Medicare and Medicaid are put forward as devices to deal with a problem with solutions derived from local cooperative initiative, funding and administration. So likewise with the programs to improve education, rebuild the cities, clean up rivers, beautify highways, reduce air pollution, decrease unemployment, minimize discrimination, and fight the great war on poverty.

We welcome the fact that the new role for Washington is not that of "big brother" but "junior partner." The "Monolithic" is out and "polycentric" is in. The old-fashioned business paradigm of the "captain of industry," and the industrial absolutist has yielded to the corporation "team approach." There is a conscious, unceasing effort to ensure that any given decision will be made at the most appropriate place—high or low, in Washington or out—and on the basis of the best information. Programs and projects are not being funded and social blueprints are not being approved unless there has been local iniatitive and, as much as possible, local consensus.

THE GREAT SOCIETY AND LOCAL INITIATIVE

The new look in the Great Society is local participation. The Peace Corps will send no one into an area without being invited; the anti-poverty program demands "maximum feasible participation" of the beneficiaries of the program and refuses funding of programs not thought out on a local level; Health, Education, and Welfare is providing little more than guidelines, blocks out options for local choice, and depends upon local administrators to come up with the specifics; the Labor Department and the White House Conference on Civil Rights are calling for the establishment of metropolitan job councils "to ensure that the business community, labor organizations and government agencies assume maximum responsibility for expanding job opportunities for Negro workers," the Model Cities program of the Department of Housing and Urban Development is little more than an invitation to local leadership backed by broadly based local community support for a locally planned proposal to rebuild one's own city. The Johnson Administration has come out four-square for the ideology that in the private sector, not in the public sector, lies socio-economic salvation.

What this means for hospitals is that the deluge of assistance offered to them by the eight major health care acts passed by the federal government during the past two years will not swamp them in a molasses sea of federal directives. The dead hand of bureaucracy is not stifling their breath or chilling their blood or choking off their initiative. Socialism is not here to take over the hospital, treat its patients, hire its staff, provide it with a minute-by-minute daily order, and do all its thinking for it. Medicare and Medicaid are considered as a challenge, not a threat. I submit that never in the history of health care has so much creativity, initiative, drive, involvement, knowledge of the best in so many fields been required of administrators and staff in the hospitals of the United States.

We welcome and need the "creative federalism" or "balanced federalism" approach. The federal government is thereby living up to its role of providing for the common welfare and recognizes its role of expediter, enabler and catalytic agent rather than as a monopolistic repository of all wisdom, creativity, resources and administrative fiats.

To summarize my testimony:

(1) I am gratified to have been asked to testify before this subcommittee since I feel that the provision of health services especially for the aged and disadvantaged is of primary importance in the forwarding of the Unfinished American Revolution's guarantee of life, liberty, and the pursuit of happiness;

(2) The central cities' overburden must be recognized and compensated;

(3) The federal government's accent upon "creative" or "balanced" federalism is appreciated.

STATEMENT OF ELMER M. JOHNSON, ASSOCIATE DIRECTOR OF THE METROPOLITAN ST. LOUIS HOSPITAL PLANNING COMMISSION, INC.

I wish to provide information about the status of home health services in the St. Louis Metropolitan area, and to cite obstacles to the further development of this service.

The present total annual expenditure for organized home health services for the sick in the metropolitan area is $1,100,000. We have about 2,300,000 persons in the area, so this represents a rate of less than 50 cents per capita.

Eight home health service agencies serve the area, employing 57 registered professional nurses and 102 home health aides. The number of nurses employed today is about 20 greater than one year ago before the beginning of medicare. There were no home health aides a year ago, although a few homemakers performed similar functions. Training programs financed by the Office of Economic Opportunity trained 88 of the presently employed home health aides. Another 20 were trained but there were no immediate job openings in this specific type of service at the time of completion of their training.

The great majority of home health service here is provided by non-hospital, community based voluntary agencies. Only one nurse from a tax-supported agency provides home health services for the sick in the metropolitan area.

Charges for visits by registered professional nurses range from $4.50 to $10.65. The lower rate is charged by a small-town visiting nurse association—the higher by a city hospital-based program. The average charge is about $9 per one hour visit—up 25 percent over a year ago. Home health aides customarily work in each home about 4 hours per visit. Charges for aides services range from $1.60 per hour to $2.50 per hour.

The ratio of aides to professional personnel is 5 to 1 in one agency, while another has no aides. The biggest agency has about 2 aides for each 3 professionals. Generally, the visiting nurse associations have lower ratios of aides to professionals than other types of home health agencies.

The total active caseload of all home health agencies in the area at any one time is approximately 1,000. This compares to average daily occupancy of 8,800 in short-term general hospitals and 8,600 in log-term care facilities, excluding mental and T.B.

At the present level of care home health services cost about $3 per active case per day in the metropolitan area.

The rate of use of this service here is only about ⅔ the rate in communities where home care is highly developed. I believe the reasons for under-use of home care locally are:

Inadequate interpretation of home health service to doctors and the public.

Lack of relationships between home health agencies and many hospitals.

No home health service benefit payments for public assistance recipients under age 65 in Missouri.

Limited number of hospitals (6 of 42) qualifying to admit Blue Cross patients to home care.

Some parts of the metropolitan area with only nominal home health service coverage.

In addition to problems of insufficient use of the service, existing home health service programs need to be examined to determine if there is:

Too little medical surveillance of patient care.

Inappropriate "mix" of professional, technical, and aide services.

Inefficiencies caused by duplication and overlap of service areas of home health agencies in metropolitan area.

Increased use and more appropriate use of home health services could be encouraged at the federal level by:

Requiring that each medicare certified hospital and extended care facility has a transfer agreement with a home health service agency, or itself provide home health services.

Adding home health services to the present list of five services that are mandatory under Title XIX of the Social Security Act.

Developing educational materials and resources for local use in interpreting home health services to doctors and to the public.

Stimulating the establishment of national accreditation for home health service agencies which involves review of patient records by a team of competent specialists in mediicne, nursing, physical therapy, etc.

STATEMENT OF BERNARD FRIEDMAN, MEDICAL DIRECTOR AND SUPERINTENDENT, ROBERT KOCH HOSPITAL, KOCH, MISSOURI

On June 3, 1967, I attended a meeting, with others, at the request of Mr. William E. Oriol, Staff Director of the United States Senate Special Committee on the Aging. At the time we discussed the question of federal programs and health services to elderly Americans. Subsequently, we were asked to write a statement on the particular facet of health services in which each of us was most interested. This present statement repeats in general the oral statement that I made at that meeting.

My own special interest in the problems of the elderly came about through my work at Robert Koch Hospital. Our hospital was originally the municipal tuberculosis hospital of the City of St. Louis. As empty beds were made available, as a result of the impact of the modern treatment of tuberculosis, these beds were used to develop our Intermediate Care Divisions. Our Intermediate Care patients are patients that come to us usually from a general hospital, municipal or private, who no longer need the intensive care of a general hospital, but who requires services greater than that obtained in a nursing home or in their home.

Experiences with these divisions have been most revealing. For one thing, these divisions have become essentially divisions for the rehabilitation of the elderly. For another, it has become evident that very often the main obstacle preventing the patient from returning home is not the medical problem for which the patient entered the hospital. Very frequently the patient overcomes his stroke sufficiently so that he may again be up and about, his hip fracture heals well enough so that he becomes essentially self-care. The problems that occur over and over again are social conditions that prevent the transfer of the patient back to the home or apartment from which he came. A third floor level apartment of a patient who is short of breath because of emphysema, a toilet in the basement of a patient who has already fallen once and broken her hip going down stairs, a patient whose neighbor has in the past done her shopping and looked in daily, but is now moving to another location—these are the kind of problems that may actually make the difference between sending a patient home or to a nursing home. There is no question in my mind but that there are thousands of patients in nursing homes who have been transferred there not because they need to be in a nursing home but because of the social problems involved in the patient living on the outside. Two patients can reach the same levels of self-care with the same diagnosis. One can be discharged to a family eager and waiting to have him back, another can not be discharged because the home circumstances are unfavorable.

The extension of home health services, home care, and such services as meals on wheels would help tremendously in keeping the elderly, chronically ill patients in their home. In working with these elderly people we find that an adequate social service staff both in the hospital and for out of hospital care is indispensable. At our Intermediate Care Divisions all efforts are made to prevent permanent institutionalization. The following is a table recording the disposition of our discharged patients in the last 3 fiscal years.

INTERMEDIATE CARE—DISPOSITION OF DISCHARGED PATIENTS

	1966–67	1965–66	1964–65
Home	221	199	175
Home care	10	6	22
Other hospitals	48	39	60
Practical nursing homes	131	79	79
Professional nursing homes	1	3	14
Domiciliary homes	32	54	54
Room and board homes	2	7	13
Total permanent discharges	445	387	417

These results are, in my opinion, not particularly extraordinary. A few years ago, however, a significant number of the people we now send home would have been sent to nursing homes. On the other hand, a significant number of patients that we still send to domiciliary care institutions or nursing homes could be discharged home if some of the social problems of home care could be solved.

STATEMENT OF MORRIS ALEX, M.D., MEDICAL DIRECTOR, HOME CARE PROGRAM, ST. LOUIS, MISSOURI

At our meeting in Mayor Alfonso J. Cervantes' Office on June 3, 1967, with Mr. William E. Oriol, Staff Director of the United States Senate Special Committee on the Aging, it was suggested that I write up and submit to your subcommittee on Health of the Elderly the following portion of our discussion. I am happy to do so.

As a result of advances in the health sciences, there has been a profound change in the type of care required for many people. In the past acute diseases were predominant but now exacerbations of chronic diseases are more prevalent. With increasing numbers of older people in our population there has been a shift toward larger numbers of chronic diseases and as a result of this, need for long-term care and rehabilitative care. During the last 10–15 years, many voluntary and state organizations have arisen to help meet certain needs from either a social or medical point of view. Now it has become necessary to coordinate existing resources in order to make maximum use of the available resources and to develop new methods of coordinated care.

It is estimated that at any one time about one per cent of a communities population are not found in the world of the well. They have been withdrawn into the hospital world as patients. Of this number, some are there because they need treatment or diagnosis, and some are there simply because they cannot be contained within the world of the well but yet, do not require acute hospitalization. The latter group are the ones we are discussing at this time for if the occupant of the bed is not in a condition to use or respond to the expensive services of the acute hospital then doctors and laymen alike say that the bed is used for social rather than medical purposes. For most efficient use, in-patient medical care is to procure patients sent to them from the world of the well and to return them to the world of the well as quickly as possible. Home Care has a far wider use, it is responsible for managing the sick and all illnesses whether curable or not that do not require the acute hospital. In this management there is more than just therapy because this home care includes aid in living with the disabilities of the illness whether transient or permanent, limitations of disturbances in all the social systems which an illness disturbs—notably the household in which it is contained and establishing a partnership with those charged with the care of the sick individual in the community.

The problem of chronic illness in the Greater St. Louis area has been primarily a problem of the core city of St. Louis because of the unusually large number of persons 65 and over residing within the City of St. Louis. In the City of St. Louis in 1960, 12.3 per cent of the total population was 65 and over. By 1970 it is estimated that it will reach 15.3 per cent. By the same token in 1970 it is estimated that in St. Louis County the percentage will be 6.4 per cent. To make this problem more apparent, almost 55 per cent of metropolitan aged population resides in the City of St. Louis; whereas about 20 per cent lives in St. Louis County. A public assistance picture adds another dimension to the extent of the problem of chronic illness. In the year 1963, of the 102,409 old age assistance cases in the State of Missouri, 13.1 per cent were located in the City of St. Louis as compared to 2.7 per cent in St. Louis County. Of the total of the permanent and total disability group 29.1 per cent were in the City of St. Louis and 4.3 per cent in St. Louis County.

It is estimated that there are some 24,000 cases of heart disease in the City of St. Louis, 22,000 cases of hypertension, 7,725 cases of diabetes, 12,225 cases of visual difficulties, 29,250 cases of hearing defects and almost 10,000 cases of paralysis of one or more limbs due to either cerebral vascular disease or to other neurological deficits.

The City of St. Louis has been and is now doing something about the problem of chronic illness and coordinating care. However, because of the extent of the problem and the late start, the solutions are not easy. In 1955, the City submitted

for vote a $100,000,000 Bond issue in which the primary health item was $4,000,000 for a new Chronic Hospital. Prior to the inclusion of this item, the Mayor requested the Health and Welfare Council of Greater St. Louis (then known as the Social Planning Council) to appoint a committee of citizens, professional and lay, to evaluate the need for this Bond Issue item. This group of citizens found that the Greater St. Louis Community provided very little (private or public) for the chronically ill person other than acute in-patient medical services and long-term institutional care (primarily custodial). This committee, therefore, advised that the Chronic Hospital Bond Issue item should be included, but with a provision that the actual building be contingent upon the findings of a study of the "health needs" of the City of St. Louis. The Chronic Hospital Bond Issue item was approved by the voters and in 1956 the City contracted with the American Public Health Association to make the survey. Additional monies enabled the survey to be extended to the Greater St. Louis area. It was completed in 1957. Among its findings pertinent to the problem of the chronically ill were these:

1. The financing of the medical care for the indigent and medically indigent is a serious problem in the St. Louis area. In Missouri, the County (the City of St. Louis is not in a county and, therefore, must assume all of the usual county functions) has been deemed responsible for medical care, other than mental illness and tuberculosis.
2. Voluntary hospitals in the St. Louis area are primarily concerned with the short term acute case; where they are adding beds for chronic disease, the purpose is to provide rehabilitation for relatively short periods of time.
3. The City of St. Louis needs a separate department of Public Health and hospitals to discharge the City's responsibility for health of the public by planning and operating a single unified program of service that range from prevention through treatment and rehabilitation.
4. A new chronic hospital is not necessary, if the City of St. Louis develops a comprehensive integrated program of medical care for the aged. Emphasis should be placed on improving patient care through an increase in prepared personnel and in services and programs to make health services more readily available—other than in-patient hospital care. This should include home care, rehabilitation and improved services in the out-patient departments.
5. Home Care programs are relatively new in the City of St. Louis. There is one comprehensive program which is operated by the Jewish Hospital of St. Louis. A home care program should be established by the municipal hospitals; the voluntary hospitals, particularly the larger ones closely associated with medical schools, should explore the feasibility of developing home care programs.

Since the survey these actions have been taken by the City of St. Louis

1958: The voters approved the creation of a single department of health and hospitals to be directed by a physician well qualified in public health and hospital administration and to be responsible to the Mayor. The director was appointed in January, 1959.

A long-term illness medical service (known as intermediate care) was established at Koch Hospital for the group of municipal hospitals with 3600 bed complement (two general, Max Starkloff and Homer G. Phillips Hospitals; one psychiatric, Malcolm Bliss Mental Center; one tuberculosis, Robert Koch Hospital; and one long-term chronic institution, (mostly custodial) St. Louis Chronic Hospital. This intermediate care service started as a 40 bed service and is now a 200 bed service with a waiting list. Medical nursing, social work, physical and occupational therapy were coordinated to provide comprehensive medical care. It includes intensive rehabilitation. The service has attained a significant level of effectiveness; approximately 70% of all live discharges return to their own homes directly or via home care, since the latter was established in 1960.

1960 (May): An Information and Referral Center for the chronically ill was established by the Department of Health and Hospitals. It had existed earlier, from 1955–1958, as an activity of the St. Louis Chronic Hospital, which discontinued it in favor of a more traditional hospital admission procedure. Of the original Information and Referral Center the American Public Health Association Survey noted: "The experience of the Information and Referral Center not only justifies its continued operation, but its expansion into a City-wide adult counseling service for the chronically ill and aged." It was re-

established on just this basis, a City-wide service. This action was necessitated because Chronic Hospital had filled almost all of its 1500 beds—despite the fact that a new domiciliary of 100 bed established at Koch Hospital a short time previously was completely filled. In the original operation there were less than 500 requests a year from chronically ill persons; in the first year of its reactivation there have been more than 800 requests. This increase is considered an index of the rise in incidence of illness requiring long term care.

Long term patients are "persons suffering from chronic disease or impairments who require a prolonged period of care, that is, who are likely to need or who have received care for a continuous period of at least 30 days in a general hospital, or care for a continuous period of more than 3 months in another institution or at home, such care to include medical supervision and/or assistance in achieving a higher level of self-care and independence."

1960 (September). A coordinated, medically directed, hospital-based Home Care Program was established by the Department of Health and Hospitals.

By now there existed in the Department of Health and Hospitals these levels of care; acute in-patient, out-patient, intermediate care, long term institutional care, home care, and Information and Referral. Coordination was required to insure that the comprehensive needs of the long term patient were known and that he received the needed level of care; to this end, the Director of Health and Hospitals appointed a Long Term Illness Committee consisting of the Chiefs of Home Care, Intermediate Care, Physical Medicine and Rehabilitation, Psychiatric, Social Work and the Medical Director of the Chronic Hospital. This group, responsible to the Commissioner of Hospitals, delegated to its Chairman (Director of Home Care) the day-to-day decisions regarding the needs of long term patients and reserves for its weekly meetings those patient situations that are difficult and/or require administrative changes, and otherwise sets guidelines.

It should be noted that 63 per cent of all applications made to the Long Term Illness Committee came from either home, nursing homes, or from hospitals other than the public ones. From that group and the total group that was referred for long term illness care, approximately one-third have been feasible medically for Home Care. However, of the one-third that were thought medically suitable for Home Care, it should be noted approximately 20 per cent of those were accepted for Home Care and the remainder were not accepted. Of those not accepted a high percentage could have been accepted on a Home Care program providing they had a substitute home, a housekeeper, or meals on wheels.

As was stated previously, as a rule care in the acute hospital is merely the first stage in the program necessary for rehabilitation or for planning for long term care, either because of medical or social needs or both. Because of these long-range developments, the Director of Health and Hospitals, ordered the creation of the Long Term Illness Committee and the Home Care Department in 1960. The purpose of these two groups was to complement and coordinate the existing services of the two acute city hospitals, the intermediate, long term or rehabilitative divisions at Koch Hospital, Chronic Hospital and the Rehabilitative Division. The Information and Referral Center was created to provide accessibility to long term care planning for those citizens not under medical care within the municipal system.

Experience has demonstrated that planning for the future needs to be initiated as soon as the patient comes under care of a physician. Often this will be at the acute in-patient level; occasionally, it may be at the out-patient or emergency room levels. It should be realized that adequate planning cannot be started until the medical needs of the patient are known. The attending physician assumes the responsibility of identification of a patient's needs for long term planning and referral to the Long Term Illness Committee which provides direction and focuses on the planning needs. Over the seven years that this program has been in action, the sole purpose of the Long Term Illness Committee has been to coordinate planning, to determine the best level of care for the patient aimed at restoration to his community when possible. We have been able to significantly reduce the number of patients requiring long term institutional care and to increase the numbers of patients who can safely return to the community. A secondary result of this program has been the movement of patients from the hospital more rapidly and results in better teaching facilities for the hospitals and for the trainees in medicine.

While this program has worked in a public system, a few voluntary institutions have attempted to intiate similar systems. Increasingly the voluntary

hospitals have utilized the Long Term Illness Committee and the Information and Referral Center for judgments in handling difficult problems.

It is apparent that there is a need for a community-wide approach to handling problems involving long term and rehabilitative care whether in the older individual or the person below 65. Communities or political subdivisions, i.e., counties, need to develop information and referral systems, home care services, and rehabilitative facilities.

With the funding third party payments through Titles XVIII, XIX and Blue Cross, the physician must take the lead to see that the necessary facilities and administrative structure is available to offer his patients the care required and still retain the private practice of medicine.

STATEMENT OF HERBERT R. DOMKE, M.D., DIRECTOR, DEPARTMENT OF HEALTH AND HOSPITALS, ST. LOUIS, MISSOURI

In my opinion the greatest contribution of the United States Senate's Special Committee on Aging is to encourage better balance of Congressional attention to health needs of the aged. There is a spectrum of health needs which begins with the maintenance of health at one end, proceeds through phases of acute illness and rehabilitation, to return to the aged person's resumption or normal family and community activity.

Most Congressional interest—and federal monies—are directed to the part of the health services spectrum which deals with management of illness in the hospital. On the other hand, there is relatively very little interest in programs of health maintenance and early detection of illness on the one hand, or rehabilitation and return to social function at the other end of the spectrum. For example, it is probable that more attention in this Congress has been directed to one aspect of financing hospital care, viz, capital depreciation accounting techniques, than has been given to early detection and rehabilitation taken together. There is, of course, a need for a sound policy for depreciation allowances, as there are also compelling reasons for continued development of medical and hospital diagnosis and treatment of acute, debilitating illness. And, of course, Medicare and other insurance programs have met a major need in financing hospital care, and deserve continued public and Congressional scrutiny.

The problem is not that the sick person deserves less attention, but that we make a greater community and Congressional effort to maintain health or to return the patient to his family. There is an imbalance of attention, and there results an imbalance of appropriation of effort and—most important of all—an imbalance of service to the aged citizen. As long as federal service and research project monies tend to focus on the obviously ill person, so also will local health agencies have to direct their attention to trying to improve services by trying to get their portion of available funds. It can and does happen that local health agencies must divert their limited planning resources to play "Grantsmanship."

Government fiscal trends in the past twenty years have produced a current situation where municipal government has no substantial funds to undertake new activities in health. The needed new local health services have become more and more dependent—and are now almost *wholly* dependent—upon federal funds. (It may very well be that if there is to be effective local planning and service that government tax policies may require revision to provide more adequately for local control.) The point, however, with regard to health services is that there is federal control of new health program development not only nationally, but locally. The responsibility, therefore, for Congress is especially great. Errors of emphasis in Congress will be multiplied in every local community.

There is ample evidence (and much of it has been presented to Congress) to show that a great deal can be done in the detection of illness before symptoms are apparent. The field of screening of diseases is one that has had a rapid technological development, and there is agreement among competent national medical authorities that much can be achieved by greater community application of screening programs. Certainly, the present expense—and the predicted escalation of expense—of hospital care requires search for development of less expensive means of patient management. Greater Congressional funding and support for programs of out-patient care obviously offer one of the opportunities to reduce demand for expensive in-hospital care. Certainly, also, there are many competent authorities in Health, and Welfare, who believe that much can be done

to return the aged person after an illness to his family and community—in the absence of which the aged person is left no recourse but the futile, long-term, nursing home placement.

We have, in this affluent society, an opportunity to choose which new health programs are to be developed. It is important to recognize that the range of choice of health services is indeed a wide one. There are great benefits to be achieved in other health programs in addition to the benefits that can be achieved in the diagnosis and treatment of the acutely ill person. Both the fiscal realities of escalating hospital costs, but more important, the social gains to be achieved for the aged person, require that more attention be given to the whole spectrum of health services, from health maintenance and disease screening to rehabilitation.

STATEMENT OF MARY E. DAVIS, M.S.W., DIRECTOR OF SOCIAL SERVICES FOR THE CATHOLIC HOSPITAL ASSOCIATION

I wish to make it very clear at the outset that although these observations are directed to the health care of the aging, I believe that comprehensive health services are the *right* of every person regardless of age or economic condition.

1. "Medicare"—Title XVIII of the Social Security Act provides to insured beneficiaries payment for care in a hospital, extended care facility and for home health services. There are deductibles and co-insurance features which were one of several compromises made with providers of services in order to get the bill passed. *No program of medical care should have deductibles or co-insurance.* They are a financial barrier to the receipt of medical care and keep the poor from receiving it.

Title XIX—"Medicaid" was passed at the same time in order to supplement the basic provisions of Title XVIII. When a state has not implemented Title XIX, the aged poor are unable to make full use of benefits provided under "Medicare" because:

a. They have no way of paying the deductibles and co-insurance.

b. They cannot pay for nursing home or other types of long term care in addition to "extended care."

c. They cannot pay for drugs, dental care, glasses and other health services.

I believe therefore that the Federal government should hold fast to the time limitations it has set for the states to get Title XIX—"Medicaid"—implemented, and hold to the present regulations within these time limitations for the provision of certain health services. We are all citizens of the United States and political boundaries should not prevent us from receiving what is a right for everyone.

2. I am becoming increasingly concerned with a growing trend in hospitals to gear services to the requirements of federal legislation. A prime example of this is the planning for and construction of "Extended Care Facilities" for people *over 65* to meet Extended Care provisions under—"Medicare"—Title XVIII. Extended Care is only one part of the continuum of care for people with long term illness and should be available to patients of any age who require it. Persons over 65, covered by Medicare, would have their care paid for under this program. Those not covered and persons under 65 might be covered through private insurance, Title XIX or other tax supported programs, or from their own funds. I am very concerned about this, because I see it as the beginning of a trend to organize health services to meet legislative requirements rather than the needs of ill and disabled persons, and this will kill initiative in the search for alternative and more appropriate ways of meeting their needs.

There is also I believe, a more grave danger that this trend could lead to the reinforcement of present methods of delivering health services rather than to the discovery of new methods. Blue Cross and other hospital insurance programs were organized to meet the cost of hospital care for individuals, because hospital care represented the largest expense in medical treatment. However, over the years, hospital insurance has been the chief reason for unnecessary utilization of hospital care by large numbers of patients who could better be cared for as out-patients or in their own homes or lesser care facilities. The trouble is that there is no insurance to cover these other kinds of care.

"Medicare" followed the same trend. Payment for hospital care is its first and major provision. Extended care and home health services were added only to offset the overutilization of hospital care, not because they offered a better

and more appropriate way of meeting a patient's medical care needs. Yet, early statistics show that surprisingly high percentage of the aged have used home health services without any hospitalization. It met their need. (I have always been very curious as to why the variety of methods of delivering medical care used at the Mayo Clinic have not been more widely imitated. The only answer seems to be that we have become "stuck" with hospitals!)

3. Health services for the poor are generally as poor as the poor themselves. They are also inaccessible because of geographic location, lack of coordination—(specialities located in different places)—and more basically a complete lack of interest in and concern for the patient as a person. All of this could be changed if the private sector wanted to change it. A vacuum does not exist forever. Something moves into it.

As has been stated so accurately by Professor Cervantes "the federal government is an enabling agency to promote the common welfare." (Lucius F. Cervantes, "Socialism and Health Care," *Hospital Progress.* September 1966, p. 86.) "Medicare" and "Medicaid" provide payment under certain minimum conditions for certain health services. The producers and providers of these services can go far beyond these minimums and they should! If they do not care enough for the poor to insure that the health services provided them are related to health needs rather than to ability to pay; if they are less in quality and quantity than those provided more affluent citizens, then government may truly move in because concerned citizens will force it to do so. The choice lies with the private sector of the health field.

STATEMENT OF SISTER MARY VINCENT, C.C.V.I., THE CARDINAL RITTER INSTITUTE, ST. LOUIS, MO.

We are all grateful for the passage of Medicare Legislation and recognize the fact that it has been a great help to some of our older people who are in need. However, we would recommend that an altogether different type program be designed to complement existing social legislation, with the philosophy of meeting the continuing health needs of the chronic and terminal patients.

For health care programs such as Title 18, we need to find measurements of self-providing capabilities which would form the basis of eliminating many who do not need assistance from such health care programs.

Elimination of all deductible and co-insurance features of the Medicare Program, removal of waiting periods and deadlines for enrollment. Deductibles form barriers to needed care for those least able to pay.

Replacement of the 65 year age requirement for Medicare benefits by a provision qualifying all women at age 62.

Extension of the coverage for drugs to all prescription drugs regardless of their association to a hospital confinement.

Extension of coverage to all surgical and orthopedic appliances and such items as wheelchairs, and hospital beds for home use, eye-glasses, hearing aids, podiatry, and everything pertaining to eye care and dental care.

Expand existing programs and encourage where needed, the starting of new education and training programs designed for health care personnel needed to provide the services made possible by existing and proposed legislation. Training and education should reflect the needs of the functions to be performed and not be put at an unrealistic level excluding many potential health care employees.

Make available to local community health service providers—grants-in-aid for the acquisition of additional staff to meet the quality standards of care for chronic and terminal patients.

WASHINGTON UNIVERSITY,
SCHOOL OF MEDICINE,
St. Louis, Mo., June 15, 1967.

Hon. ALFONSO J. CERVANTES,
Mayor of the City of St. Louis,
St. Louis, Mo.

DEAR MR. MAYOR: This letter is in reply to your letter of June 5, 1967, asking about costs and delivery of health services to older Americans.

Persons over the age of 65 not only require more hospitalization but stay longer. In Barnes Hospital, Medicare patients now stay 4.2 days or 42.4% longer

than non-Medicare patients. The ancillary service billings are $97.00 more than the average non-Medicare patient. Thus, with rising costs, some borderline patients face serious financial problems.

In addition, the traditional charity given by large private hospitals is not as effective as formerly for two reasons. First, the same dollar amount will not buy as much medical care and, second, the government policies will not permit these costs to be included as part of legitimate overhead charges. It seems to me that this particular reimbursement policy might be re-examined.

Yours sincerely,

WILLIAM H. DANFORTH, M.D.
Vice Chancellor for Medical Affairs.

STATEMENT OF HOWARD C. OHLENDORF, CHAIRMAN, PLANNING COMMITTEE ON AGING, HEALTH AND WELFARE COUNCIL OF METROPOLITAN ST. LOUIS

As Chairman of the Planning Committee on Aging of the Health and Welfare Council of Metropolitan St. Louis, I was asked by the Honorable Alfonzo J. Cervantes, Mayor of St. Louis, to prepare some brief comments regarding problems, as I see them, of the cost and delivery of health services to older Americans.

I have had contact with a number of individuals in the past few months regarding generally the problems of the elderly. The Health and Welfare Council is conducting a program sponsored by a Title III grant from the Older Americans Act. This program, called Aging Information and Direction Service (AIDS), is one of providing information and referral services to older adults. I could cite you case histories regarding some of these problems, but in the interest of time, I will merely describe the problems as I see them.

With the advent of Medicare, older individuals qualifying under the program, who previously used the out-patient clinic services provided at City Hospitals, are now billed the full fee for a clinic visit, whereas prior to Medicare, they were billed approximately one-eighth of this amount. This is very frustrating to many of them who are living on reduced or fixed incomes and cannot afford to pay this fee. Once the hospital has billed the patient in the amount of the $50 deductible, they are no longer billed for services. They are, however, charged the 20% of the full clinic fee at each clinic visit. If the patient could not pay the $50 deductible fee, or the following 20%, this is collectable under Medicare as a bad debt. It would seem that some different way of handling this situation could be arranged to alleviate the personal suffering and worry on the part of the older patient.

Another problem that still faces us is in the area of nursing home care. The quality of much of the nursing home care available today still leaves much to be desired. A nursing home can be licensed by the State of Missouri as a professional or practical nursing facility. At the time the inspection of the home for licensure takes place, the home may meet staffing standards. However, one month after licensure, staffing may change, which means an inadequate staff available to provide needed and requested services. This is an unfortunate situation and I recognize the many problems involved in staffing nursing homes today, but I do feel that something should be done to more adequately insure that a home which is to receive payment for a certain quality and quantity of care, is qualified to provide that care. This might be in the form of inspection teams, which would periodically inspect these nursing homes on an unannounced basis.

There are nursing homes in operation in Missouri and St. Louis which have repeated and numerous violations at the time of their "regular" inspections by authorities. It seem that it is very difficult to revoke the license of a nursing home operator. When the inspectors do find a situation which warrants and allows them to bring action against a nursing home operator, only the violations found at the last inspection are permissable as evidence. The past history of the operation of the home, no matter how deplorable, is not used. It is possible, also, for operators to obtain continuances for lengthy periods of time, meanwhile continuing to operate their home in a manner which does not meet standards. Something needs to be done about this where there is federal money involved.

It is also brought to my attention that in many cases medical records kept in the nursing home may not be adequate to insure the patient a continuity of quality care necessary to promote their living in as optimum a situation as their illness or disability will permit.

Some provision should be made to insure that each patient in an extended care or other nursing facility have a medical and social re-evaluation and diagnosis at least each year. This is required for those patients receiving Medicare payments but for those on public assistance, this may not be the case. It would seem that far too often an individual patient is diagnosed and evaluated upon admission to a home and cared for on the basis of this diagnosis for too extended a period of time, even though their medical situation might have changed during this time.

We have tried in this country for some time to promote the idea that when an older person goes into an institution, he be made to feel that this institution is in fact his home while he is there. Nursing home, homes for the aged, and domiciliary care facility operators have come a long way in recognizing the need for this kind of philosophy of care. Now we have a situation in which an extended care facility may provide both a residential and domiciliary care facility and a nursing home facility. Suppose a person living in the domiciliary facility could benefit from some home health services. Could not these home services be provided to them in the domiciliary facility from the nursing home facility. This, I believe, needs some clarification and redefinition.

We have many elderly living in public housing projects. Getting services to people in public housing would seem, at first glance, to be an easy matter due to the fact that you have such a large number of clients living in close proximity. This does not always prove to be the case. The problems of people in public housing are of such a magnitude as to be overwhelming. One is struck by the amount of difference which exists between public housing designed specifically for the elderly and public housing designed generally for the total community. For example, in public housing for the elderly, the elevators stop on every floor, and there is more community space available. I ask you, is this disparity desirable? Suppose an older person lives in public housing where the elevators may not stop on every floor. If this person becomes ill, they may be requested to climb many steps in order to get to and from their apartment and the services in the community which they may require. Of course, for some medical reasons these elderly can have their apartment changed and be placed on a floor where they have access of an elevator, but I submit to you, gentlemen, that this reshuffling of human beings in degrading and frustrating.

Another problem which I would present to you today is the one of the older person's ability to travel distances to get to services they need. We have facilities in a metropolitan area designed to provide services to many of our elderly, but whether the individual can get to that service is another matter. I am sure we have heard time and again about the need of localizing services. Providing services where people live is of great importance.

There is still much confusion on the part of the elderly about Medicare benefits. A need still exists to acquaint them with their rights under the legislation. Many elderly still fear to utilize services available under the new law.

A common complaint of older persons is that the cost of various services has gone up since Medicare became operational. Until they reach the $50 deductable limit, this causes a hardship in many cases.

I do not envy the task of this Subcommittee but believe me when I say that you have my sincerest support and best wishes for finding solutions to some of our country's most pressing problems.

JEWISH CENTER FOR AGED,
St. Louis, Mo., June 16, 1967.

Mayor ALFONSO J. CERVANTES,
City Hall,
St. Louis, Mo.

DEAR MAYOR CERVANTES: I hope that this letter is received in time, by you, for submission of your testimony to Senator Smathers' Committee.

The thinking expressed in this letter is part of the problem which I reviewed in my letter to you of June 9, 1967.

The legislative definition of "a spell of illness" is very detrimental to the benefits of many elderly people of advanced age who cannot move from a nursing institution or an Extended Care Facility.

A resident of such an institution who becomes acutely ill at the beginning of the year and is hospitalized, say for the maximum of ninety days and then returned to the Extended Care Facility, say for a maximum of the one hundred

days benefits, cannot become eligible again during the year for any hospital benefits unless transferred out of the Extended Care Facility or nursing home to a domiciliary center for sixty days.

As I mentioned, such transfer would be detrimental, and in many instances, dangerous to the health of the advanced chronically ill aged. As a result they are not able to end "a spell of illness" and lose the benefits mentioned in the Medicare Law.

This inequity has become quite obvious and serious, and many efforts have been made to secure legislative change; but to no avail.

I hope your testimony can emphasize this point and help secure remedial legislation.

Sincerely yours,

SAMUEL ZIBIT,
Executive Director.

THE CARDINAL RITTER INSTITUTE,
St. Louis, Mo., June 8, 1967.

Hon. ALFONSO J. CERVANTES,
Mayor of St. Louis,
City Hall,
St. Louis, Mo.

DEAR MAYOR CERVANTES: A giant step has been taken to enactment of Medicare legislation in bringing to the older people within society the quality and quantity of medical and health care which is their right.

The exposure and services provided by the Medicare Program have enabled us in our activities to experience and appreciate the enormous benefits being made available to society. However, in addition hereto it is focusing our attention on numerous additional aspects of health care needs which must still be considered.

One example might be elimination of all deductible and co-insurance features of the Medicare Program, removal of waiting period and deadlines for enrollment. Deductibles form barriers to needed care for those least able to pay.

Secondly, extension of coverage for drugs regardless of their association to hospital confinement.

I hope these comments will be of some help.

Sincerely,

REV. ROBERT P. SLATTERY,
Director.

Mr. ORIOL. Now, I call the last witness, Mrs. Mary Guiney, who is project director for Project Well-Being in Detroit, Mich., and planning consultant on aging to the United Community Services of Metropolitan Detroit and who has so many honors and a history of work on the project relating to the elderly and others in need of health that we will insert this description we have in the record.

(The information follows:)

BIOGRAPHICAL NOTES ON MARY K. GUINEY, ACSW, PLANNING CONSULTANT, SERVICES TO THE AGING, UNITED COMMUNITY SERVICES OF METROPOLITAN DETROIT

The welfare of Senior Citizens has commanded the devoted energies of Mrs. Mary (Molly) Guiney for more than a quarter of a century. Regarded as one of the nation's foremost authorities on the aging, she has been Planning Consultant for Services to the Aging, United Community Services of Metropolitan Detroit (UCS), since 1953.

Mrs. Guiney's major responsibility currently at UCS is as administrator of Detroit's "Well-Being Project for the Aging". Regarded as a "first" in the nation, this Project was launched in June, 1964, as a three-year demonstration program to help older people maintain their health and precious personal independence in their own homes. It receives its major financial support from a U.S. Public Health Service grant and is being carried out in three geographic areas of Detroit which was high concentrations of older residents.

A native of Rochester, New York, graduated from the Rochester Institute of Technology and later completed studies at the New York School of Social Work at Columbia University.

Her broad experience and knowledge of the needs of older people was gained in both public and private agencies in Detroit. When the Bureau of Social Aid was established in 1940 in Detriot, she was named its supervisor and given the job of organizing it. During the years she remained with the agency, Mrs. Guiney administered old age assistance to many thousands and was responsible for licensing convalescent and other homes for the aged.

Prior to joining the Bureau of Social Aid, Mrs. Guiney served in a supervisory capacity with the Emergency Relief Administration and was general case supervisor for the Public Welfare Department of Detroit. Her first position was as a home economist with the Visiting Housekeepers Association in 1919.

She serves on both the Michigan Commission on Aging and the Mayor's Departmental Committee on the Aging. She is a past president of the Detroit Chapter, National Association of Social Workers, and holds memberships in several state and national organizations, including the American Public Welfare Association, the National Committee on Aging, the Michigan Society of Gerontology, and the National Society of Gerontology, Inc. She was a delegate to the first White House Conference on Aging, called by President Dwight D. Eisenhower in January, 1961.

Honors: Community-wide recognition of her efforts on behalf of the aging was accorded Mrs. Guiney in 1958 when she was named "Woman of the Year" by the Detroit Soroptomist Club, and again in 1965 when she received the "Award of Merit" from the Detroit Chapter, National Association of Social Workers.

Mr. ORIOL. We are very happy to have you here today.

STATEMENT OF MRS. MARY K. GUINEY, PROJECT DIRECTOR AND PLANNING CONSULTANT ON AGING TO UNITED COMMUNITY SERVICES OF METROPOLITAN DETROIT

Mrs. GUINEY. Thank you, Mr. Oriol.

I am honored to be here and I thank you for the opportunity of allowing me to come. I apologize for the public relations department in sending that stuff out without letting me see it. A lot of the material really is, I think, just for windowdressing.

I have prepared a very short narrative report of this project and I will try in the time allotted to offer some clarifying comments and some examples about the Well-Being project.

We will in the next few weeks be preparing a full 3-year report of the project.

I would like to refer to how this project came about. It was a combination of circumstances. The determination on the part of the metropolitan Detroit committee, to undertake the project was a culmination of 10 years of concerted effort to achieve its objectives, of finding and helping older people where they are and when their need arises, through other means.

It is unusual, of course, for a voluntary community planning body to provide direct service. In spite of the significant list of programs which were promoted, encouraged, and given financial support by the United Community Services, we found that the missing link in all of them was a way to reach and know older people before they became the statistics which we are all so familiar with, the newspaper stories of them being found dead, of fires started by the frail, of the exploitation of their resources by promoters of schemes of all kinds, and so on.

The project is a direct individualized service to the aging people who live in three geographic areas of Detroit, where the Detroit Housing Commission in its Department of Urban Renewal and Housing is carrying out neighborhood improvement activities. The core of the

service, which is called a sociomedical service, is a team of social workers and public health nurses on loan from the Visiting Nurses Association, who work directly with older people in their own homes.

They give nursing care and social services which are aimed at helping them to remain independent and avoiding or delaying unnecessary placement in institutions. They work with them on an intensive basis, covering a wide variety of problems.

Some of the older people are alone and have no family ties. Others are alienated from their families because of what the families call "their ways".

The staff people work with the families as well as with the older individuals. Some of them are financially independent, but do not know how to go about getting needed services. The problems which we deal with include financial, transportation, senility, social isolation, ill health, protective care, and guardianship.

Many have difficulty in finding proper housing, as they face eviction from their homes in the central cities because of condemnations brought about by the urban renewal, homes which they often occupied since they went into them as brides and grooms. Also, they have difficulties in taking care of their homes because of the infirmities of old age.

They are, in the main, those people whose health and social needs are not met by existing agencies in the community. They include, of course, the very elderly, the crippled, the recluse, the nonjoiner and they are people who have remained for the most part unknown and unseen.

The services of the Well-Being project includes such things as finding doctors. Doctors really are an essential part of the team. They find doctors in the community who will make home calls. They secure housekeepers, themselves turning in on occasion to do some cleaning, some cooking. They give nursing care, from simple things like clipping toenails to intensive care. They ride in the ambulances, take them to the old age assistance office, help them to fill out forms for medicare, deal with emergencies, go to court, taking guardianships, find volunteers, et cetera.

The teams, as I have said in the statement, employ the oldest techniques of the trade. These techniques were employed long ago by the Curés in old France who went up and down the streets doing good, and by the workers in the early settlement houses in this country, who also went up and down the streets. But these practices have now fallen into disuse as professionals of all kinds have become officebound.

They wait for people to come to them and to be able to tell what their problems are and then to respond to a request for service.

The lessons which we have learned in the project we believe can be applied in rural as well as in other urban communities. in fact, they can be employed wherever older people are.

The other witnesses here this morning have referred to the need for providing services for the ambulatory in their own homes, whether it be in group medical practice or other forms of cooperative services established in the community.

Desire to Stay at Home

We have confirmed what those who work with the aged already know, that regardless of advanced age or of economic or social status,

there is a fierce desire to remain in a dwelling of one's own, among familiar and treasured possessions, even though they may be broken-down chairs or old china cups without handles.

The major thrust of the project is to help the elderly achieve this goal of remaining in their own home even until death, if possible.

One of the lessons we have learned is that there is an advantage of being in the neighborhood. The home visits and the store front offices of the project add a new approach to helping older people. The workers have become familiar figures as they go up and down the streets and in and out of the homes. They are viewed by the community as friends, as well as competent professionals.

They can be compared to policemen on the beat, but the policeman on the beat, of course, is a thing of the past.

The staff team works in the here and now, they do what has to be done. They can always be reached. There is a secretary-receptionist in each office who knows where the workers are at all times. The offices have become sort of local institutions, something like the bank and the post office and the stores.

As the elderly go by to get groceries, to mail a letter or whatever, they often stop in to the neighborhood office to chat or to rest. Many of them serve an important function. They tell us when they know of a neighbor who is sick or in trouble.

Geographic Barriers

Another lesson which we have learned is that there are disadvantages to placing geographic limitations around services. A substantial number of the calls for the Well-Being staff have been for people who live outside of these prescribed areas. They come from relatives and friends of those who have been helped by the project, they come from public officials who get letters, especially during campaigns. They come from newspapers. Many come from Action Line, which you may be familiar with in your own paper. They come from other agencies and hospitals who can find nobody else to do the job.

The visiting nurse coordinator in one of our major hospitals appealed to the Well-Being project as a "last resort." She had called everybody in town without results. A patient in her seventies had had surgery for terminal cancer of the bladder. She had been told by the doctor that she could go home, which she longed so much to do, if a way could be found to take her to another hospital in another part of town every day for several weeks for cobalt treatments.

The nurse and social worker went to the hospital the same day and talked with the patient and with the doctor. They assured them that they would follow through with doctor's orders and they would take her for treatments themselves until another way could be found.

She was released the next day and the social worker and the nurse went to the home. The nurse drove her to the hospital that first day and the social worker arranged with a sister who lived nearby to come into the home and stay with the patient. The nurse was able to arrange with the cancer society to take up the daily trips from there on.

The conclusion is clear that we cannot confine the kind of service of the Well-Being project to any geographical boundary.

In the same category are people who are under the prescribed age limits. This, too, has been found unrealistic. Human needs are universal; ill health, loneliness, lack of knowledge of rights and resources, are found in people under 65 as well as over.

Men and women in their fifties, still trying to work, have the same problems as their older brothers and sisters. While these problems are not as frequent in the younger groups as in higher age levels, they cannot make a go of it without help.

In fact, a consultant of the National Council on Aging who recently did an evaluation of our project suggested that consideration be given in the future to extend this kind of neighborhood-based services to all categories of persons in the neighborhoods with emergency needs.

We have found that there is a high value in giving immediate attention, especially in situations where health problems exist. A substantial portion of calls which come in for Well-Being service are of the nature which require immediate attention. In order to accommodate this kind of what someone here has referred to as "putting out the fires" service, the workers have ignored hours and left their home telephone numbers where they could be reached after 5 and over weekends. Broken fingers or broken hips do not conform to any time schedule.

Mr. ORIOL. I ask just what the average age is of the people who participate.

Mrs. GUINEY. The people who are participating range from about 53 to 95.

Mr. ORIOL. Did you discover that there were special benefits in getting mature people in this age group?

Mr. GUINEY. Of getting——

Mr. ORIOL. Benefits. Did you discover they were more effective than younger people might get?

Mrs. GUINEY. Well, we found that in the younger aged services did not have to be so intense or provided for a long time. Actually with a little lift or a little change or less intensive services, the cases could be closed. Then by continuing acquaintance with them and occasional contact, they would do all right.

Mr. ORIOL. What was the training for the participants? How were the people trained to do the sort of thing you are describing?

Mrs. GUINEY. You mean, the social workers and nurses or the older people themselves?

Mr. ORIOL. The older people themselves.

Mrs. GUINEY. Well, they have established a series of meetings on health education. These meetings are held regularly in the community, in churches, libraries, or schools, and experts from the medical profession speak on caring for the feet, diabetes, glaucoma and cancer and the rest.

Old people learn from them something about the need to protect their health, some ways of caring for themselves, some ways of caring for their sick relatives in their own homes. They have a chance to ask questions and believe me they do ask them.

I remember recently when we had the director of the Dental School of the University of Detroit come in to talk about care of the mouth and teeth. Of course, many of the teeth were of the store variety.

Senator WILLIAMS. What does that mean?

Mrs. GUINEY. I mean that they were false.

Senator WILLIAMS. False teeth.

Mrs. GUINEY. They asked many questions, everything from mouthwashes to "were electric toothbrushes better than the other kind?" and so on.

These meetings are helpful not only in providing information and knowledge and in stimulating them to think and to take action on their own behalf, but they also have a social experience. They get dressed up to come to the meetings and then there are always cakes and tea and an opportunity to visit after the educational part is over.

As one elderly lady said, "they don't just teach me to dance and play games, they give me some real knowledge."

Mr. ORIOL. Would you just describe what one of your store front offices is like and some of the services that are available there?

Mrs. GUINEY. A storefront office is the kind you see along the main street in these small communities.

Senator WILLIAMS. Small communities. What do you mean, "rural communities"?

Mrs. GUINEY. No, small neighborhoods within the big city.

Senator WILLIAMS. Within Metropolitan Detroit?

Mrs. GUINEY. Yes, the storefront office has the name of the mayor on the window and the housing department is working to try to upgrade the physical aspects of the community, to get the supermarkets to build on vacant property there, to get small business places to put new fronts on their stores, and residents to put up new fences around their houses, to paint up and fix up.

They are really small offices, but most of the work is done from out of the office rather than in the office, although the older people do stop in as they go by on their way to the merchants or whatever.

Does that answer it about the storefront?

Mr. ORIOL. Yes. Thank you.

Mrs. GUINEY. We found, I think, that one of the major advantages of this kind of a decentralized service is its flexibility. We have no formal structure to delay the delivery service. The clients are seen without any kind of application or without appointments. Information and referral services are being multiplied over the country. We have a very good one in our own community supported by United Community Services. Many existing agencies also provide these services.

They are effective in telling the older people where the other resources are but, this does not guarantee the delivery of service. Our experience is that you cannot just tell them where the Detroit River is or where the hospital is, but if they are going to get service there, you have to go with them and help them to actually get the service or you have to bring the service to them.

I think of a client who was a highly emotional, volatile severe diabetic, woman of 65 with a heart condition. She had just been told by a young doctor at General Hospital that she was rapidly going blind. She began a round of visits and appeals to agencies, 18 of them in all. She made unreasonable demands, she was abusive, but what she was really seeking was some help in trying to face the terrifying experience

of losing her ability to see, on top of all of the other physical problems she had.

Each one of these 18 agencies referred her on to some other agency. A service for the blind gave her a white cane. They told her to go to Catholic Charities. Catholic Charities sent her to Family Service. On and on she went until she finally got to a young councilman in the city hall where she had gone to see about paying her taxes.

This councilman was also a professor of sociology at one of our universities and he listened to her, let her talk, let her threaten and then referred her to the Well-Being project.

When we went to the home to see her, she met us at the door with a gun. She said "there is no need of coming in here unless you can do something for me" and then she held forth for almost an hour, during which we listened. Then as we listened, we tried to hear what she was saying.

We heard her plead to have the benefit of the Reader's Digest. She said she loved the Reader's Digest. She had not been able to read it for 4 months.

In this we saw something tangible that we could do something for her that might inspire her confidence in us. So we went out to the Library for the Blind and got a talking book apparatus and 4 months back issues of the Reader's Digest. This gave her a feeling that somebody did care about her. We were able to continue to work with her, to get her to go for regular checkups to the doctor, and to pay attention to her diet. Although she is still abusive at times, she comes to the health education meetings and she is behaving pretty well.

We find that this storefront decentralized kind of structure——

Senator WILLIAMS. Could I interrupt?

Mrs. GUINEY. Yes.

Senator WILLIAMS. She went the whole gamut of the social service agencies. Why was it that they could not help her? Fortunately she ends up with your protective——

Mrs. GUINEY. Well, maybe I can take this case and follow it through for you. Most agencies have a specialized function and it often takes many kinds of service to solve one problem.

Senator WILLIAMS. They were not staffed for this particular kind of service?

Mrs. GUINEY. When she went to the hospital clinic for a diabetic checkup, the young doctor who discovered that she was losing her sight tried to break this gently to her, and said, "you are going to be eligible for a pension" for the blind.

He referred her to the public assistance office, to apply for aid to the blind. She was found to be ineligible because she owned two houses—they were in urban renewal areas and not worth much—in addition to the house where she was living.

She was referred to the Metropolitan Service for the Blind. They gave her a white cane. She told them that she needed someone to sew buttons on her husband's shirt, because she could no longer do it and she would like a young girl, a child, to stay with her, who could run errands and do other things for her.

On the basis of this request, they sent her to the Catholic Family Service. They are an adoption agency. She was told that people over 65

are not eligible to adopt children and she was referred on. I forget which one it was, one was a family agency.

Senator WILLIAMS. For one reason or another, she was ruled out at every step along the way.

Mrs. GUINEY. She didn't fit in, and no one agency had the quality of personnel, the time or didn't consider it their function.

Senator WILLIAMS. Until finally she got to city hall and then this young man took the time to bring her into his office and let her talk it out.

Now, is your entire budget furnished by the Public Health Service?

Mrs. GUINEY. No, but it is the major source of support. The budget is about $109,000 or $110,000 a year. Public Health Service has provided about $80,000 of that.

Senator WILLIAMS. Do you have a Community Chest or United Fund in Detroit?

Mrs. GUINEY. Yes.

Senator WILLIAMS. Are you one of their recipients?

Mrs. GUINEY. Yes. The United Community Services is the agency which allocates funds raised in the United Foundation Drive to the majority of the voluntary social agencies. It is a budgeting as well as a planning agency.

United Community Services absorbed certain bookkeeping, secretarial and office expenses; the Visiting Nurse Association contributed the technical supervision of their project nurses and the services of therapists, nutritionists and so forth. This amounted to about $15,000 a year, and the Public Housing Commission contributed office space and the help of their staff which amounted to about $5,500 a year.

It has been mentioned here today by the last speaker that he feels very warmly toward the Federal Government, and so do I, because without that grant from the Public Health Service we would never have gotten this project off the ground. The competition for funds by established agencies in the voluntary field has made it difficult to initiate such a project. Some of these agencies have been child welfare-oriented for 40 or 50 years, not recognizing the aged had problems. They don't want to change this. They still approach community problems in a traditional way and they are reluctant to establish a service for the aged, because it takes away staff and personnel from their major focus of service.

Senator WILLIAMS. I regret that I could not be here to hear all of your testimony, Mrs. Guiney. How long has the Well-Being Project for Aging been in existence?

Mrs. GUINEY. It came into being on June 1 of 1964, as a 3-year demonstration. Public Health Service funds ran out on the 31st of May, United Community Services has allocated funds to continue the service at its present level.

We will need to find new sources of funds because of the problems that we have had to deal with, which are expensive, especially the problem of guardianship and protective care. We found as we worked with the older people that many of them were unable to manage their own money.

The public assistance agency has been our largest source of referral of people whose old age assistance had to be cancelled because they

could not manage their money. Public assistance cannot take guardianships for the people that they give the money to, so we went into the business of becoming guardians.

This is expensive in terms of time and money and we will have to have help to carry on these additional services which we had to incorporate in the project.

Mr. NORMAN. Mrs. Guiney, is my understanding correct that at the present your only source of income is the United Fund—Community Chest?

Mrs. GUINEY. The only source as of June 1.

Mr. NORMAN. Have you ever considered seeking assistance under the Economic Opportunity Act?

Mrs. GUINEY. Yes, indeed, we did, Mr. Norman. We developed a project some 2 years ago, but this never got off the ground. First of all, there was not very much money coming into Detroit for the aged. It was already spoken for for youth, as you know, and although we had written up an elaborate project involving six counties, there were so many different evaluations and committees of all kinds that this number of jurisdictions simply stopped us from trying to get through.

The community action centers of OEO have cooperated in many ways with the project staff, but you know that they have very little money for comprehensive services to the aged. Recently Oakland County OEO was funded for Project FUND and we are very encouraged about this.

This will help to alert the community, will help to locate older people, but we still have to have somebody to deliver the service needed and this takes a high level of know-how.

Mr. NORMAN. Thank you.

Senator WILLIAMS. Do you have the support of the municipal city government?

Mrs. GUINEY. Yes, indeed.

Mayor Cavanagh is a stanch supporter. There are letters in the record, maybe I didn't give them to you, Mr. Oriol, of support from the mayor, from the public housing commission, from the Social Security Administration who we worked with hand-in-glove in the medicare programs.

We held numerous neighborhood meetings with the social security representative there talking with the older residents, individually and in groups.

Senator WILLIAMS. How about the newspapers in Detroit, do they help you?

Mrs. GUINEY. My, they really do.

Senator WILLIAMS. The Detroit Free Press?

Mrs. GUINEY. The Detroit Free Press and the Detroit News. The editors serve on the UCS board and planning committees. We have had tremendous support not only from the major newspapers, but from the little community newspapers. You know, this has been a two-edge kind of blessing, because while it brings us greater community support, it also brings us an awful lot of business.

Senator WILLIAMS. A lot of new clients?

Mrs. GUINEY. Yes, new clients.

Senator WILLIAMS. That is my battle call, that bill.

Mrs. GUINEY. I just want to say one thing before you go, Senator Williams. We have found in this project that we cannot overlook the potentials and the skills of older people. These are the opportunities which you promoted in the bills which you introduced and we have had some success in the neighborhoods with this.

Just one example. We had a very wealthy old lady who lives in a very expensive nursing home, but her family is away, far away. They wanted someone to take her out in a wheelchair around the block, pin a rose on her shoulder, pat her and make her feel that somebody cared about her.

We found a retired nurse in the neighborhood who comes in at 2 o'clock in the afternoon, works 4 hours, just giving her these little extra comforts. For this she is paid $10 a day. This extra money makes it possible for her to live independently in her own apartment which she would have had to give up if she didn't find a job.

Senator WILLIAMS. You brought these two together, is that right?

Mrs. GUINEY. That is right. We have done this in many ways. We brought a woman out of a convalescent home where she had been for 2 years after breaking her hip by finding another older person who needed a home and a job to go in and become a housekeeper. I can't recall the exact figures, but it costs much less to care for her in the house which she owned for 45 years and where she wanted to be.

It took the help of many others—the public assistance worker and the neighborhood resources, including a group of teenage volunteers who cleaned the house and cut the grass but, it served again the needs of two people and it worked out very well.

Senator WILLIAMS. Well, yours is a very inspiring story of success, help for older people that need help. You are in a settled major city and as I glance through your prepared statement, you almost went house-to-house to find older people that needed attention.

Mrs. GUINEY. Yes, and we still do.

RURAL POSSIBILITIES

Senator WILLIAMS. Well, let's hope that this example spreads through other metropolitan areas in this country.

Now, let me just ask you this. How is this kind of service and attention and care going to be brought to rural older people? That is a lot harder, I think.

Mrs. GUINEY. Well, I don't believe so.

Senator WILLIAMS. I hope you are right.

Mrs. GUINEY. We have had some experience in the rural areas, of Metropolitan Detroit. We found that in a rural community some 50 miles out of Detroit, older people are absolutely homebound. There isn't any way for them to get transportation to the nearest hospital clinic.

There used to be a train and then that went out. Then there was an interurban and that went out. Today there is a high level expressway and you can't thumb a ride on an expressway. There is no way for them to get to needed services without a team of circuit riders who will go to them.

Senator WILLIAMS. Do you have that?

Mrs. GUINEY. We have improvised it.

Senator WILLIAMS. Have you done that?

Mrs. GUINEY. Certainly. We have gotten service to them. In rural areas we have county health department nurses who make home visits. If we can add other people to the team—we need lawyers. We need doctors to make home calls; the whole community has to become part of the team. Pockets of poverty exist in the rural areas as well as in the central cities.

Senator WILLIAMS. Is this circuit rider described in your testimony, that concept of going to the rural areas?

Mrs. GUINEY. No, it is not. It will be in the upcoming summary report.

Senator WILLIAMS. We sure want that report. Your report will be comprehensive of all of your activities?

Mrs. GUINEY. Yes.

Senator WILLIAMS. But, as you indicated, it is not only those who are living with inadequate income, even a woman of wealth was in need.

Mrs. GUINEY. A case example of the economically independent is a woman of considerable wealth who was brought to our attention by the social security office, OASDI. They called to say that this lady was not cashing her checks. We went to her apartment and found a dirty, crotchety, old gal dressed in a bathrobe and slippers. The bathrobe was the kind that was made out of an Indian blanket that has not been seen in quite a while.

She was reluctant to let us in. The caretaker said she would not have a telephone. She kept sticking notes under other tenants' doors, saying, "You stole my check."

She was paranoid, she was accusing everybody of stealing things. After the first visit we received daily calls from the landlady telling us that she had lost her bankbooks. She could not find the records of her safe deposit. As we gained her confidence by going there constantly, and finding her papers for her we discovered that she was getting $800 every quarter from her stocks. That was quite an investment when the dividend check is $800. We found that she had savings and checking accounts in four different banks. She was a very wealthy woman, but she lived like a pauper.

We took temporary guardianship with the help of a trust officer and lawyer from one of the banks. Lawyers and judges serve on our advisory committees and they help us to quickly become guardians. We went with her to open the safe-deposit box. We found there letters which indicated she had a brother in Spokane. We telephoned the brother in Spokane, who was 92, but his wife was younger and there was a son, a nephew of the old lady, who said that they would make a home for her if we could get her there.

She agreed to go and to have us use her money to bring the nephew from Spokane. We helped her to pack up her hearing aid and little trinkets and to go back with the nephew to live in the home of the brother and sister-in-law and is now cared for by her relatives.

She was inviting robbery and attack by writing notes indicating that she had money and she could have been one of those casualties you read about in the paper.

Human needs are easy to name, but they are difficult to serve, when the frailties of the human frame make people inadequate, mentally frail, physically frail, to carry on their own business.

Senator WILLIAMS. Well, we certainly have responded inadequately, and we certainly have not met the economic needs of older people, but with our social security program, retirement plans, and pensions and trying to update them to economic levels that are realistic today, we still are left with human problems which money does not solve at all.

Mrs. GUINEY. Yes; and we still have the problem of helping the elderly to take advantage of the great social advances that have come about through the new legislation.

The medicaid program in Michigan is in a state of chaos. The person who has no money and is on old-age assistance is protected by the title XIX benefits, but the person with a few dollars too much—the medically indigent—cannot afford drugs or doctors. The brochure which explains the State program says people with marginal incomes can now get clinic services, drugs, and service from their own doctors—but, because of the fiscal situation in Michigan, the appropriation was stopped almost as soon as it began.

Senator WILLIAMS. Well, the Governor would not permit that would he?

Mrs. GUINEY. I think he is the man who gave the order. It was an executive order. Of course, it was based on the amount of money which it was going to cost, but it leaves the person who is solvent otherwise without drugs and care if he becomes ill.

Senator WILLIAMS. I have to leave, Mrs. Guiney. I just want to observe that the State of New Jersey that I come from was highly honored yesterday with Governor Romney as a visitor, today with Kosygin and the President.

Mrs. GUINEY. Yes.

Senator WILLIAMS. We are on the map.

Mrs. GUINEY. We have Governor Romney most of the time. We don't have the President very much. We do have a very great feeling of gratitude for what this committee and this Government and especially the Public Health Service did in giving a direct grant to a local nonprofit agency like ours, to make it possible for us to work so closely in partnership with both the public and private sectors.

Senator WILLIAMS. We are very grateful to you, I am sure of that.

Mrs. GUINEY. It is a thrill for me to come.

Senator WILLIAMS. Mr. Oriol and Mr. Norman would probably like to keep this conversation going. As I said earlier, it is inspiring and it gives us great promise for better days for older people.

Thank you.

Mrs. GUINEY. This is a rewarding kind of job, although it is hard work and often frustrating, it is a very exciting opportunity.

Senator WILLIAMS. We are the only special committee of the Senate and we have to be reinstated every year, but this kind of testimony, I think, will show the importance of the work we are trying to do in cooperation with you.

Mrs. GUINEY. It is reaching out to those who fall in between the services of other programs.

Senator WILLIAMS. Thank you.

Mrs. GUINEY. Thank you.

Mr. ORIOL. Mrs. Guiney, have you concluded your presentation?

Mrs. GUINEY. Well, I think mainly I was going to talk about the need to involve the total community, as I mentioned, from the barber

to the banker, from the merchant, from every person in the community, from the volunteer, the young mother with a station wagon to haul her six kids who comes and picks up our older people, from the professional people, the doctors who will make home calls in spite of their personal feelings about medicare. This disappears when they are confronted with an older person who is sick—the firemen who give up their card game for 15 minutes, and go across the street with a ladder to take down the storm windows of an old lady who could not possibly get them down herself.

So every aspect of the community is part of the team in a way. This makes support not only for the community, but it opens up many tangible resources for us. When a banker on one of our budget committees heard about individual cases, he remembered that he had a small trust fund of $2,500 which had been left in an estate to help needy old people. He said, "You can help me find the needy people."

We will be able to put a new fence around a haunted house in the downtown area where an old lady lives alone with her dog. The kids in the neighborhood broke down the old fence, and the dog got loose. He was her only protection. A fence will keep the dog in and the kids out.

We can get some needed dental care for an elderly woman who for 2 years has been going to the public clinic for a sore mouth. She had gotten a new set of dentures—I should not have said "store teeth," before, but they never fit her mouth and her mouth continued to be sore. She has a serious fungus condition in her gums. We have no way of getting this expensive treatment except through a special fund.

Money is often needed to call an ambulance or to pay a gas bill when the gas has been shut off. The utility companies have been very cooperative in prolonging shutting off dates if we can find the resource.

The telephone company contributes gifts and clothing.

One of the banks gave us a dozen baskets for Easter. Each with a 10-pound ham, 5 pounds of sugar, and large packages of food that one older person or two could not use all summer. We took the baskets to a little supermarket in the neighborhood which repackaged the food in smaller quantities, and we were able to give Easter baskets to twice as many people. They also deliver. This is the kind of cooperation which comes from being an institution in the neighborhood.

Need for a "Hub" Organization

Mr. Norman. Mrs. Guiney, it seems to me you are making a very important point here if I understand your point. It is my understanding you are saying there are perhaps in many communities resources and sources of assistance for elderly people if there is an organization to tap these resources and to bring the resources together with the elderly people, and that by organizing a group like your Project Well-Being, it makes it possible to find these resources and to make them available to the older people.

Mrs. Guiney. This is really the hub of it all. It calls for a competent staff who can make independent decisions without calling up the central office and asking a consultant who is at least one step removed from the older person and the community resource.

You have to be on the spot, to be known in the community. If you are downtown in a big building the older person thinks that he can never get service if he has to call up and wait for appointments and make out applications.

There is a close cooperation with the public assistance agency. One of the old age assistance staff referred to the project as his left arm in serving his clients. Michigan did not implement the Social Security Amendments of 1962 which provided matching funds for increased services to aged recipients. The project has helped in many ways not only those receiving assistance but in helping those technically eligible to apply for help. Many need protective care previously referred to. This is not available in Michigan and we cannot provide this with voluntary money alone.

Mr. ORIOL. Mrs. Guiney, on the subject of organization, the National Council on the Aging report on your project concludes with the recommendation:

> It is recommended that a special autonomous sociomedical agency be organized to receive and disburse funds for the continuance of the Well-Being Project for the Aging. This agency should be metropolitan in character, should have representation from the professions of social work, nursing, medicine, and law; should have a built-in research function for continuing self-analysis and evaluation; and should be capable of estimating close working relationships with all other on-going services of the community.
>
> This new agency should continue to experiment with ways of improving and meeting unmet needs.

Now, you remember the question I addressed before to Dr. Roemer and to Dr. James. They were describing health services of the future and how they might be reorganized to serve the elderly better.

Now, you have made it sociohealth, because the two are intertwined. In fact, health becomes the wedge that helps you do other social services.

This sort of central special agency to do this, do you see this perhaps as the nucleus of the kind of things that Dr. Roemer and Dr. James were talking about and that you as a person who has worked over a quarter of a century in Detroit on social problems, do you see this as the sort of thing that might work in many places?

Mrs. GUINEY. Yes, it seems to me that the combined skills are very effective, and I would like to see an independent agency to develop this concept more fully—dental problems are acute—we almost had a dental service in connection with the project. The University of Detroit Dental School applied for a grant from Public Health Service to work out of our neighborhood office. It was approved but in the meantime the man who was the spearhead, left the university and the funds were not taken up.

Leadership is terribly important and you have to have the right climate and the people have to believe in it.

Mr. ORIOL. Would a formal government agency help develop this kind of thing or might it discourage it?

Mrs. GUINEY. In the community, you mean? Well, I think the local government agency is so overburdened with what they have to do now with shortages or personnel, with the constant changes and regulations in the law, with the traditional requirement of determining eligibility, I know that the state department of social services recognizes the need for service, and wants it.

Mr. ORIOL. What I was talking about was the kind of agency that could do what you had done.

Mrs. GUINEY. You mean a government agency?

Mr. ORIOL. A government agency that can get social workers together, get physicians and lawyers and so forth to forget the old categories of trying to fit people into different programs and to make the program more flexible to meet the needs of the people.

Do you think a government agency, when supported by a private agency as you have and all the support you have built up—I think you can take credit for having built in that climate or created the kind of climate in which this would work—given all this, could a government agency be a good innovator and work with what we already have?

Mrs. GUINEY. I am sure that Government agencies can be good innovators. In fact, I think they are becoming the major innovators. You know, it used to be that the private sector of the community began and experimented and innovated a program and then it was taken over by Government. For example: the private agency used to give the financial relief. It was then taken over by Government for many reasons, but it seems to me today it is the Government that is doing the innovating. They have the vision and they have the concern and they have, of course, knowledge and funds.

Then, of course, when they pull out, it is difficult for voluntary funds to foot the bill. The aging come in last in the race for local voluntary money because funds raised in the United Foundation Drive are already spoken for by established agencies.

RELATIONSHIPS TO HOSPITALS

Mr. ORIOL. Mrs. Guiney, it seems to me you do a service by giving home care and not adding the total burden of hospitals. Do you, in turn, get cooperation from hospitals in speeding their processing on people who do have to go? In other words, do they feel that because they have you to support them, they know that they can get a person out of the hospital faster?

Mrs. GUINEY. Yes, and we work with them. They call us. I think I mentioned one case. In turn, we can call the hospital. The other day a 94-year-old woman had a severe coronary, and was taken into the hospital.

She lived in a home for the aged. Although the doctor was ready to release her, she could not be returned to her former room in her present condition and the family was desperate to know what to do. The hospital, agreed to keep her for 3 or 4 more days until we could make a plan so that she would not die on the way.

The nursing homes will do this, too. We work with nursing home administrators, who, if we are trying to make a home plan, will keep a patient for a few more days. Hospitals are, I think appreciative of our service.

Henry Ford Hospital is our big group practice hospital. They have called us, to help persuade people to accept the kind of care that they are prescribing, because we know the person.

The social service department and the doctors work within the hospital, and patients go to the hospital to see the doctors.

We had an old lady and she was completely broke, poverty-stricken who had had open heart surgery at Henry Ford. The doctors were interested in her, and she wanted to see them. After a joint conference with the doctors, and the social service department two doctors went out to call on her.

These things are not spectacular. They just come naturally when you are working closely with the services in the community.

Mr. ORIOL. Would you not say that is the big ingredient here, concern?

Mrs. GUINEY. Somebody who cares.

Mr. ORIOL. I also want to ask about physician attitudes. Did you have any plan at the beginning of your program or because of your long years of cooperation did you find that physicians were very receptive?

Mrs. GUINEY. We had the fortunate circumstance in having a very well-known and highly respected private physician as the chairman of the committee on aging of which I am the staff consultant.

Mr. ORIOL. You do have widespread support throughout the medical world.

Mrs. GUINEY. Yes, throughout the medical world. The fact that the medical men were interested in this service has brought us a great deal of cooperation. Actually, we have gotten doctors to make home calls like those from the hospital and to see patients after hours. This is another thing that I think we must not lose sight of, the time limits of service.

We have learned so much from medicine about responding to need when it happens. We have to consider some way of providing 24-hour service through some kind of a telephone answering service or making staff responsible for certain weekends, certain times, so that we have coverage 7 days a week, 24 hours.

I think we have learned this. Doctors have to be available when crisis strikes, so do other services.

Mr. ORIOL. I think you explained that, given us a good understanding of it.

Have you ever tried to make an estimate in dollars of how much your kind of service can save simply by keeping a person out of the hospital, for example?

Mrs. GUINEY. Well, I don't have the facts and figures but we can prove it is much less costly to keep people in their own homes even if we pay fulltime housekeepers in cost of dollars than in a convalescent home. We have cases that will demonstrate this. Under Medicaid, the public department will pay in our city $375 a month for nursing home care and some of it is less than high quality. This is a profit business, of course, and while there are some very good ones, there are some that are not very good.

Mr. ORIOL. Can you tell us offhand about how many people?

Mrs. GUINEY. I would say that we have had between 9,000 and 10,000 contacts.

Mr. ORIOL. Approximately how many people were involved in giving that service.

Mr. GUINEY. Well, we have a staff of seven.

Mr. ORIOL. Seven?

Mrs. GUINEY. We have three social workers and three nurses, a team of two in each office, and then we have one roving social worker who is a troubleshooter whenever one office is overworked and with cause.

Mr. ORIOL. Have you ever thought of doing what Operation Reason does in Baltimore—that is, enlisting several of the elderly people living right in the neighborhood to come to do some of this outreach or policemen-on-the-beat sort of thing?

Mrs. GUINEY. Yes, we have and it has been a major concern of ours to do it. I think you can understand that in the administration of this project we wanted to learn as much as we could—we felt that it was important for the professionals to give the direct service—simply didn't want to spread ourselves too thin to take on another project.

Mr. ORIOL. But now if you could have a stage 2 in this project——

Mrs. GUINEY. We have been talking about this for 3 years and the committee is very concerned with this very aspect. We now have an on-going plan. If we can have an on-going agency, as recommended, with a basic source of community support, then we can try to get project grants for other projects. We cannot exist just on projects alone. With a basis of operation which is supported by Government and the local community. We could undertake what we call a home helper service.

They are already alerters, the old people are a big source of referral. Of course, they refer their relatives in Illinois and Cleveland and all over Detroit.

Incidentally, we meet those needs. But we can use the older people and we can also use the assistant to the professional, but they have to be under the guidance and the supervision of someone with an awful lot of know-how and an awful lot of moxy. In other words, a skilled professional.

This is the next thing that we want to concentrate on, the use of the older person recognizing his abilities, giving him an opportunity not to just deteriorate because he has no decisions to make. There are many able people.

Mr. ORIOL. In the Williams bill you placed before——

Mrs. GUINEY. What happened to it?

Mr. ORIOL. I believe it will be the subject of hearings very soon. As soon as another bill is cleared on that committee, I think they intend to turn to that.

Mrs. GUINEY. It would fit our program perfectly, but you see, we could not divert the time of the professional staff during the demonstration. We didn't have enough time to promote this kind of thing.

Mr. ORIOL. That is one of the purposes of the bill, to give you just that extra bit of assistance.

Mrs. GUINEY. Yes. Then if we could get moneys to do this, we would have to have an administrator because this takes administration. This kind of program takes time. It takes knowledge of the person you are going to send out to serve the other older person and it takes work with the person who is going to be served in order to bring the two together.

It just does not happen and you can't push a button. We tried this. Years ago we felt that we learned from one of our many studies which

are gathering dust that older people wanted to work. We set up an employment project with the employment security commission, the telephone company, and our office. Every day in the front page of our newspaper there was a block prominent on the front page, which said "To employers: Would you employ an older worker? If you will, call this number."

The telephone company gave us instruments that would stretch across this room, telephones. The employment security put clerks on the telephones.

When these calls came in from employers, they went to their records of people who had said they wanted to work. We got 1,900 jobs offered in a matter of about 2 weeks, but we could not fill them and the reason was that there was not any go-between, you see.

You could not just call up those people who had said they wanted to work and who had put a card in the employment security office, saying they wanted the job.

When you call them up and say, "Report to Tool & Die Co. on Eight Mile Road tomorrow," they said, "Oh, well, I need transportation and my glasses are not very good and I don't know if I could go every day and my feet could not stand it."

See, we learned from that. That was a complete flop. Only six of them continued to work. I guess 20 went to work in the beginning. We have to have the in-between of counseling helping them to get ready. We have to make arrangements for part-time work.

They cannot respond to the alarm clock at 6 o'clock in the morning and working until 5. You need to condition them, because when they have not made decisions, suddenly they are cut off from decision making, they deteriorate very rapidly.

They can be rebuilt, but this is the process. It takes time and skills. When you talk about losing the right of decision and the cost in human values as well—think of putting people in convalescent homes unnecessarily when that door opens in, the old person never makes another decision.

They can't decide even what time they will have a bath or what time they will have lunch; they make no decisions. Someone else makes them all. They go downhill just like mashed potatoes, with too much milk.

A human being can't live without the opportunity to make some decisions for himself. Those people stay there for the rest of their lives, that door never opens out.

Well, we have opened those doors out in a few cases, because in one of our communities in Detroit, a project funded by the older Americans Act has a part of the equipment—what they call a minibus—where they can shuttle the old people to the stores and to the hospital and so on.

Mr. ORIOL. Senator Williams would have been happy to hear you say that. The first minibus was developed as a result of the Mass Transit Act of 1963 and he was the chief author of it.

Mrs. GUINEY. Is that so?

Mr. ORIOL. Here we have an example of a minibus.

Mrs. GUINEY. This should be most useful.

Mr. ORIOL. Is that bus designed in such a way you cannot step up into it, you can just step right ahead?

Mrs. GUINEY. I have not seen the bus. It was gotten from the Oldsmobile Co., in Lansing and it was not a new one. I think it was gotten for little or no money and the project has not gotten too far yet, because again they have not been able to find a person—you know, it takes a catalyst. Well, I don't know——

Mr. ORIOL. Someone like you.

Mrs. GUINEY. Well, not a crusader, but somebody around whom people can rally. They have not been able to find that kind of a staff.

The acute shortage of personnel is a serious problem everywhere. Our doctors have shown us that a high percentage of the people now in convalescent homes can come out given this kind of comprehensive service.

Mr. ORIOL. Mrs. Guiney, you touched upon transportation and we have heard other testimony showing how difficult it is for aged, isolated, and ill persons to get around. I wonder whether anyone is thinking about just as we have school buses to round up youngsters to take them to school, might it be feasible in a high-density area to have a hospital bus or a clinic bus that would take people at regular times?

Your neighborhood storefront offices can do so much. There comes a time when they might be more intensified. Do you think that might be feasible?

USES FOR MOBILE UNITS

Mrs. GUINEY. I think it would be very feasible. I think the mobile unit idea that we have learned from the health screening and TB could be useful here. As a matter of fact, one of the big automobile companies just within the past week called and said they would provide a bus and a driver and take 50 of our people on a picnic, wherever they wanted to go, out to the lake or wherever.

I think there exists in every community, and especially in ours, with the big automobile industry resources which can be tapped without too much cost. Industrial people have hearts, too and they sit on our committees.

Mr. ORIOL. I would love to sit here and talk to you out of sheer fascination, but I ask Mr. Norman if he has any questions.

Mr. NORMAN. No, thank you.

Mr. ORIOL. We have several articles from Mrs. Guiney, as well as other information, which we will seek from you on several other points we have made.

Was there anything else you wanted to say at this point?

Mrs. GUINEY. I would be very happy to supply information, I feel that this was a very curtailed kind of statement I submitted, but it is easier for me to talk, as you see, than it is for me to write these things all down.

I hope we can do something in the legislative halls. Didn't Senator Moss and Senator Kennedy submit bills which would penalize the nursing homes that don't have trained administrators and staff?

Mr. ORIOL. Yes.

Mrs. GUINEY. If we could penalize States—I believe in States rights, but I tell you the direct grants that we have gotten from the national level are so much freer of redtape and do not have to go through so

many hands. If direct help could be given in the areas where people live. The Medicaid example in our State has left perhaps the most needy group, the one with the dollar too much, out in the cold in terms of the costs of drugs and medicine. We did not get into this, but without the help of the World Medical Relief, who gave us $3,750 worth of drugs in the last 3 years to supply just those people who had marginal incomes, our work alone would not have saved them from going to a hospital or nursing home.

The wonderful promise of Medicaid was that for the first time in their lives they could have a private doctor and then it was cut off. The cost of drugs is prohibitive. We have worked with the private druggists in our neighborhood and we have gotten 30 percent reduction, by giving our card to the druggist. It is not unusual to get a drug bill of $30, $50, $80 a month.

I had a letter referred to me, from Niles, Mich. That is over on the border of Chicago. The head of the United Fund told of an old couple who live on social security and a private pension of $200 a month. Their drug bill is $80 a month. The letter asked if I could suggest any way to get free drugs?

The doctor is concerned. He knows that the drugs are necessary, but $80 a month out of $200 leaves little to live on.

Mr. ORIOL. Mrs. Guiney, I have received a note saying because of the unusual floor session today, we had better adjourn. We might be objected to, so I would like to thank you once again for giving us, I think, just what we needed at this point.

For the past 2 days we have been talking about problems, we have been talking about needs, we have been grouping to a sort of organization of community resources. I think you have given us an example that certainly should have a lot of study at this stage in our thinking about medical services for the elderly.

So thank you once again.

Mrs. GUINEY. I enjoyed being here. I thank you for letting me tell you, haltingly as it was, about our Detroit experiences. It was an honor to be included with the distinguished witnesses who appeared here this morning.

(Mrs. Guiney's complete statement follows:)

STATEMENT OF MRS. MARY K. GUINEY, DIRECTOR, WELL-BEING PROJECT FOR AGING, UNITED COMMUNITY SERVICES OF METROPOLITAN DETROIT

Mr. Chairman, thank you for the opportunity to appear here today. I have prepared a narrative report of the Well-Being Project which I will submit for the record, and then, with your permission, I would like to make further comments and perhaps discuss some of the questions which the Committee may have.

First of all, I would like to mention the objectives of the Well-Being Project which are more fully outlined in the attached evaluation report. Briefly, our goals were:

1. To develop methods of helping aging people maintain physical health while living in their own homes, and to prevent, as far as possible, the development of health crises; and

2. To mobilize, coordinate, and realign existing services to serve the aging.

(See attached description of the Well-Being Project and excerpts from an evaluation by the National Council on Aging. Also, *please note:* A statement on Detroit's Well-Being Project for the Aging was submitted to this Committee on June 14, 1965, and appears in, "The War on Poverty as It Affects Older Amer-

icans, Hearings Before the Special Committee on Aging, United States Senate, Eighty-Ninth Congress, Part I—Washington, D.C., June 16 and 17, 1965.")

PROJECT'S BEGINNING

When the Well-Being Project began, a tandem of social workers and public health nurses were given a map showing the numbers of people over 65 in the three selected neighborhoods. They went up and down the streets looking for the human consequences of the statistics which the figures never show. These teams used the oldest techniques of the helping arts, practiced by the Curés in old France and by the workers in this country's early settlement houses—Hull House of Chicago and Henry Street of New York. As they talked with them on their porches, in their gardens and in their kitchens, they heard from the lips of the old people about their ideas, their interests, their fears, and their hopes. They saw the impact of the old world culture on the foreign-born in the west-side area—frugal and suspicious. They saw the helplessness of those who sit in the city slums bereft of hope. They saw the boredom and dejection of those inappropriately placed in convalescent homes only because services to sustain them in their own homes are not available. Among the economically independent, these teams saw those in better homes deprived of the things that money cannot buy—good health, friendship, someone to counsel with and to guide them in times of personal stress or grief. The combined skills of our teams were available to all; and they went into action on-the-spot when problems were encountered.

LESSONS LEARNED

We believe that many of the lessons learned from the Well-Being Project can be employed in *rural* as well as other urban communities when given the proper climate and concern for finding new ways to protect the health, the safety, and the precious personal autonomy of older people.

We have found that *concern* is the important component. It means someone who cares—the architects of public policy; the purveyor of public and private health and welfare services; the doctor; the social worker; the nurse; the lawyer. It calls for knowledge and skill and integrity and compassion, and—above all—the ability and willingness to *blend* these skills and to *marshall* the kinds of help needed by the sick and impoverished aged.

We have found that regardless of advanced age or regardless of economic or social class, there is a fierce desire to remain in a dwelling of one's own among familiar and treasured possessions, no matter how meager.

Other lessons we have learned:

1. Advantages of services being accessible in immediate neighborhoods;
2. Disadvantages of geographic limitations;
3. Time and effort required and the need to reach out to the unserved; high value of immediate attention to calls for service;
4. Flexibility of structure—no formal policy to hamper delivery of service;
5. Need for professional competence of the highest caliber at all levels;
6. Value of the team approach;
7. Case examples illustrating Project scope—involvement of all segments of the community; individuals helped;
8. Obstacles encountered by the elderly in getting services from established health and social agencies.

The Social Security Act and its recent amendmendts, although presently fraught with ferment, represent a tremendous social advance in health and housing and personal services for the aging. As a social worker who worked face-to-face with Detroit's aged before Social Security or private pensions, I knew the alternatives well. I often accompanied the aged to the welfare office and saw them herded into a black carryall (a polite name for the paddy wagon) and driven off to the County Home with its beautiful gardens and jail-like, red brick buildings surrounded by high wrought-iron fenses and locked gates where old couples were separated. The men's and women's buildings were far apart on the spacious grounds.

The legislative reforms have brought us a long way. As wonderful as this is, the full benefits will not be reaped until we remove the barriers which still stand between the elderly individual and needed services. We cannot be complacent while tens of thousands remain unreached and unserved. The greatest stumbling block is attitudes. As Senator Smathers has said, "Many people would probably

like to think that Medicare and Medicaid have solved the major health problems of the elderly."

CONCLUSION

We would never have gotten off the ground with the Well-Being Project without the generous contribution made by U.S. Public Health Service—both through financial support and professional consultation and guidance. I thank you again for allowing me to tell you about the program.

EXCERPTS FROM EVALUATION REPORT OF THE WELL-BEING PROJECT FOR THE AGING OF THE UNITED COMMUNITY SERVICES OF METROPOLITAN DETROIT

BY THE NATIONAL COUNCIL ON THE AGING

The objectives underlying the WELL-BEING PROJECT FOR THE AGING are set forth in the original proposal to the U.S. PUBLIC HEALTH SERVICE on March 17, 1964, as:

1. To develop methods of helping aging people maintain physical health while living in their own homes, and to prevent, as far as possible, the development of health crises.
2. To mobilize, coordinate and realign existing services to serve the aging.

Sponsorship of the Project and responsibility for its day-to-day operations is by the UNITED COMMUNITY SERVICES, with Mrs. Mary K. Guiney, Planning Consultant, serving as the Project Director, and the funds administered by the UCS.

The financial support of the Project has been supplied by the Public Health Service through its Division of Chronic Diseases, Gerontology Branch, which allocated $79,420 for each of the first two years, beginning June 1, 1964, and $73,000 plus, for the third year which terminates May 31, 1967.

The operation of this Project is unique in that:

(a) Its officers are located in neighborhoods where it is felt the need of older persons is acute, and

(b) The staff assigned to each Project includes a trained Social Case Worker and a trained Public Health Nurse.

Two agencies work in close cooperation with the Project: the DETROIT HOUSING COMMISSION, through its Neighborhood Improvement Department which shares offices with the neighborhood staff and the VISITING NURSE ASSOCIATION which has assigned trained Public Health nurses on a loan basis to each of the neighborhood offices, and provides supervision for the technical nursing activities of these nurses. In addition, all of the health and social work agencies of the community are utilized by the Project both as sources of referral and as resources for the provision of services to clients or patients referred to them by the Project staff. Thus, the Bureau of Legal Aid is occasionally called upon to give legal assistance or consultation; the Family Service Agency is utilized for long-term counseling cases; hospital social service departments serve as both sources of referral and as a resource, etc. The list of agencies to which clients of the Well-Being Project have been referred occupies a full page, single space, in a recent report prepared by a consultant. That list includes public agencies such as the Detroit Department of Health, the Bureau of Social Aid for Old Age Assistance, Social Security Administration, etc., and voluntary health and welfare agencies such as hospital clinics. Neighborhood Service Organization, Homemaker Services, etc., and private physicians.

The organization of each of the neighborhood offices is unique. A social case worker and a public health nurse constitute the core of the staff together with a secretary-receptionist in the office. There is a second social worker assigned on a roving basis to all offices, and in all cases there is a social work student assigned by a school of social work. There is also an Advisory Committee in each Project office chosen from among the residents of the area served. These committees have been selected by the staff and include local merchants and articulate representatives of various types of residents living in the neighborhoods.

The operation of these offices has followed a fairly clear pattern. The three neighborhoods in which the services were established by the METROPOLITAN COMMITTEE ON SERVICES TO THE AGING were lodged in store front locations where visibility and ready accessibility were shared. In each instance the

store front office was shared with the staff of the NEIGHBORHOOD IMPROVEMENT SERVICE, a branch of the Detroit Housing Commission. Thus, the status of the Well-Being Project was established, and its relationship to the City's Neighborhood Improvement Program was indicated by the name of the Mayor on the window. In addition, the partnership between the Well-Being Project and the Neighborhood Improvement Office offered an opportunity for easy communication between these two forms of service. Once the office was established and the staff employed, they spent several months calling upon the older residents of the neighborhood. They located these residents through a variety of sources, such as churches, merchants, and other organizations in the area, and went calling door-to-door to inform the residents of the neighborhood of the existence of the Project and its availability to the neighborhood's older residents for any problem with which they felt they needed help. Circulars were distributed, group meetings were addressed by the staff, and altogether an intensive effort was made to acquaint the neighborhood with the Project.

It was not long after this intensive public relations effort was begun that applications for service began to come in; people dropped into the office, others telephoned, and quite frequently other agencies began referring neighborhood seniors to the Project for assistance not readily available from the established health and welfare agencies of the community. By the time the neighborhood office was in existence for a few months, the calls for service reached such proportions as to require the full time of the staff.

Gradually intensive public relations efforts were lessened, and concentration on services directed to clients became the major order of business. In addition, the Advisory Committees were selected and regular meetings by them and the staff established.

At the same time, the staff established a system of neighborhood meetings primarily focused on health education. Although the subject matter of these meetings was usually some phase of health care, the nature of these meetings was also social in effect. Residents attending them tended to dress up for the occasion, some of them contributed cakes and cookies for the refreshment period which always followed the more formal period of the meeting. The meetings thus have taken on the character of a semi-social occasion for which residents dress up and meet their neighbors as well as learn something of benefit to themselves.

Project Value

The Well-Being Project for the Aging provides an excellent service in response to a genuine need. Its uniqueness lies, first, in the fact that the neighborhood offices are situated in stores located in the middle of neighborhoods where the services are given. Hence, the Project is both visible and easily accessible to the residents of the neighborhood. This has made for strong indentification of residents of the neighborhood with the Project staff—so much so indeed, that a frequent comment by older residents in the area is, "What will we do if this office is closed? You are needed here."

A second factor which affects the value of the Project is its staff structure. Combining services from the two professions, nursing and social work, has proved effective in meeting the great majority of the problems which are brought to the staff for solution. For cases where these two professions need other assistance as, for instance, legal or medical help, these are brought in on a case-by-case basis.

An added factor which was clearly visible in each of the neighborhood offices was the high sense of dedication of the staff. Both the social workers and the nurses evinced enthusiastic response to the calls for help; they often left their home telephone numbers with clients who might have need of assistance in the evenings or during the weekends, and were not at all averse to making home calls after regular office hours, or on weekends.

There is a fourth factor which is valuable in this Project: the flexibility of its operations. The staff will go into the home of any client quickly and without any restrictions as to functional limits. This is unique in the organization of health and social agencies, where rigidity of function and procedures are sometimes a deterrent to the provision of services needed quickly and effectively.

Recommendation

It is recommended that a special autonomous socio-medical agency be organized to receive and disburse funds for the continuance of the Well-Being Project for the Aging. This agency should be Metropolitan in character; should have represen-

tation from the professions of Social Work, Nursing, Medicine and Law; should have a built-in research function for continuing self-analysis and evaluation; and should be capable of establishing close working relationship with all other on-going services of the community.

This new agency should continue to experiment with ways of improving and meeting unmet needs.

MOST HOLY TRINITY RECTORY,
Detroit, Mich., June 17, 1967.

Senator GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate Building, Washington, D.C.

HONORABLE AND DEAR SENATOR: This letter is written in behalf of the petition made to the Federal Government to assist in the work done by the Well-Being Project, a program initiated by the Metropolitan Committee on Aging here in Metropolitan Detroit.

I am a parish priest in the Inner-City of Detroit and have followed the work of the Well-Being Project with great interest over the years of it's existence. I could enumerate many case histories in which their work is illustrated, but I cite only two. Their work seems to be most effective because it is not work that stays in an office and requires aged people to come to them. They are constantly seeking out those who are in the greatest need and their effectiveness has been very good.

The first case is one of an old woman, quite intensive alcholic, living in a horrible old house in squalor. By reason of the team work; the nurse, the social worker, and the secretary by repeated visits convinced the woman of her illness and her ability to live in better circumstances where she would have a fine room in a hotel designed for the aged, and good food. After visits to her that were friendly and gracious she saw the wisdom of this and left her house. The things she wanted were carefully picked up and packed for her. Whether she has surmounted the alcholic problem I do not know, but certainly she was very happy in her move and this was a most difficult thing. Other people had tried to get her to move without success.

The second case involves a very neurotic woman living in an extremely noisy apartment, crowded and unkept. Repeated visits to this woman convinced her that her health required a quiet place. The social worker then worked hard to get her aid budget moved up so that she could move to a fine campus living quarters called Kundig Center for the Aged. She is very happy there, her health has improved, and her outlook on the world has helped her conquer her neurosis.

There are similar cases but primarily the effect of this team work is most interesting because they constantly are in poor neighborhoods.

They have established a wonderful esteem for their agency and the word-of-mouth gives them so much attention and so much work that they really could benefit a great deal if your esteemed agency would help them establish more teams, not only in this town but in every Metropolitan Center where the aged are in such large numbers.

Respectfully submitted,

FATHER CLEMENT KERN.

Mr ORIOL. The subcommittee will hold future hearings on the subject, but we don't have a date at this time.

(Whereupon, at 12:55 p.m., the subcommittee recessed, to reconvene at the call of the Chair.)

APPENDIXES

APPENDIX 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1: INFORMATION FROM REPRESENTATIVES OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

A—MEMORANDUM UPDATING REPORT TO THE PRESIDENT

NOTE.—A Report to the President on medical care prices by the Department of Health, Education, and Welfare, dated February 1967, is printed in full beginning on p. 319 as appendix 3. A memorandum updating that report to June 22, 1967 was submitted by the Department of Health, Education, and Welfare at the request of the Special Committee on Aging, U.S. Senate as follows:

Now then, what effect has Medicare had on the costs of health care? It might be said that the Medicare and Medicaid programs are helping the elderly to avoid the difficulties others of our population are facing. Medicare is most effective in the areas where costs have been rising more rapidly—inpatient hospital care and physicians' services.

Recent Price Rises to December 1966

Between 1960 and 1965, *medical care prices* rose at a rate of between two and three percent per year. In 1966, however, the Medical Care Index increased 6.6 percent—the largest annual increase in 18 years.

The 1966 acceleration in medical care prices was largely accounted for by substantial increases in the prices of both major objects of medical care expenditures—hospital and physicians' services.

Hospital daily charges, which had been rising about 6 percent per year between 1960 and 1965, went up 16.5 percent in 1966—the largest annual increase in 18 years, since the post World War II inflationary period. The increase in hospital daily charges was particularly sharp in the second half of 1966—11.5 percent as compared with 4.5 percent for the first six months.

In contrast, *physicians' fees*, which had been rising about 3 percent per year in the period 1960–65, went up 7.8 percent in 1966. This was the largest annual increase since 1927. Physicians' fees increased 3.8 percent in each half of 1966.

Drug prices have not been a major factor in rising medical prices. There has been no appreciable change in the drug component of the Consumer Price Index during the six-year period ending March 1967. The prices of prescription drug items in the CPI actually declined by almost 12.0 percent in the past six years.

Drug industry sources give a slightly different picture than the Consumer Price Index. The average retail price per prescription, as reported in the *American Druggist*, increased at an annual rate of slightly less than one percent per year between 1960 and 1966.

The average prescription price reflects the use of new drug products, and changes in the quantities of drugs prescribed. In contrast, the Consumer Price Index reflects changes in the unit price of the same or similar drug items over periods of time.

PRICE RISES, 1967

In the first quarter of 1967, the rate of increase in *medical care* prices continued at about the same pace as in the last quarter of 1966. They rose 2.0 percent in the first quarter of 1967. While *physicians' fees* continued to rise at about the same rate as in 1966 (1.9 percent increase for the first three months of 1967), *hospital daily room rates* have continued to rise at a rapid rate, up 6.1 percent in the first quarter of 1967.

THE IMPACT OF THESE PRICE RISES

Price increases of this magnitude impose a major burden upon many Americans. In 1965, per capita expenditures on health care were 6.0 percent of personal income after taxes. Nearly 60 percent of these expenditures were on hospital and physicians' services.

The impact of the rise in hospital charges upon the elderly has been largely mitigated by the advent of Medicare, since most hospital bills for the elderly would have exceeded the $40 inpatient hospital deductible in the absence of these price rises. However, these increases will, of course, substantially increase the costs of Part A of Title 18 of the Social Security Act.

The recent acceleration of the rate of increase in physicians' fees has not significantly affected the elderly. The coinsurance provisions of Medicare have blunted the impact of these price rises.

However, this conclusion relates to physicians' customary charges—the fees the physician charges to most of his patients for his services. As of July 1, the average fees of physicians, and their incomes, have increased because of the payments of customary charges under Medicare. Many elderly persons previously were paying charges lower than the customary charges of physicians.

Therefore, many aged persons, although the exact number is not known, will now find that they are being charged more for a given service, since their physician is now charging them the same fee he charges to the majority of his patients. This anticipated development will primarily affect those elderly persons who spend less than $50 on the medical and other health services covered by Part B of Medicare.

Although the price of drugs has not risen significantly in recent years, there are a number of reasons for concern about the cost of drugs. Before Medicare, average per capita drug expenditures by the elderly were about twice as high as the average for all persons in the population. Thus, the cost of drugs imposes a major financial burden upon many elderly Americans.

A large proportion of the total drug expenditures by the elderly are incurred by aged persons who are high users of medical care. For example, in 1962, 10 percent of these persons over the age of 65 incurred 40 percent of the expenditures on drugs by all persons over the age of 65. But out-of-hospital drug costs are generally not covered by health insurance.

THE EFFECT OF MEDICARE ON RECENT PRICE RISES

The available evidence suggests that Medicare has not had a significant effect upon the recent acceleration of the rate of increase in *physicians' fees.* Although Medicare will increase the use of physicians' services by the elderly, the impact of Medicare upon the total demand for physicians' services is likely to be on the order of 2 percent.

In the past, physicians' fees have tended to increase faster when other prices in the economy were increasing rapidly—as they did in 1966.

If anticipation of Medicare was a major factor underlying fee increases, it would be expected that fees charged the elderly would move up faster than fees charged younger patients in the period before July 1, 1966. A special analysis by the Social Security Administration showed, however, that the price indexes for child and adult care moved up more rapidly during the six-month period before Medicare went into effect, than the five special indexes of surgical and medical procedures particularly applicable to aged persons.

In the absence of Medicare, the 1966 acceleration in *hospital costs* would not have been surprising. Rising wages in tight labor markets were bound to exert pressure on hospital costs. Further, collective action upon the part of nurses became more predominant in 1966. Several nurses strikes took place in major cities throughout the country. Thus, hospital payroll per employee went up 9.0 percent in 1966, in contrast to an average of 4.7 percent per year between 1960 and 1965.

The influence of Medicare upon *hospital charges* probably came primarily through the impetus it provided hospitals to reexamine their costs and charges. It is likely that many hospitals decided to increase their charges sooner than they otherwise would have in the obsence of Medicare.

The total *occupancy rate* in hospitals was four percent higher in August 1966 than in August 1965. However, after an initial upsurge in hospital admissions in July and August of 1966, the number of hospital admissions for the balance of 1966 was not significantly different from the number for the comparable months in 1965.

Higher occupancy rates and numbers of admissions to hospitals would be expected to lower, not raise, hospital costs per patient day. Information from the American Hospital Association indicates that hospital costs per patient day actually declined slightly during the period from June to November 1966.

In contrast, average hospital costs per patient day increased from about $45 in January 1966 to $52 in June 1966. Therefore, the increase in the demand for hospital services attributable to Medicare was probably not the most important causal factor influencing the recent acceleration in hospital charges.

Thus, although anticipation of Medicare may have resulted in higher medical costs, the recent acceleration in medical care prices seems to reflect the more general rapid price increase in 1966.

Mr. Chairman, I should like at this point to call to your attention a National Conference on Medical Care Costs which is to be held at the Washington-Hilton Hotel on June 27–28.

This conference, called by Secretary Gardner, will bring together physicians, hospital planners, hospital administrators, health insurance experts, drug manufacturers, economists, representatives of consumer groups, and others to discuss the factors which influence medical costs and ways to improve the delivery and quality of medical services.

The discussions will be divided into five panels, each to consider a different aspect of medical costs.

The panel on "Hospital Costs" will consider such issues as increased productivity and better use of personnel, extension of health services outside the hospital, and improved coordination of all community health services.

The panel on "Community Health Systems, the Costs of Underdevelopment," is expected to discuss the following types of questions: What is the community's responsibility for developing health facilities and manpower?

Will community planning for health services be effective in containing costs? What should be the community's role in planning its health care system?

The third panel will focus on the costs of physicians' services. The panel will discuss ways of increasing physician productivity, the efficacy of group practice, the role of the physician in family health management, and the organization of medical practice in rural areas.

The panel on "The Costs of Pharmaceutical Services" will discuss the likely impact of prescription reimbursement plans on the cost of drugs to the consumer. Discussion is also expected to include the relation between prescription practices and drug costs, the functions of the pharmacist in drug control and distribution, and the professional fee system as opposed to the traditional "mark-up" system.

The fifth panel will discuss "The Impact of Third-Party Payment." The panel will consider such problems as the effects of present prepayment mechanisms on rising costs, the gaps in present coverage by private insurance plans and Medicare, and the standards for minimum coverage.

In addition to the panel discussions, several speeches will be delivered to emphasize the need to provide high quality medical care in an efficient manner to all Americans.

As you may judge from the conference program, we are concerned that Medicare will take part in the effort to prevent undue increases in health care costs.

B—Health Insurance for the Aged: Claims Reimbursed for Hospital and Medical Services*

Claims for reimbursement of part of the cost of hospital and medical services under the health insurance program for the aged are recorded in the central

*Division of Health Insurance Studies, Office of Research and Statistics.

records of the Social Security Administration. The data on these claims provide a means of measuring the extent of utilization of covered services, as well as information on the total charges and amounts reimbursed for these services.

The January 1967 issue of the Bulletin presented data on inpatient hospital claims for the first 3 months of the operation of the health insurance program for the aged. More complete inpatient claims data covering the first 6 months of the program's operation are now available and are presented here. Also included are the first available figures on the bills reimbursed and recorded in the Social Security Administration central records during the first 8 months of the medical insurance program.

INPATIENT HOSPITAL CLAIMS

For July–December 1966, approximately 1.7 million inpatient hospital claims were reported by intermediaries as approved for payment under the hospital insurance program as of February 24, 1967. Claims approved are reported in table 1 according to the specific month of intermediary approval and include those recorded in the central utilization record as of the February date.

Because of lags in the reporting and processing of claims under the hospital insurance program, the number of monthly claims reported here probably do not represent all the claims for services approved in any given month. As more time elapses, claims data for the earlier months will become more nearly complete. For example, claims approved for payment during the first 3 months of the program and recorded in the Social Security Administration tape record as of February 24, 1967, totaled 629,833, or about three-fifths more than the number recorded for the same period 4 months earlier.[1]

The number of claims approved by intermediaries and recorded in the tape record each month only partially reflects actual inpatient hospital utilization under the program. Delays in submission of claims by hospitals, in claims processing by intermediaries, and in recording the data in the central utilization record result in understating the number of cases receiving inpatient hospital care during the month.

Distribution of the 1.7 million claims by month approved shows only 2 percent recorded in July, a sharp increase in the following month, a continued monthly upward trend to a peak of 381,355 in November, followed by an 8-percent drop in December. The small number reported for July reflects the delay in transmittal of forms and claims at the beginning of the program. The drop in December from the previous month may be the result of the lag in reporting and recording the data as of February 24, 1967, the date of summarization.

The 1.7 million claims account for 21.8 million days of care covered under the hospital insurance program, or an average of 12.6 days per claim. A claim is defined here as the submission of a bill requesting reimbursement for inpatient hospital care. Claims are generally submitted after a person is discharged from the hospital. Interim bills or claims requesting payment for part of an inpatient hospital stay may, however, be submitted. The average length of stay per claim is therefore less than the average per discharge, especially for long-stay hospitals, which are more likely to submit interim bills when the stay covers an extended period.

The average number of days of covered care increased monthly from 7.0 days in July to 13.6 in December. Claims approved and processed during the early months included a considerable number of stays for persons who were in hospitals on July 1 so that only the part of these stays after June 30 is reflected in the number of days that were covered under the program and for which reimbursement was requested.

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[1] See Howard West, "Health Insurance for the Aged: The Statistical Program," *Social Security Bulletin*, January 1967, page 13, table 6. (Reprinted on p. 167–182.)

TABLE 1.—HOSPITAL INSURANCE—NUMBER OF CLAIMS APPROVED FOR PAYMENT, COVERED DAYS OF INPATIENT CARE, TOTAL CHARGES AND REIMBURSED AMOUNT, BY MONTH CLAIM WAS APPROVED AND TYPE OF HOSPITAL, AS OF FEB. 24, 1967 [1]

Month claim approved [2]	Approved claims			Hospital charges				
	Number	Covered days of care [3]		Total (in thousands)	Per claim	Per day	Amount reimbursed	
		Total	Average per claim				Total (in thousands)	Percent of total
	All hospitals							
Total [4]	1,734,853	21,843,398	12.6	$939,753	$542	$43	$748,700	79.7
July	40,475	284,676	7.0	11,264	278	40	8,364	74.3
August	268,640	2,776,155	10.3	116,057	432	42	90,878	78.3
September	320,718	3,977,478	12.4	167,758	523	42	133,525	79.6
October	372,227	4,909,498	13.2	208,796	561	43	167,442	80.2
November	381,355	5,103,484	13.4	223,470	586	44	179,250	80.2
December	351,438	4,792,107	13.6	212,408	604	44	169,240	79.7
	Short-stay hospitals [5]							
Total	1,708,936	21,057,538	12.3	$921,710	$539	$44	$733,474	79.6
July	40,354	283,463	7.0	11,229	278	40	8,336	74.2
August	265,757	2,712,427	10.2	114,332	430	42	89,336	78.1
September	316,696	3,864,869	12.2	164,810	520	43	130,928	79.4
October	365,266	4,699,714	12.9	204,229	559	43	163,550	80.1
November	375,353	4,913,395	13.1	219,159	584	45	175,764	80.2
December	345,510	4,583,670	13.3	207,951	602	45	165,560	79.6
	Long-stay hospitals [6]							
Total	21,613	738,900	34.2	$16,297	$754	$22	$13,993	85.9
July	116	1,150	9.9	33	286	29	26	79.7
August	2,880	63,715	22.1	1,725	599	27	1,542	89.4
September	3,613	108,792	30.1	2,797	774	26	2,489	89.0
October	5,655	195,807	34.6	4,039	714	21	3,518	87.1
November	4,649	175,395	37.7	3,756	808	21	3,091	82.3
December	4,700	194,041	41.3	3,948	840	20	3,326	84.2

[1] Includes only those claims approved and recorded in the Social Security Administration central utilization record before Feb. 24, 1967.
[2] Month in which the intermediary approved the claim for payment.
[3] Includes covered days of care after June 30, 1966 (not exceeding 90 days in a spell of illness).
[4] Includes 4,302 claims with type of hospital unknown.
[5] General and special hospitals reporting average stays of less than 30 days.
[6] General and special hospitals reporting average stays of 30 days or more; tuberculosis, psychiatric, and chronic disease hospitals; and Christian Science sanitoriums.

Only a small percentage of claims—about 1 percent—is for care in long-stay hospitals. The average number of days per long-stay hospital claim is nearly three times that of the short-stay hospital claim—34 days compared with 12 days. The long-stay hospital claims include only the days of care covered under the program—up to 90 days of care in a "spell of illness." Inpatient hospital care beyond the maximum covered is not reported here. Although the data presented cover the first 183 days of the program's operation, the period is not long enough to reflect many long stays. Thus, the average length of stay will probably con-

tinue to increase monthly as the program progresses, especially for long-stay hospitals.

Total charges for the 1.7 million tabulated claims amounted to approximately $940 million, representing $542 per claim and $43 per day. Distribution of the claims by type of hospital shows that the total charges per claim are almost 30 percent less in short-stay hospitals than in long-stay hospitals but the daily charges for the former are double those for the latter. Total charges averaged $22 per day in long-stay hospitals and $44 per day in short-stay hospitals.

Approximately four-fifths of the $940 million in total charges was reimbursed under the hospital insurance program. The amounts reimbursed during these early months of the health insurance program are based on interim per diem rates that will be adjusted in the future on the basis of reasonable costs of operation of the hospital. Deductible and coinsurance payments by beneficiaries and noncovered services are, of course, excluded from the amounts reimbursed.

The proportion of total charges reimbursed under the program varies with the type of hospital—79.6 percent in short-stay hospitals compared with 85.9 percent in long-stay hospitals. This difference is a function of the variation in length of stay. When the stay is short, the $40 deductible and any noncovered items (private rooms, if not medically indicated, and other luxury services) account for a larger proportion of the total bill. Conversely, when the hospital stay is long, the deductibles and noncovered items represent a relatively smaller part of the charges. For stays beyond 60 days and up to 90 days in a spell of illness, the eligible beneficiary pays a coinsurance amount of $10 per day. For these very long stays, the proportion of total charges reimbursed will decline.

SUPPLEMENTARY MEDICAL INSURANCE CLAIMS

The data on inpatient hospital claims presented above are obtained from the bill form approved for payment by the intermediary and forwarded to the Social Security Administration for recording in the central record. The data on medical insurance claims (excluding home health and outpatient hospital services) are based on a payment record consisting of tape, punched card, or other machine-readable records of each bill paid by the intermediary to a physician, beneficiary, or supplier of service under the program.[2] Thus the payment record provides a rapid method for summarizing data on the number of bills paid and recorded in the Social Security Administration central records, type of service provided, total reasonable charges, and amounts reimbursed under the medical insurance program. For home health and outpatient hospital services, claims data are based on bills approved for payment by the intermediary and forwarded to the Social Security Administration.

Reasonable charges are determined by intermediaries on the basis of customary charges for similar services generally made by the physician or other supplier of covered services and on prevailing charges in the locality for similar services. They cannot be higher than the charges applicable for the intermediary's own policyholder for comparable services under comparable circumstances. Reimbursed amounts are payments by intermediaries after the $50 deductible has been met and excluding the 20-percent coinsurance.

Data are presented for almost all of the first 8 months of the operation of the program, divided into four specified periods based on the date of record summarization: July 1–October 14, 1966; October 15–December 2, 1966; December 3, 1966–January 20, 1967; and January 21–February 23, 1967. All the payment records processed during these periods are now included so that, unlike the claims reports in the hospital insurance program, future monthly reports of payment records data under the medical insurance program will not provide additional data for the earlier months. The payment record is intended to provide fairly current data on bills paid by carriers.

These data, however, should not be construed as current information on the utilization of services under the program. Nor should the average charge per bill be construed as that for the average enrollee. For example, a patient receiving services in a specific month may possibly wait to submit all his bills at the end of the year or, if his physician accepts assignment, the latter may accumulate bills for periods of several months. Current data on the utilization of services

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[2] For a more complete description of the payment record and other basic records, see Howard West, *op. cit.*, pages 5–8.

TABLE 2.—MEDICAL INSURANCE—NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL REASONABLE CHARGES, AND REIMBURSED AMOUNT, BY TYPE OF BILL AND PERIOD RECORDED AS OF FEB. 24, 1967 [1]

Type of bill and period recorded	Number of bills	Reasonable charges		Amount reimbursed	
		Total (in thousands)	Per bill	Total (in thousands)	Percent of total
All bills [2]	2,582,207	$217,871	$84	$146,765	67.4
July 1 to Oct. 14, 1966	138,035	16,433	119	10,449	63.6
Oct. 15 to Dec. 2, 1966	328,082	32,785	100	21,482	65.5
Dec. 3, 1966 to Jan. 20, 1967	893,765	76,811	86	51,782	67.4
Jan. 21 to Feb. 23, 1967	1,222,325	91,842	75	63,052	68.7
Surgical bills	516,373	98,416	191	70,527	71.7
July 1 to Oct. 14, 1966	44,715	9,419	211	6,486	68.9
Oct. 15 to Dec. 2, 1966	84,628	16,846	199	11,834	70.2
Dec. 3, 1966 to Jan. 20, 1967	183,210	35,048	191	25,115	71.7
Jan. 21 to Feb. 23, 1967	203,820	37,103	182	27,091	73.0
Medical bills	1,812,577	111,051	61	70,951	63.9
July 1 to Oct. 14, 1966	89,654	6,774	76	3,812	56.3
Oct. 15 to Dec. 2, 1966	229,300	15,155	66	9,198	60.7
Dec. 3, 1966 to Jan. 20, 1967	636,850	38,919	61	24,902	64.0
Jan. 21 to Feb. 23, 1967	856,773	50,203	59	33,039	65.8

[1] Includes only those bills for which reimbursement was made by the intermediary and which were recorded in the Social Security Administration central utilization record before Feb. 24, 1967.
[2] Includes 253,257 bills for medical services other than physicians' services, such as home health, outpatient hospital, independent laboratory, and other services covered under the program.

under the medical insurance program are being collected by means of the Current Medicare Survey.[3]

By February 24, 1967, almost 2.6 million bills had been reimbursed by intermediaries under the medical insurance program and were transmitted to and recorded in the Social Security Administration central utilization record. A bill is defined here as a request for payment from or in behalf of a beneficiary as a result of services provided by a single physician or supplier. The bill may cover one or more covered services provided to an eligible beneficiary on the same or different dates. Thus, one bill may cover an office visit to a surgeon before an operation that includes diagnostic procedures, the inhospital surgical procedure, and several postoperative visits in and out of the hospital.

Of the 2.6 million bills for physicians' and related services, 70 percent were classified as medical services and 20 percent as surgical services, and the remaining 10 percent were for other services covered under the medical insurance program (table 2). When a physician includes charges on a single bill for both a surgical procedure and a nonsurgical procedure, the highest-priced service is the determining factor in classifying a bill as surgical or medical.

Total reasonable charges for the 2.6 million bills amounted to approximately $218 million, or an average of $84 per bill. Total charges include the entire amount of the individual's bill, including the deductible and coinsurance, where no previous bills for covered services had been submitted and the bill is more than the $50 deductible. Medical bills totaling less than $50 are submitted to the intermediary but not included here as these are used only to satisfy the deductible and are not reimbursable. Where the beneficiary had previously incurred bills of less than $50, the part of the last bill that was used to meet the deductible is included in the total charges shown.

Although the number of recorded medical bills outnumbered the surgical bills by more than 3 to 1, the total reasonable charges for surgical bills almost equalled the total for medical bills—$98 million for surgical bills and $111 million for medical bills. The average charge for surgical bills is, of course, significantly larger than that for medical bills—$191 compared with $61 per bill. As indicated

[3] For a complete description and first findings, see Jack C. Scharff, "Current Medicare Survey The Medical Insurance Sample," *Social Security Bulletin*, April 1967. (Reprint begins on p. 182.)

previously, one bill for medical services may and, in fact, often does include more than one covered service provided to an enrollee.

The supplementary medical insurance program provides payment for 80 percent of the reasonable charges for physicians and other covered services following payment by the patient of the first $50 of such charges. Thus, in the early months of the program, relatively large medical expenditures were required in order to be reimbursed. It is likely that the first bills were mainly for illness requiring hospital care where the outlays are high. This assumption is supported by the fact that about half the amount reimbursed in the first period was for surgical bills, for which total reasonable charges averaged $211.

Average charges per bill, as shown on table 2, decreased from $119 in the first reporting period (July 1–October 14, 1966) to $75 in the last period (January 21–February 23, 1967). This decreasing average charge per bill during successive months is undoubtedly the result of the application of the deductible provision to payments for covered services at the beginning of the program. Many of those who had met the deductible in the first months of the program may have used some covered services during succeeding months, for which the charges were relatively small. In addition, some persons may have partially met the deductible in the early months of the program and the bill used later for meeting the deductible may be relatively small.

Of the aggregate total reasonable charges of $218 million for physicians and related medical services, $147 million or more than two-thirds was reimbursed through payments made by intermediaries. The percentage reimbursed is higher for surgical bills than for medical bills (72 percent compared with 64 percent) because the amount paid by the patient ($50 deductible and 20-percent coinsurance) constitutes a relatively smaller proportion of the total when it is applied to the larger surgical bill.

The proportion of total reasonable charges reimbursed rises slightly in successive periods from 64 percent for bills reimbursed July 1–October 14, 1966, to 69 percent in January 21–February 23, 1967. This increasing trend in the later months probably reflects the increasing number of persons who had met the deductible in previous months and, consequently, only needed to pay the coinsurance amounts on all subsequent bills for medical services incurred during the year. Nearly all the recorded payments for the first 2 months of 1967 probably reflect utilization of services in 1966.

Table 3 presents a more detailed distribution of the bills, by type of service, their total reasonable charges, and the amount per bill. Of the 253,000 paid bills for services other than physician services, the majority are for outpatient hospital services. The average charges per bill per outpatient hospital service are considerably smaller than for any other type of service, and amount to $19. Bills for home health and independent laboratory services averaged $61 and $32, respectively. Included in the latter group are only those charges for laboratory services billed directly by independent laboratories. Where the bill for physicians' services includes charges for laboratory services, these are classified as physicians' services.

Approximately 38,000 bills are classified as other medical services. These include rental of durable medical equipment, ambulance service, internal and external prosthetic devices, and appliances, and supplies. The average charge per bill reimbursed during the period July 1, 1966, to February 23, 1967, for these other medical services amounted to $52.

The distribution, by type of service, of the bills reimbursed during each of the four periods shows an increasing number of bills for other than physician services in the later periods. At the beginning of the program, there were relatively few bills for these other services, perhaps because procedures for reimbursement for the new benefits were developed somewhat more slowly than for other medical services. In addition, many beneficiaries may not have been fully aware of the coverage for these services early in the program. Finally, these are relatively inexpensive services and, without a large physician's bill, require a cumulation of several bills to meet the $50 deductible before reimbursement of the claim is made.

Data have been presented that relate to inpatient hospital claims for the first 6 months of the program and to medical insurance claims reimbursed in the program's first 8 months. Similar data will be published in the Bulletin in its regular series of tables.

TABLE 3.—MEDICAL INSURANCE—NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL REASONABLE CHARGES, AND AMOUNT PER BILL, BY TYPE OF SERVICE AND PERIOD RECORDED, AS OF FEB. 24, 1967 [1]

Type of service	Total	July 1 to Oct. 14, 1966	Oct. 15 to Dec. 2, 1966	Dec. 3, 1966 to Jan. 20, 1967	Jan. 21 to Feb. 23, 1967
	Number of bills				
All services [2]	2,582,207	138,035	328,082	893,765	1,222,325
Physician services	2,328,950	134,369	313,928	920,060	1,060,593
Surgical	516,373	44,715	84,628	183,210	203,820
Medical	1,812,577	89,654	229,300	636,850	856,773
Home health services	38,939	[3]	2,518	13,821	22,600
Outpatient hospital services	141,606	433	2,671	35,610	102,892
Independent laboratory services	30,429	1,320	3,586	9,172	16,351
All other services [4]	38,001	1,821	4,635	13,573	17,972
	Total reasonable charges (in thousands)				
All services [2]	$217,871	$16,433	$32,785	$76,811	$91,842
Physician services	209,467	16,193	32,001	73,967	87,306
Surgical	98,416	9,419	16,846	35,048	37,103
Medical	111,051	6,774	15,155	38,919	50,203
Home health services	2,373	[3]	202	883	1,288
Outpatient hospital services	2,683	16	112	867	1,688
Independent laboratory services	983	55	133	297	498
All other services [4]	1,992	159	270	660	903
	Amount per bill				
All services [2]	$84	$119	$100	$86	$75
hysician services	90	121	102	90	82
Surgical	191	211	199	191	182
Medical	61	76	66	61	59
Home health services	61	[3]	80	64	57
Outpatient hospital services	19	36	42	24	16
Independent laboratory services	32	42	37	32	30
All other services [4]	52	87	58	49	50

[1] See footnote 1, table 2.
[2] Includes 4,281 bills, $371,480 in total reasonable charges, and $87 in amount per bill for which type of service is unknown.
[3] Fewer than 50 bills.
[4] Includes rental of durable medical equipment, ambulance service, internal and external prosthetic devices and appliances, and supplies.

C—Health Insurance for the Aged: The Statistical Program

By Howard West*

[Reprint from *Social Security Bulletin*, January 1967]

On July 1, 1966, the health insurance program for the aged under the Social Security Act went into effect. This program helps to close a major gap in the economic security of the elderly by providing protection against the high costs of hospital and medical care. The program will have a significant impact on the organization, provision, and financing of health and medical care in the country. Information on the broad scope of benefits and the large population group involved is being incorporated in a comprehensive data-collection system that will provide a means for evaluating the effectiveness of the program.

This article describes briefly the provisions of the health insurance program for the aged, outlines the various components of the statistical system for collection

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and maintenance of data on the utilization and financing of hospital and medical services and delineates the analytical studies envisioned. State data are presented on the number of hospitals and home health agencies participating under the program. Also presented are 3 months' data on claims paid, based on the bills received from hospitals that have been processed and approved for payment by intermediaries under the hospital insurance program.

BASIC PROVISIONS OF LAW

The 1965 amendments to the Social Security Act added title XVIII to the Act, which provides for two coordinated programs of health insurance for the aged: a basic hospital insurance plan (part A) and a voluntary supplementary medical insurance plan (part B).[1]

Benefits

The hospital insurance program provides payment for a large part of the cost of hospital services in a participating hospital for up to 90 days in a "spell of illness" (a period beginning with the first day of hospitalization and ending 60 days after discharge from a hospital or an extended-care facility). The first 60 days of hospitalization are covered essentially in full after a deductible of $40. For each of the remaining 30 covered days in a spell of illness, the patient pays $10 of the daily cost. The program pays 80 percent of the cost outpatient hospital diagnostic services furnished during a 20-day period, after a deductible of $20.

The program also covers the cost of care up to 100 days during a spell of illness in a participating extended-care facility after transfer from a hospital following a stay of 3 or more days. (This part of the program began January 1, 1967.) The cost of the first 20 days is covered in full; the patient pays $5 of the daily cost for each of the remaining 80 covered days. For the cost of home health services, up to 100 visits during the year are covered, following discharge from a hospital (after a stay of at least 3 days) or from an extended-care facility.

The supplementary medical insurance program provides payment for 80 percent of the reasonable charges for physician services and other covered services following payment by the patient of the first $50 of such charges during the calendar year. The program covers the following services: physician services, regardless of place of service; up to 100 home health visits each year; various other medical and health services, such as diagnostic X-ray and laboratory tests; X-ray, radium, and radioactive isotope therapy; prosthetic devices; and the rental of durable medical equipment.

Eligibility

The nearly 19 million persons identified as eligible for the hospital insurance benefits as of July 1, 1966, consist of all persons aged 60 or over who are entitled to monthly cash benefits under the old-age survivors, and disability insurance (OASDI) or railroad retirement programs and all other aged persons, except retired Federal employees covered under the Federal Employees Health Benefits Act of 1959 and aliens admitted for permanent residence but having less than 5 consecutive years of residence.

As of July 1, 1966, about 17.6 million persons (including retired Federal employees eligible for the supplemental program) had elected to contribute 03 a month to pay their share of the premium for the supplementary medical insurance plan. For approximately 1,000,000 persons receiving public assistance in 25 States, the $3 premium will be paid by the State welfare agencies. About 30,000 retired Federal employees are enrolled in the supplementary medical insurance program but are not eligible to receive hospital insurance benefits.

The March issue of the Bulletin will carry data on the number, characteristics, and State of residence of persons enrolled in the hospital and medical insurance programs on July 1, 1966.

Financing Health Insurance Benefits

The hospital insurance program is financed on a long-range, self-supporting basis through a separate schedule of increasing tax rates on the first $6,600 of earnings, with the same rate for employees, employers, and self-employed persons.

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[1] For a full description of the provisions of the health insurance program, see Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," *Social Security Bulletin*, September 1965; see also Robert M. Ball, "Health Insurance for People Aged 65 and Over: First Steps in Administration," the *Bulletin*, February 1966.

The rate was 0.35 percent in 1966, it rose to 0.50 percent for 1967, and it is scheduled to increase until it is 0.80 percent in 1987 and thereafter. A separate trust fund was established for the hospital insurance program. Included in the law is a special provision to reimburse the hospital insurance trust fund from general tax revenues for the costs of providing hospital insurance coverage for the almost 2.5 million persons not entitled to monthly social security or railroad retirement cash benefits.

The voluntary medical insurance program is financed by $3 monthly premiums from enrollees and a matching payment from general revenues of the Federal Government. A separate trust fund has also been established for this supplementary program.

Fiscal Intermediaries

Under the hospital insurance program, intermediaries are selected by each hospital to act as the link between the hospitals and the Social Security Administration. A vital role of the intermediaries is to review and pay hospital claims for the costs of providing care to the beneficiaries. The intermediary makes these payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services.

Under the supplementary medical insurance program, insurance carriers are selected by the Secretary of Health, Education, and Welfare to serve as intermediaries. The principal functions of these carriers are to determine the reasonable charges in their respective areas for each medical care service paid for under the program and to review and pay claims to or in behalf of beneficiaries for the services provided.

The number and types of intermediaries for each of the health insurance programs are summarized below.

Type of intermediary	Hospital insurance	Medical insurance
Total	87	51
Blue Cross-Blue Shield	74	33
Commercial insurance companies	11	15
Other	[1] 2	[2] 3

[1] New York Department of Health and the Social Security Administration, which deal directly with 187 hospitals in 29 States, the District of Columbia, and Puerto Rico.
[2] Group Health Insurance, Inc., Nebraska Department of Public Welfare and the Social Security Administration, which deal directly with more than 100 group-practice prepayment plans.

THE STATISTICAL SYSTEM

Characteristics of the system

The primary objective of the statistical system of the health insurance program is the provision of data required to measure and evaluate the operations and the effectiveness of the two parts of the program. The benefit payment operations furnish the means of obtaining extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by the aged, as well as the costs of such services. The applications of hospitals and of extended-care facilities to participate in the program provide data on the characteristics of such providers of services. The claim number that is assigned to each individual serves as the link between the various services utilized under the program and the demographic characteristics of each individual recorded in the eligiblity files.

The data-collection system has two inherent characteristics that determine to a considerable degree the scope, detail, and flexibilty of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records for each bill paid under the hospital insurance program and for a sample of beneficiaries under the medical insurance program are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, time lags, costs, and the like, all program statistics are centrally prepared.

The basic records

The statistical system is based on five distinct but related computer-tape record systems: master eligibility record, provider record, hospital insurance (part A)

utilization record, medical insurance (part B) payment record, and the record containing a sample of medical insurance bills.

Master Eligibility Record.—The master eligibility record identifies each aged person eligible for health insurance benefits and indicates whether he is entitled to hospital benefits, to supplementary medical insurance benefits, or to both. The master eligibility file was established by combining the existing OASDI and railroad retirement beneficiary records with the records created from the applications of uninsured persons aged 65 and over to participate in the health insurance program. The same sources are used to maintain the eligibility records on a current basis—to add the newly aged, eliminate those who die, and identify those who withdraw from the supplementary medical insurance program.

This record was used to create the health insurance card that was sent to each insured person. The card contains the individual's claim number (an adaptation of the number used for OASDI or railroad retirement monthly cash benefit) and indicates the eligibility of the individual for the two parts of the program.

The claim number is the link between the eligibility record and all other records used in the program. The master eligibility record also contains information identifying the State and county of residence, date of birth, sex, and color of each enrolled person. In addition, the record has been further annotated to indicate selected subgroups, such as public assistance recipients whose medical insurance premium is being paid by the State welfare agency, as well as other major groups. The master eligibility record thus provides significant demographic characteristics linked to the utilization and cost data for both parts of the program. Finally, the eligibility record provides the population data for each part of the program and therefore serves as the base for the computation of a variety of utilization rates, limited only by its demographic content.

Provider Record.—Every hospital, home health agency, extended-care facility, and independent laboratory must apply for participation in the hospital insurance program in order to be reimbursed for services provided. Each institution or agency must also meet the conditions of participation spelled out in the health insurance provisions of the Social Security Act and by the regulations under the Act. Designated State agencies, operating under agreement with the Department of Health, Education, and Welfare, have the responsibility for determining the extent to which each institution or agency meets these health and safety conditions for participation and for certifying those that satisfactorily do so.[2]

Data included on the application forms used by these institutions (SSA–1514 for hospitals, SSA–1515 for home health agencies, SSA–1516 for extended-care facilities, and SSA–1517 for independent laboratories) to indicate their desire to participate and to provide needed information have been recorded in the central provider record and will be updated as facilities are recertified periodically, as new ones apply for participation, or as some leave the program.

These application forms are the source for a variety of data on the characteristics of hospitals, home health agencies, extended-care facilities, and independent laboratories participating in the program.

The detailed information about each provider recorded in the statistical tapes includes such items as the State and county in which the institution is located; the number of beds; type of control; the major types of services provided; accreditation status, medical school affiliation, and approved training programs; staff characteristics, including the number of physicians, registered nurses, qualified speech therapists; licensed practical nurses, home health aides, and other skilled medical care personnel; the annual total of adult admissions and discharges; the number of patient days and persons served; and the current reimbursement rate.

When the information in this provider file is combined with utilization data, it serves to relate the characteristics of facilities and agencies that provide care to the kinds and amounts of service used by the aged.

Utilization Record For Hospital Insurance.—The administration of the hospital insurance program requires that two items of information be known about each aged person at the time of his admission to a hospital—his eligibility under the program and the extent to which he has used the benefits available to him under the "spell of illness" concept. It is therefore necessary to maintain a master record of the number of days of care received by each aged person in a hospital

[2] For a full description of the conditions, see Social Security Administration, *Conditions for Participation for Hospitals* (HIM–1), *Conditions for . . . Home Health Agencies* (HIM–2), *Conditions for . . . Extended Care Facilities* (HIM–3), and *Conditions for . . . Independent Laboratories* (HIM–4).

or extended-care facility and of the number of home health visits received. This central record system is maintained on computer tape by the Social Security Administration.

When the patient is admitted to a hospital, the admission section of the Inpatient Hospital Admission and Billing Form (SSA–1453) is completed by the hospital and forwarded through its intermediary to the Social Security Administration central record. As soon as the record is checked, normally in less than 24 hours, the hospital is informed of the patient's eligibility status and of the number of days remaining during the "spell of illness." At discharge, the hospital completes the billing section of the form and sends it to the intermediary for payment. When approval for payment has been made, the intermediary forwards the claim to the Social Security Administration for recording in the central record. Copies of admission and billing forms are handled in a comparable manner by home health agencies (SSA–1487) and extended-care facilities (SSA–1478). The outpatient diagnostic billing form (SSA–1483) is also transmitted to the Social Security Administration for recording in the central record after the bill is approved for payment by the intermediary.

All the information on utilization experience in hospital and extended-care facilities that is needed to administer the "spell of illness" provision is recorded in the central record. This information includes stays in nonparticipating institutions and days of care not covered or reimbursable under the program.

As a byproduct of the admission and billing procedures a history will be built up for each individual that will permit the summarizing or cumulation of a considerable variety of statistical information. The more important of these items are the dates of admission to and discharge from hospitals and extended-care facilities; length of stay, frequency of use, and discharge status (alive or dead); charge and payment data (including both the covered and noncovered charges, with the former separated with respect to the amount reimbursed and the deductible and coinsurance amounts not reimbursed); the payment source for charges to patients; a report of one or more hospital discharge diagnoses, with the primary diagnosis coded for a 20-percent sample of all beneficiaries; surgical procedures, including the dates of surgery, with the procedure related to the primary discharge diagnosis or the most significant procedure coded for the same 20-percent sample; and diagnostic information coded from all bills from home health agencies and extended-care facilities. For outpatient diagnostic bills, diagnosis and procedure data are coded for 40 percent of the beneficiaries.

Each admission and billing form contains both the beneficiary's claim number and the provider's number, and the resulting tape record can be readily matched to the beneficiary files and the provider files. By this process, a statistical tape record is created that contains all the available information needed for tabulation from the three files.

Payment Record For Medical Insurance.—Administration of the supplementary medical insurance program does not require the establishment of a detailed central record of providers since all licensed physicians and osteopaths are eligible to participate in the program. No "spell of illness" concept is involved and payment or reimbursement is made only after receipt by the carriers of bills having reasonable charges exceeding $50 during a calendar period.[3]

Carriers need to know from a central source only that the deductible has been met; during the remainder of the calendar year, no additional information is required for reimbursement or payment purposes.

For administration and operation of the program, the Social Security Administration must have accurate and complete information on the amounts paid by the carriers for physician services and for other services and supplies under this part of the program. For outpatient psychiatric services, the maximum payment limitation of $250 requires that a cumulative central figure be maintained. To meet these needs, carriers were instructed to furnish a payment record consisting of tape, punched card, or other machine-readable record of each bill paid. A "bill" is defined as a request for payment from or in behalf of a beneficiary as the result of services provided by a single physician or supplier.

The payment record also contains selected items of information needed to provide an efficient basis for drawing samples of the bills. These items provide

[3] In figuring the $50 deductible, reasonable charges for services received between January 1 and December 31 are considered unless the $50 is not met until the last quarter of the year. In such cases, charges for services received in the last 3 months of the year can be used to meet the deductible for the next year.

a sampling frame that will be used to draw additional small samples designed to provide specific information not obtainable from the bills furnished for the basic 5-percent sample of eligible persons under the medical insurance program. (This sample is described in a later section.)

The items in the payment record are:

1. Code number assigned by the carrier to each physician and medical supplier
2. Physician's specialty and board certification
3. Identification of medical degree (M.D., D.O., or D.D.S.)
4. Dollar amount of the reasonable charge as determined by the intermediary for the most expensive procedure itemized on the bill
5. Place (office, home, inpatient hospital, extended-care facility, outpatient hospital, independent laboratory, other) where the most expensive procedure took place
6. Type of service represented by the most expensive procedure (surgery, medical care, consultation, diagnostic X-ray, diagnostic laboratory, radiation therapy, anesthesia, assistance at surgery, other)
7. The number of dates of service shown on the bill
8. The number of dollar charges shown on the bill
9. Indication of payment to beneficiary or to the physician
10. Indication of whether the illness or injury requiring treatment was employment-related.

Sample of Bills Under Medical Insurance.—While the payment record provides a rapid method for summarizing payment data and a sampling frame for efficiently drawing additional samples of bills, it does not provide specific data on diagnoses, procedures, and related charges.

Basic statistics on the utilization of physician and other services covered under the supplementary medical insurance program are derived from a continuous sample of the bills paid by intermediaries to or in behalf of 5 percent of all enrolled persons. Intermediaries have been given specific digits of the health insurance claim number to be used in selecting the sample. The payment record for all bills provides the information needed to assure the Social Security Administration that the sample is complete.

The Request for Payment Form (SSA–1490) is designed to provide information on the time and place of each service, the exact procedure carried out or service provided, the condition treated (diagnosis), and the physician's or supplier's charge for the specific service.

For nonsurgical medical services, this information will provide comprehensive and descriptive data on the type of services provided by the physician during each visit. For surgical cases, where the usual practice is to report the surgical procedure, the diagnosis, and the charge without specifying the number of times the patient may have been seen by the surgeon, the statistical unit will be the surgical procedure and not the visit.

As previously indicated, data reflecting physician and other services are based on bills paid. For persons in the 5-percent sample to and for whom payment is made under the program, all their bills, including those used to meet the annual $50 deductible, will be included in the sample and coded. Data will not, however, be available through these procedures for persons in the sample who do not meet the $50 deductible. Such data are being collected by means of the Current Medicare Survey, which will be described in detail in a subsequent issue of the Bulletin.

For hospital-based physicians who have authorized the provider to collect the fee for their services, Form SSA–1554 (Provider Billing for Patient Services by Physicians) is used. This form is to be completed for each patient. It also includes descriptive information on the date and place of each service, the diagnoses, procedures, and the charges. The same form will be furnished for the 5-percent sample of beneficiaries.

INITIAL OPERATING DATA

The statistical system outlined above will provide considerable data about the providers of services, the characteristics of the aged persons enrolled, and the utilization and financing of health services under the hospital and medical insurance programs. Basic program operating data will be reported in the Bulletin and in special reports to be issued by the Office of Research and Statistics as the data become available.

This first report presents State data on the number of participating hospitals and home health agencies as well as selected characteristics of the providers on a national basis. Preliminary data on the number and amount of inpatient hospital claims approved for payment under the hospital insurance program during the first 3 months of operation have also been reported. Because of lags in reporting and recording the data on the statistical tape record, these data are incomplete and will be revised each month in a new series of tables to be published monthly in the Bulletin, which will also publish a monthly series on claims paid, based on the bills received from physicians or enrollees that have been processed by intermediaries under the supplementary medical insurance program.

Participating providers

As of September 30, 1966, there were 6,680 hospitals and 1,400 home health agencies certified for participation in the program. Certifications are made by State agencies to the Department of Health, Education, and Welfare indicating that the providers meet the conditions for participation promulgated by the Secretary of Health, Education, and Welfare. A participating provider is a certified institution that has entered into an agreement with the Social Security Administration not to make charges for covered items and services except deductibles and coinsurance amounts; to return any money incorrectly collected; and to provide services on a nondiscriminatory basis in compliance with title VI of the Civil Rights Act of 1964. Approximately 280 hospitals that had applied for participation in the program were not certified, on the basis of noncompliance with the standards. This number does not reflect an unknown number of hospitals that withdrew their applications when it appeared certain that they could not meet the standards and be certified. At the same time, about 175 additional hospitals failed to meet the civil rights requirements.

Hospitals and other providers of service could have been certified for participation under the program if they were found to be in substantial compliance with the conditions for participation, despite the fact that significant deficiencies were found with respect to one or more standards. In order to be certified as being in substantial compliance in the presence of significant deficiencies, the provider must be in general compliance with the initial statement of each condition, must develop an adequate plan to correct the deficiencies, and the deficiencies must not be so serious as to interfere with adequate care or represent hazards to health and safety. Of the 6,680 hospitals that are now participating under the program, more than 2,000 have significant deficiencies with respect to one or more conditions of participation. A third of these hospitals are reported to have significant deficiencies in six or more conditions of participation, including problems with respect to medical staff, pharmacy, nursing services, dietary arrangements, medical records, and physical environment.[4] State agencies are now in the process of assisting hospitals to upgrade their facilities, staff, or services so that their deficiencies will be reduced.

Table 1 gives the number of participating hospitals and beds by type of facility, geographic division, and State. Data are presented for the 6,526 hospitals that were recorded in the provider record as of September 30. The remaining 154 hospitals were certified but not recorded because the data were incomplete. Data on number and type of hospitals do not agree with those reported by the American Hospital Association in their annual guide issue[5] and by other agencies for several reasons. As indicated above, the group of hospitals participating under the Social Security Act excludes those denied and those not applying for certification. The American Hospital Association does not accept hospitals with less than six beds for registration; there is no such limitation for participation under the certification requirements. In addition, the participating hospitals include about 100 general hospitals that are actually distinct parts of psychiatric and tuberculosis hospitals not accredited by the Joint Committee an Accreditation of Hospitals and represent the active-care medical and surgical beds in these facilities. In some instances, active-care psychiatric units of the same hospitals may also be counted here as psychiatric hospitals. At the same time, a number of medical centers are counted as one hospital while, in other cases, different components of the medical centers are counted separately. Finally, only adult-care beds are reported by hospitals participating under the program.

[4] John W. Cashman, *Medicare: Standards of Service in a New Program—Licensure—Certification—Accreditation*, paper presented at the 94th Annual Meeting of the American Public Health Association, San Francisco, California, October 31, 1966.

[5] *Hospitals* (Journal of the American Hospital Association), Guide Issue, August 1, 1966.

TABLE 1.—HEALTH INSURANCE FOR THE AGED—NUMBER OF PARTICIPATING HOSPITALS AND BEDS, BY TYPE OF FACILITY, GEOGRAPHIC DIVISION, AND STATE, AS OF SEPTEMBER 30, 1966 [1]

Geographic division and State	Total [2]		General [3]		Psychiatric		Tuberculosis	
	Hospitals	Beds [4]	Hospitals	Beds [4]	Hospitals	Beds [4]	Hospitals	Beds [4]
United States	6,526	1,201,447	6,111	798,150	305	379,799	110	23,498
New England	374	93,960	335	59,814	31	32,996	8	1,150
Maine	61	4,866	59	4,266	1	485	1	115
New Hampshire	34	5,012	32	2,530	1	2,400	1	82
Vermont	24	3,715	21	1,790	2	1,850	1	75
Massachusetts	186	53,495	166	36,320	16	16,597	4	578
Rhode Island	19	7,202	15	4,671	3	2,231	1	300
Connecticut	50	19,670	42	10,237	8	9,433	0	0
Middle Atlantic	793	284,288	724	155,923	62	126,943	7	1,422
New York	390	154,926	356	78,350	30	75,904	4	672
New Jersey	117	42,621	107	23,799	8	18,132	2	690
Pennsylvania	286	86,741	261	53,774	24	32,907	1	60
East North Central	1,124	246,976	1,010	164,443	69	74,639	45	7,894
Ohio	252	67,748	216	43,007	19	22,271	17	2,470
Indiana	131	23,709	118	17,267	8	5,829	5	613
Illinois	286	72,973	261	45,509	16	25,218	9	2,246
Michigan	278	58,683	252	38,271	18	18,341	8	2,071
Wisconsin	177	23,863	163	20,389	8	2,980	6	494
West North Central	889	111,300	849	78,594	32	31,065	8	1,641
Minnesota	193	25,768	183	18,513	7	6,951	3	304
Iowa	144	15,776	139	13,424	4	2,096	1	256
Missouri	167	33,282	156	21,783	10	11,834	1	665
North Dakota	57	5,157	56	3,462	1	1,695	0	0
South Dakota	62	4,931	61	3,181	1	1,750	0	0
Nebraska	103	9,532	99	6,637	3	2,765	1	130
Kansas	163	15,854	155	11,594	6	3,974	2	286
South Atlantic	765	137,960	723	97,524	30	35,676	12	4,760
Delaware	9	2,764	7	1,588	1	1,001	1	175
Maryland	61	23,695	50	11,960	10	11,235	1	500
District of Columbia	15	12,017	13	5,312	2	6,705	0	0
Virginia	100	14,181	97	13,582	1	145	2	454
West Virginia	84	10,003	80	8,377	4	1,626	0	0
North Carolina	142	18,471	136	16,619	2	358	4	1,494
South Carolina	66	12,038	64	6,633	2	5,405	0	0
Georgia	121	13,286	117	12,408	3	197	1	681
Florida	167	31,505	159	21,045	5	9,004	3	1,456
East South Central	426	46,667	405	39,420	9	5,146	12	2,101
Kentucky	124	16,122	113	10,711	5	4,502	6	909
Tennessee	148	17,061	140	15,437	3	585	5	1,039
Alabama	105	9,880	103	9,668	1	59	1	153
Mississippi	49	3,604	49	3,604	0	0	0	0
West South Central	859	82,794	841	66,988	14	13,960	4	1,846
Arkansas	99	8,883	97	7,455	2	1,428	0	0
Louisiana	87	10,415	85	9,705	2	710	0	0
Oklahoma	144	14,734	141	9,766	3	4,968	0	0
Texas	529	48,762	518	40,062	7	6,854	4	1,846
Mountain	384	38,512	368	32,100	13	5,976	3	436
Montana	65	3,683	62	3,246	1	142	2	295
Idaho	45	2,224	45	2,224	0	0	0	0
Wyoming	29	2,207	27	1,444	2	763	0	0
Colorado	88	16,068	83	12,182	5	3,886	0	0
New Mexico	46	3,318	44	3,051	2	267	0	0
Arizona	58	5,528	55	5,269	2	118	1	141
Utah	33	3,861	32	3,061	1	800	0	0
Nevada	20	1,623	20	1,623	0	0	0	0
Pacific	811	148,614	761	96,419	42	51,004	8	1,191
Washington	120	14,664	113	10,795	5	3,445	2	424
Oregon	86	14,435	81	10,065	4	4,191	1	179
California	560	115,133	525	72,121	31	42,456	4	556
Alaska	18	831	16	574	1	225	1	32
Hawaii	27	3,551	26	2,864	1	687	0	0

See footnotes on next page.

TABLE 1.—HEALTH INSURANCE FOR THE AGED—NUMBER OF PARTICIPATING HOSPITALS AND BEDS, BY TYPE OF FACILITY, GEOGRAPHIC DIVISION, AND STATE, AS OF SEPTEMBER 30, 1966 [1]—Continued

Geographic division and State	Total [2]		General [3]		Psychiatric		Tuberculosis	
	Hospitals	Beds [4]	Hospitals	Beds [4]	Hospitals	Beds [4]	Hospitals	Beds [4]
Other jurisdictions	101	10,376	95	6,925	3	2,394	3	1,057
American Samoa	1	145	1	145	0	0	0	0
Guam	1	199	1	199	0	0	0	0
Puerto Rico	94	9,826	88	6,375	3	2,934	3	1,057
Virgin Islands	5	206	5	206	0	0	0	0

[1] Excludes approximately 150 hospitals certified for participation, but not recorded in the provider record.
[2] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoriums.
[3] Short-stay and long-stay hospitals.
[4] Adult beds only; for phsychiatric and tuberculosis institutions not accredited by the Joint Commission on Accreditation of Hospitals, only active care beds are included.

TABLE 2.—HEALTH INSURANCE FOR THE AGED—NUMBER AND PERCENTAGE DISTRIBUTION OF PARTICIPATING HOSPITALS AND BEDS, BY TYPE OF CONTROL AND TYPE OF HOSPITAL, AS OF SEPT. 30, 1966

Type of control	Number				Percentage distribution			
	Total [1]	General [2]	Psychiatric	Tuberculosis	Total [1]	General [2]	Psychiatric	Tuberculosis
	Hospitals							
Total	6,526	6,111	305	110	100.0	100.0	100.0	100.0
State [3]	440	192	196	52	6.7	3.1	64.3	47.3
Local	1,535	1,485	5	45	23.5	24.3	1.6	40.9
Voluntary	3,624	3,557	58	9	55.5	58.2	19.0	8.2
Proprietary	927	877	46	4	14.2	14.4	15.1	3.6
	Beds [4]							
Total	1,201,447	798,150	379,799	23,498	100.0	100.0	100.0	100.0
State [3]	428,686	62,168	353,464	13,054	35.7	7.8	93.1	55.6
Local	185,109	170,658	5,444	9,007	15.4	21.4	1.4	38.3
Voluntary	534,161	516,075	17,043	1,043	44.5	64.7	4.5	4.4
Proprietary	53,491	49,249	3,848	394	4.5	6.2	1.0	1.7

[1] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoriums.
[2] Short-stay and long-stay hospitals.
[3] Includes 4 Federal hospitals.
[4] Adult beds only: for psychiatric and tuberculosis institutions not accredited by the Joint Commission on Accreditation of Hospitals, only active-care beds are included.

TABLE 3.—HEALTH INSURANCE FOR THE AGED—NUMBER AND PERCENTAGE DISTRIBUTION OF PARTICIPATING HOSPITALS, BY SIZE AND TYPE OF HOSPITAL, AS OF SEPT. 30, 1966

Number of beds	Number				Percentage distribution			
	Total [1]	General [2]	Psychiatric	Tuberculosis	Total [1]	General [2]	Psychiatric	Tuberculosis
Total	6,526	6,111	305	110	100.0	100.0	100.0	100.0
Under 24	653	650	2	1	10.0	10.6	.7	.9
25 to 49	1,562	1,538	21	3	23.9	25.2	6.9	2.7
50 to 99	1,622	1,547	52	23	24.9	25.3	17.0	20.9
100 to 199	1,275	1,192	43	40	19.5	19.5	14.1	36.4
200 to 299	609	575	20	14	9.3	9.4	6.6	12.7
300 to 399	303	286	4	13	4.6	4.7	1.3	11.8
400 to 499	150	140	7	3	2.3	2.3	2.3	2.7
500 and over	352	183	156	13	5.4	3.0	51.1	11.8

[1] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoriums.
[2] Short-stay and long-stay hospitals.

TABLE 4.—HEALTH INSURANCE FOR THE AGED—NUMBER AND PERCENTAGE DISTRIBUTION OF PARTICIPATING HOSPITALS, BY SIZE AND TYPE OF CONTROL, AS OF SEPTEMBER 30, 1966

Number of beds	Number					Percentage distribution				
	Total[1]	State[2]	Local	Voluntary	Proprietary	Total[1]	State[2]	Local	Voluntary	Proprietary
Total	6,526	440	1,535	3,624	927	100.0	100.0	100.0	100.0	100.0
Under 24	653	41	195	221	196	10.0	9.3	12.7	6.1	21.1
25 to 49	1,562	12	498	710	342	23.9	2.7	32.4	19.6	36.9
50 to 99	1,622	44	424	895	259	24.9	10.0	27.6	24.7	27.9
100 to 199	1,275	70	213	887	105	19.5	15.9	13.9	24.5	11.3
200 to 299	609	42	79	466	22	9.3	9.5	5.1	12.9	2.4
300 to 399	303	27	44	230	2	4.6	6.1	2.9	6.3	.2
400 to 499	150	15	21	113	1	2.3	3.4	1.4	3.1	.1
500 and over	352	19	61	102	.....	5.4	43.0	4.0	2.8	.....

[1] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoriums.
[2] Includes 4 Federal hospitals.

Hospitals

The 6,526 hospitals recorded as participating include 1.2 million adult beds. General hospitals comprise 94 percent of the total and include 66 percent of the beds. Only 5 percent of the hospitals and 32 percent of the beds are in participating psychiatric hospitals. The remaining 1 percent of the hospitals and 2 percent of the beds are in tuberculosis hospitals.

Analysis of the hospital data by type of control shows that the vast majority of the general hospitals are nongovernmental and mainly under voluntary control. Of the 6,111 general hospitals participating under the program, 58 percent are voluntary hospitals and include 65 percent of the general hospital beds. Beds in local government general hospitals constitute 21 percent of the total (table 2).

As would be expected, the type of control in participating psychiatric and tuberculosis hospitals is different from that of general hospitals: 9 out of 10 psychiatric hospital beds and 6 out of 10 tuberculosis hospital beds are in State-owned facilities.

Participating psychiatric and tuberculosis hospitals also differ from participating general hospitals in terms of number of beds (table 3). The general hospitals are considerably smaller: about three-fifths have fewer than 100 beds, compared with less than one-fourth for the psychiatric and tuberculosis hospitals. More than half the psychiatric hospitals have 500 beds or over.

Hospital size varies considerably with type of hospital control (table 4). State hospitals are by far the largest, with 43 percent in the 500-or-over bed category. This category includes no proprietary hospitals and only 4 percent and 3 percent, respectively, of the local and voluntary hospitals. The smallest participating hospitals are proprietary, with 86 percent having fewer than 100 beds and one-fifth with fewer than 25. Local government hospitals are also relatively small, with nearly three-fourths in the less-than-100-bed category.

Type of service	Agencies offering service	
	Number	Percent
Physical therapy	918	72.0
Occupational therapy	190	14.9
Speech therapy	287	22.5
Medical social service	260	20.4
Home health aide	455	35.7

TABLE 5.—HEALTH INSURANCE FOR THE AGED—NUMBER OF PARTICIPATING HOME HEALTH AGENCIES, BY TYPE OF AGENCY, GEOGRAPHIC DIVISION, AND STATE, AS OF OCT. 15, 1966[1]

Geographic division and State	Total	Visiting nurse association	Combination government and voluntary agency	Official health agency	Hospital based program	Other
United States	1,275	506	83	579	81	26
New England	325	243	8	60	12	2
Maine	13	10	----	3	----	----
New Hampshire	28	23	----	2	2	1
Vermont	5	5	----	----	----	----
Massachusetts	151	100	6	36	8	1
Rhode Island[2]	25	23	----	1	1	----
Connecticut	103	82	2	18	1	----
Middle Atlantic	212	107	9	76	19	1
New York	97	30	5	60	2	----
New Jersey	52	29	2	14	7	----
Pennsylvania[2]	63	48	2	2	10	1
East North Central	225	69	15	124	13	4
Ohio	89	20	8	59	2	----
Indiana	17	7	1	7	1	1
Illinois	41	17	3	19	2	----
Michigan	36	11	3	19	3	----
Wisconsin	42	14	----	20	5	3
West North Central	87	18	7	46	14	----
Minnesota	25	3	1	18	3	----
Iowa	14	10	3	1	----	----
Missouri	13	3	----	4	4	2
North Dakota	6	----	----	5	1	----
South Dakota	3	----	----	3	----	----
Nebraska	4	1	1	----	2	----
Kansas	22	1	2	15	4	----
South Atlantic	124	18	29	70	3	4
Delaware	3	1	----	----	1	1
Maryland	25	1	----	23	1	----
District of Columbia	2	1	----	1	----	----
Virginia[2]	5	4	----	1	----	----
West Virginia	15	2	1	12	----	1
North Carolina	12	----	2	9	----	----
South Carolina[2]	1	----	----	1	----	----
Georgia	10	1	2	6	----	1
Florida	51	8	24	17	1	1
East South Central	100	4	----	92	3	1
Kentucky	3	1	----	----	1	1
Tennessee	74	1	----	73	----	----
Alabama	3	2	----	1	----	----
Mississippi	20	----	----	18	2	----
West South Central	23	5	----	18	----	----
Arkansas[2]	2	1	----	1	----	----
Louisiana[2]	2	----	----	2	----	----
Oklahoma[2]	2	----	----	2	----	----
Texas	17	4	----	13	----	----
Mountain	44	4	9	24	6	1
Montana	7	----	----	5	2	----
Idaho	7	----	2	3	2	----
Wyoming[2]	5	----	----	5	----	----
Colorado	12	1	6	4	----	1
New Mexico	1	----	----	1	----	----
Arizona	5	2	----	2	1	----
Utah	5	1	----	3	1	----
Nevada	2	----	1	1	----	----

See footnotes on next page.

TABLE 5.—HEALTH INSURANCE FOR THE AGED—NUMBER OF PARTICIPATING HOME HEALTH AGENCIES, BY TYPE OF AGENCY, GEOGRAPHIC DIVISION, AND STATE, AS OF OCT. 15, 1966[1]—Continued

Geographic division and State	Total	Visiting nurse association	Combination government and voluntary agency	Official health agency	Hospital based program	Other
Pacific	133	38	6	67	11	11
Washington	26	3	4	16	3	----
Oregon	28	3	----	23	1	1
California	77	32	2	27	6	10
Alaska	----	----	----	----	----	----
Hawaii	2	----	----	1	1	----
Other	2	----	----	2	----	----
American Samoa	----	----	----	----	----	----
Guam	1	----	----	1	----	----
Puerto Rico	----	----	----	----	----	----
Virgin Islands	1	----	----	1	----	----

[1] Excludes about 125 home health agencies certified for participation but not recorded in the provider record.
[2] For these States, approved applications submitted by the State health department include 400–500 local (mostly county) departments. Information identifying each of these local subunits is currently being collected.

TABLE 6.—HOSPITAL INSURANCE—NUMBER OF CLAIMS APPROVED FOR PAYMENT, DAYS OF INPATIENT HOSPITAL CARE, AND AMOUNT OF PAYMENTS, BY MONTH OF CLAIM APPROVAL AND TYPE OF HOSPITAL, AS OF OCT. 15, 1966

Month of claim approval [1]	Approved claims			Total hospital charges (in thousands)	Reimbursed by hospital insurance			
	Number	Days of care			Amount (in thousands)	Percent of total charges [2]	Per claim [2]	Per day [2]
		Total	Average per claim					
	Total inpatient hospital services [3]							
Total	387,413	4,015,081	10.4	$166,898	$130,186	78.0	$336	$32
July	33,014	221,508	6.7	8,690	6,409	73.8	194	29
August	221,625	2,234,951	10.1	92,857	72,531	78.1	327	32
September	132,774	1,558,622	11.7	65,351	51,246	78.4	386	33
	Short-stay hospitals [4]							
Total	384,481	3,949,551	10.3	165,017	128,501	77.9	334	33
July	32,927	220,706	6.7	8,666	6,390	73.7	194	29
August	219,555	2,189,480	10.0	91,613	71,407	77.9	325	33
September	131,999	1,539,365	11.7	64,738	50,704	78.3	384	33
	Long-stay hospitals [5]							
Total	2,816	64,694	23.0	1,854	1,667	89.9	592	26
July	84	774	9.2	24	19	80.9	227	25
August	2,068	45,461	22.0	1,243	1,123	90.4	543	25
September	664	18,459	27.8	587	524	89.3	790	28

[1] Month in which the intermediary approved the claim for payment.
[2] Based on unrounded figures.
[3] Includes 116 claims with type of hosptial unknown.
[4] General and special hospitals with average stays of less than 30 days.
[5] General and special hospitals with average stays of 30 days or over; tuberculosis, psychiatric, and chronic disease hospitals; and Christian Science sanitoriums.

Note: Includes only those claims approved and recorded in the Social Security Administration central utilization record before Oct. 15, 1966.

Home Health Agencies.—About 1,400 home health agencies are certified for participation under the program. The provider record is still incomplete so that definitive data are available at this time only for 1,275 agencies, which are shown in table 5 by type of agency, geographic division, and State. Of the 1,275 agencies, 579 or 45 percent are official health agencies. Visiting nursing associations also represent a large proportion of the agencies—about 40 percent. Of the total agencies, "combination government and voluntary" agencies comprise 7 percent, hospital-based programs comprise 6 percent, and the remaining agencies, classified as "other," 2 percent.

Home health agencies must provide skilled nursing services and at least one other therapeutic service. The following tabulation summarizes the number of agencies offering specified therapeutic services.

Inpatient Hospital Claims Approved for Payment.—Data relating to inpatient hospital claims for the first 3 months of the program, approved for payment as of October 15, 1966, are presented in table 6. Expenditures by the hospital insurance trust fund are reported elsewhere in this issue of the Bulletin (table M–5, page 36). The amount reimbursed by the hospital insurance program, as shown in table 6, does not coincide with the amount for trust fund expenditures reported by the Treasury Department for the period. There are several reasons for this difference. Trust fund expenditures include—in addition to bills paid by intermediaries—current financing and emergency payments. Current financing is an optional financial arrangement for reimbursement to providers to pay on a current basis for hospital services incurred by beneficiaries. Computation for current financing payments is made quarterly and is based on provider operation experience for the last month of the preceding quarter. Intermediaries may disburse current financing payments up to the amount arrived at through these quarterly computations. Emergency payments represent special advancements to providers to cover cost of services actually provided but for which bills had not yet been processed by the intermediary. When the system has been in operation for a time, such advances should no longer be necessary.

In addition, the data reported in table 6 are based on the month in which the claim is approved by the intermediary and subsequently recorded in the Social Security Administration central utilization record. There is a short lag between the time that the claim is approved and the time of actual payment to the provider of service. Furthermore, not all the claims for the first 3 months had been received and recorded in the statistical tape record as of the time of summarization of the data. Corrected figures will be published later.

The following tabulation compares the monthly amounts reported for trust fund expenditures and for claims approved as of October 15, 1966, under the hospital insurance program.

Days of care as well as total charges and reimbursement data are reported in table 6. For the first quarter of the fiscal year 1967, 387,413 inpatient hospital claims had been reported by October 15, 1966, as approved for payment by the intermediary. Almost all of these claims (99 percent) are for reimbursement for care in short-stay hospitals. As would be expected, the average number of days per short-stay hospital claim is considerably less than in the long-stay hospitals: 10.3 days compared with 23.0 days in long-stay hospitals (general and special hospitals with average stays of 30 days or over; tuberculosis, psychiatric, and chronic disease hospitals; and Christian Science sanitoriums). As the program continues, average hospital stays will undoubtedly be greater because the claims presented here are only for the first quarter of the program's operation—a period not long enough to reflect many long stays.

Total charges for the 387,413 claims amounted to approximately $167 million. Almost four-fifths—78 percent—of the total hospital charges were paid by the hospital insurance program. The deductibles and noncovered items on the bill account for differences between total charges and reimbursed amounts. The actual amounts reimbursed to hospitals are based on interim per diem rates that will be adjusted in the future on the basis of actual reasonable costs.

The reimbursed amount per claim averaged $334 in short-stay hospitals and almost twice that amount in long-stay hospitals because of the considerably longer stays in the latter. Total charges averaged $29 per day in long-stay hospitals, compared with $42 per day in short-stay hospitals.

[In thousands]

Month, 1966	Trust fund expenditures [1]	Inpatient hospital claims approved for payment [2]
Total	$271,389	$130,186
July	3,824	6,409
August	104,339	72,531
September	163,226	51,246

[1] Data from table M–5, p. 36 of this issue.
[2] Amounts recorded in Social Security Administration central utilization record, as of Oct. 15, 1966.

Because reimbursement by the hospital insurance program was only for inpatient care beginning July 1, average stays per claim approved in the program's first month were considerably shorter than for the next 2 months. For example, the average length of stay in short-stay general hospitals was only 6.7 days in July, compared with 10.0 days in August and 11.7 days in September. Average stays in long-stay hospitals in each of the 3 months reported show a similar pattern. July claims obviously included a considerable number of stays for aged persons who were in hospitals on July 1, and August claims also included some who were admitted before the effective date of the program.

The small number of inpatient hospital claims for the month of July—8.5 percent of the 3-month total—reflects the delays in transmittal for forms and claims at the beginning of the program rather than a small number of aged persons receiving inpatient hospital care during the month. Likewise, claims approved in September and recorded in the Social Security Administration tape record as of October 15 are 40 percent below the number for August because of the lags in reporting and recording the data. These data will be updated and revised each month and more complete information for the earlier months will be reported in future issues of the Bulletin.

ANALYTICAL STUDIES

In addition to providing basic data on program operations on a recurrent basis, the statistical system has been designed to provide the basis for a variety of analytical studies to evaluate the program and measure its performance. These studies will be concerned with assessment of program operation and achievements in terms of the program goals: to protect the aged person against the catastrophic costs of hospitalization and illness and to provide quality hospital and medical care in the most efficient and economical manner.

The statistical system has been designed to make possible studies to analyze the utilization experience in relation to the demographic data available from the eligibility records, to the charges and costs of providers, and to carrier operations. Such studies will provide the knowledge necessary for appraising the program's attainment of its purposes and for determining the need for legislative changes to facilitate effective operation.

These studies can be categorized in three main groups: utilization and costs of health services, effectiveness of administration, and questions relating to specific provisions of the law. Several examples of the type of analytical studies to be undertaken are sketched below.

Studies of utilization and costs of health services

The availability of a population base permits the calculation and presentation of a wide variety of utilization rates for population subgroups. In addition to the utilization data, the basic statistics include data on total and covered charges for the various types of service. The potentialities for combining and cross-classifying utilization data by characteristics of beneficiaries and providers of services open new vistas for analysis and study of variations in patterns of use for hospital and medical services and the factors affecting such variation, including geographic and certain demographic differences.

The availability of statistical data on utilization of hospital and medical services for each individual beneficiary provides the opportunity for longitudinal studies of the patterns of covered services received by individuals over a period of time. Use of services by specific groups of individuals, beginning at age 65 (or the start of the program), can be followed and studied in terms of the characteristics of the beneficiaries and the type and extent of services received. A tie-in with the basic record system of the Social Security Administration will make possible a unique opportunity for analysis of the medical history after age 65 in relation to the person's work history in covered employment, age at retirement, and benefit status.

The considerable fund of data relating to the characteristics of the providers of service, their reimbursement rates, and the utilization of their services provides the basis for a variety of studies. Geographic differences in reimbursement rates will be analyzed in terms of the providers and the services provided. Studies will be undertaken to determine where beneficiaries in a given

geographic area receive their medical services and where hospitalized persons come from.

Studies of effectiveness of administration

The central statistical system will provide the data required for a variety of studies of the program's administration. Under the hospital insurance plan each group of providers, or association of providers in behalf of their members, has nominated a national, State, or other public or private agency or organization to serve as fiscal intermediaries between themselves and the Federal Government. The intermediary determines the amount of payments due on receipt of bills from hospitals and other institutional providers and makes such payments.

Studies will be undertaken to analyze the operations of the intermediaries with respect to the effective operation of the program. Differences among carriers in their operating costs, methods of payments, procedures for claims review, billing lags, and other administrative responsibilities will be reveiwed and analyzed in detail.

Where payment is on the basis of charges for physician services and medical and other health services, the intermediaries or carriers are to take action to assure that the charge on which the reimbursement is based is reasonable and not higher than the charge used for reimbursement in behalf of the carriers' own policyholders or subscribers under comparable circumstances. In determining reasonable charges, the carriers are to consider the customary charges for services generally made by the physician furnishing the covered services, as well as prevailing charges in the locality for similar services.

Analysis will be made of the geographic variation in actual charges for physician services for comparable procedures in relation to their characteristics and those of beneficiaries. The studies will give some clues on the extent to which the carriers are effectively carrying out this important function.

Hospitals and extended-care facilities participating in the hospital insurance program must have a utilization review plan in effect, providing for review, on a sample or other basis, of the following: admissions of beneficiaries of the hospital insurance program to the institution, length of stays, and the medical necessity for services provided. Statistical studies analyzing the variations in institutional stays for comparable diagnostic categories in terms of geographic location and types of institution will assist in evaluation of the utilization review process.

Studies relating to specific provisions

The 1965 amendments to the Social Security Act include several special provisions embodying unique concepts in health insurance programs, the effects of which will be studied and analyzed. For example, inpatient hospital and extended-care services within specified limitations are provided under the law for each spell of illness. The term "spell of illness" is defined as beginning the first day (not in a previous spell of illness) in which an individual is furnished covered inpatient hospital or extended-care services and ending with the last day of the first period of 60 consecutive days during which he was not an inpatient in a hospital or extended-care facility. Studies of the impact of this requirement will be made in terms of the average duration of spells of illness, number of beneficiaries who exhaust benefits during single spells of illness, average duration of time between exhaustion of benefits and beginning of a new spell of illness, and the proportion of total costs of care in hospitals not covered because of the spell-of-illness concept.

Payments to providers of service under the hospital insurance program are made on the basis of reasonable costs for the services furnished. The costs of services in hospitals and extended-care facilities vary widely from one institution to another, reflecting differences in quality and intensity of care. Reimbursement rates and the method for determining reasonable costs will be analyzed in terms of geographic variations, type of facilities, and services provided.

One of the conditions of participation for an extended-care facility is that it must have a transfer agreement with at least on participating hospital (except under special circumstances). A transfer agreement is one that provides, in writing, for the transfer whenever such action is medically appropriate, as de-

termined by the attending physicians. Analysis will be made of the various types of transfer agreements, the implementation of this requirement on a geographic basis, and its effect on patterns of care received under the program.

There is a lifetime limit of 190 days of covered services in psychiatric hospitals. Psychiatric care in general hospitals, however, does not count against the 190-day lifetime limit. Statistical study will be undertaken to determine the number of persons who exhaust these benefits, the number and extent of psychiatric services in general hospitals, and emerging trends in this area.

Reporting plans

Many of the analytical studies described above cannot of course be carried out until the health insurance program for the aged has been in operation for some time. On the extent of services and on charges, the Current Medicare Survey is designed to yield program data on a national basis in advance of the detail to be obtained from the record. Current plans for reporting these survey data as well as basic data on program operations include publication of monthly, quarterly, and annual data in the Bulletin and in special releases and reports by the Office of Research and Statistics as the data become available and the studies are completed.

The need for statistical data by agencies, organizations, and researchers outside the Social Security Administration will also be taken into account in our tabulation plans. In reporting all program data, the Social Security Administration's general policy relating to confidentiality will be continued. Information will not be released identifying individual beneficiaries and their specific utilization of services under the program.

The health insurance program for the aged will have a significant impact on the entire structure of the organization and financing of health services in the country in addition to its impact on the ability of the aged individual beneficiary to meet the costs of needed hospital and medical care. The broad scope of benefits affecting this large population group and the financing of these benefits will require substantial adjustments in the entire system of health services, involving not only the aged beneficiary but the remainder of the population. In addition to the analytical studies outlined above, a broad research program will be undertaken to measure the impacts on both public and private programs, identify and define program gaps and unmet needs, and examine and evaluate the economic consequences of the program.

D.—Current Medicare Survey: The Medical Insurance Sample

By Jack Scharff*

[Reprint from the *Social Security Bulletin,* April 1967]

The January issue of the Social Security Bulletin carried a full description of the statistical program established to record and maintain data on the utilization and charges for medical care services covered under the health insurance program for the aged. The statistical system is based on the receipt by the Social Security Administration of bills presented to and paid by fiscal intermediaries throughout the country. Considerable delays in the statistical reporting of current information are inherent in the billing system. The Social Security Administration has therefore initiated a continuing monthly Current Medicare Survey (CMS) to provide current estimates of the hospital and medical care services used and of the charges incurred by persons covered under the program. This article describes the medical insurance sample of the CMS and presents information for July, August, and September 1966—the first 3 months of the program's operation. A subsequent article will describe the hospital insurance sample of the CMS and report data for the initial months of the program.

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CMS HIGHLIGHTS

Periodic household interviews of persons enrolled in the medical insurance program for the aged form the basis for the medical insurance sample of the CMS. Information on the use of and charges for medical care and related services has been collected since the beginning of the program. Highlights of the first 3 months of the program's operation (without adjustments for seasonal variations) reveal that—

during July 1966, approximately one-third of the medical insurance enrollees—5.6 million persons—used medical services covered under the program, and of this total, about 10 percent met the $50 deductible during the month.

charges per person using covered medical services in July averaged $31.

utilization of medical services increases somewhat with age, is greater for women than men, but does not vary materially by region.

the number of enrollees utilizing medical services and total charges incurred remained relatively unchanged in August and September.

approximately the same number of people met the deductible in July, August, and September.

about 2 million persons or 11 percent of the enrollees met the deductible by the end of September.

by the end of the first quarter of operation, charges potentially reimbursable by the program totaled about $227 million.

The health insurance program for the aged, popularly known as "Medicare," went into effect on July 1, 1966. The program comprises two related parts: The hospital insurance program (HI) provides financial assistance in paying part of the cost of hospital care, post-hospital extended care and home health services, and outpatient hospital diagnostic services. The supplementary medical insurance program (SMI) provides for payment of part of the charges for physicians' and other medical services.

The statistics for the medical insurance program depend upon receipt by the Social Security Administration of copies of bills transmitted to and paid by about 50 intermediaries throughout the country. It was anticipated, and actual experience during the first months of the program's operation has demonstrated, that there are time lags and delays of varying duration in the receipt and payment of bills by the intermediaries. Several factors contribute to this delay. Beneficiaries may accumulate their bills until the charges exceed the $50 deductible. This process may present special problems to the aged who have difficulties in fully understanding this part of the program. For the beneficiaries whose bills are not assigned to physicians, delays occur when they must present receipted bills to the intermediaries for reimbursement.

Knowledge of the volume of services and charges incurred for specified periods is helpful for administrative purposes to provide a current picture of the extent of obligations incurred by the Federal Government and to estimate the future claims against the trust fund. The CMS is intended to produce program information on a statistical basis about 3 months after the reference period. It will provide, considerably in advance of the time when data become available from operating records, national estimates of the number of persons receiving medical care and related services and the charges incurred, including deductibles and coinsurance.

SMI SAMPLE DESIGN

To obtain information on the utilization and charges for medical care and related services under the medical insurance program, the survey design calls for monthly personal interviews of nearly 4,000 persons selected from the primary 5-percent statistical sample of those enrolled in this part of the health insurance program.[1] The sample, chosen to be self-weighting within 105 primary sampling units, represents the 17.5 million persons residing in the 50 States and the District of Columbia who were enrolled for medical insurance benefits as

[1] For a description of the 5-percent sample, see Howard West, "Health Insurance for the Aged: The Statistical Program," *Social Security Bulletin*, January 1967.

of July 1, 1966. Persons selected in July remained in the sample through the end of December 1966. A sample of persons was selected for interviews starting in October 1966. This group will remain in the survey for 15 months. The cycle was determined by the fact that any expenses incurred by an individual in the last 3 months of a calendar year and applied to the deductible for that year may be carried over and applied to the deductible for the next calendar year.

The SMI sample, used to provide estimates in this report, consists of: (1) A basic sample of 3,800 individuals who will normally remain in the sample for 15 months and (2) a small incremental sample drawn to include persons "aging in" to the universe and added to the sample each month.

SMI SURVEY PROCEDURES AND DATA COLLECTION

The basic sampling unit is the individual beneficiary. To obtain current information on medical insurance benefits, the beneficiaries are contacted periodically to supply the required information. Personal interviews, utilizing a questionnaire and a diary form, are conducted by the Bureau of the Census acting as a collector of data for the Social Security Administration. Experienced field interviewers obtain information about the use of medical care and related services during the preceding month. A careful editing and screening process identifies those items not covered by the program, and, up to the present, only bills incurred for covered services have been coded and tabulated. Charges are accumulated so that the total covered charges for an individual may be located along a continuum from any point below the deductible to any point above.

The questionnaire and diary form are designed to obtain the following items of information: name and address of respondent, date and place of doctor visits, type of physician, condition treated, other medical services received, including covered medical services received in the hospital and nursing home as well as X-rays, medical tests, ambulance services, and the like. Also included are questions relating to the total amount of the bill, the portion not covered by the program, and the source of payment.

No attempt is made to ascertain charges or services for hospital-based physicians such as pathologists and radiologists, except where the patient is aware of such treatment and is billed separately for the physician's services.

Information on the dollar amount of the physician's bill is often unknown because no bill had been received by the date of the interview. The interviewer attempts to obtain this information in the following month. Experience has proven that the doctor's bill is frequently available during the follow-up interview.

There are several instances where the bill information is not normally available to the beneficiary regardless of the elapsed time. Welfare beneficiaries, for example, would not generally know the amount of the doctor's bill. Where no information on charges is available, an estimating procedure was established that is based on the assumption that charges will be the same for similar services rendered in the same area. For example, a doctor's home visit in a specific city is valued at the amount last reported in the sample for this type of service in the same geographic area.

The nonresponse rate, where no interview was obtained, amounted to 9 percent in July, 8 percent in August, and 8 percent in September. Two techniques were employed to impute the required data: First, for persons known to be hospitalized during the survey month and, therefore, not available for interview, the imputation was based on the hospital experience of reported persons. Second, a random substitution of experience of other persons in the same color, sex, and age group was used.

The monthly survey results were derived by multiplication of the sample data by a single weight obtained from the ratio of an independent estimate of the persons enrolled in the medical insurance program as of the beginning of the month to the sample population. For July, tabulated enrollment data were employed as the independent figure. For August, enrollment data were independently estimated by adjusting the July 1 tabulated enrollment for increments of persons reaching age 65 and for decrements of persons who died or dropped from enrollment. The estimated August 1 enrollment was used in a similar manner as a basis for deriving the estimated September 1 enrollment figures.

TABLE 1.—CURRENT MEDICARE SURVEY, MEDICAL INSURANCE SAMPLE: ESTIMATED NUMBER AND DISTRIBUTION OF MEDICAL INSURANCE ENROLLEES, BY SELECTED CHARACTERISTICS AND USE OF MEDICAL SERVICES, JULY-SEPTEMBER 1966

Characteristic	Total	Enrollees using no services	Enrollees using services		
			Total [1]	Deductible not met	Deductible met [2]
July 1966					
Total number (in thousands)	17,507	11,872	5,635	4,697	607
Total percent	100.0	67.8	32.2	26.8	3.5
Age: [3]					
65 to 74	100.0	68.7	31.2	26.4	3.2
75 to 84	100.0	67.0	33.1	27.2	3.7
85 and over	100.0	63.8	36.3	28.8	4.4
Sex:					
Men	100.0	71.6	28.4	23.0	3.8
Women	100.0	65.0	35.0	29.7	3.2
Census region: [4]					
Northeast	100.0	67.4	32.6	27.9	3.2
North Central	100.0	68.5	31.6	25.3	3.6
South	100.0	68.5	31.5	26.8	3.1
West	100.0	65.9	34.2	28.1	4.7
August 1966					
Total number (in thousands)	17,533	11,958	5,575	4,248	1,079
Total percent	100.0	68.1	31.8	24.3	6.1
Age: [3]					
65 to 74	100.0	70.0	30.0	22.5	6.2
75 to 84	100.0	66.0	34.0	27.1	5.7
85 and over	100.0	61.1	38.8	26.9	8.5
Sex:					
Men	100.0	71.1	29.0	21.4	5.9
Women	100.0	66.0	33.9	26.4	6.3
Census region: [4]					
Northeast	100.0	68.1	31.9	24.5	6.2
North Central	100.0	68.2	31.6	24.1	6.0
South	100.0	69.7	30.3	23.6	5.3
West	100.0	64.9	35.1	25.2	8.0
September 1966					
Total number (in thousands)	17,561	11,964	5,597	3,761	1,538
Total percent	100.0	68.1	31.9	21.4	8.8
Age: [3]					
65 to 74	100.0	70.1	29.9	20.3	7.9
75 to 84	100.0	65.7	34.2	23.2	9.5
85 and over	100.0	61.9	38.1	22.5	13.0
Sex:					
Men	100.0	72.7	27.3	17.4	8.2
Women	100.0	64.8	35.3	24.4	9.2
Census region: [4]					
Northeast	100.0	68.3	31.7	21.1	9.0
North Central	100.0	67.2	32.7	22.4	8.6
South	100.0	70.3	29.7	21.0	7.1
West	100.0	65.5	34.4	20.7	11.7

[1] Includes those using services for which a bill is not expected.
[2] Includes those for whom the first $50 of covered expenses have been met by the end of the month and for whom a chargeable expense has been incurred during the month.
[3] Age attained in 1966.
[4] Based on mailing address of enrollee when selected for sample.

Special efforts are made to obtain the data for persons in the sample who died during the survey month because these individuals probably had higher utilization of medical services during the survey month than that of other persons. The results of the first month's attempt to obtain this information pointed to the desirability of postponing the interview with the next of kin or any other proxy respondent until the following month. On this basis, interviews were obtained for 93 percent of the known deaths occurring between July 1, 1966, and September 30, 1966.

CMS FINDINGS ON SMI

During the first month of the program's operation, approximately 5.6 million aged persons, or about one-third of the 17.5 million persons enrolled, used medical

services covered under the medical insurance program (table 1).[2] No adjustment was made for seasonal variation. Excluded are services and charges by hospital-based physicians such as pathologists and radiologists. Included are persons using covered services for which a bill is not expected. All services performed by relatives are included, for example, as well as those provided by government agencies such as health departments, with the possibility that these services may in the future become chargeable to the program. Charges are not imputed, however, to those services for which a bill will not be rendered.

Although information was collected during the field interview on the use of noncovered services, such as eyeglasses and routine physical examinations, the information on use of services presented here refers only to covered services. On this basis, an aged person purchasing eyeglasses during July, without a visit to a physician for any covered services, is classified here as having used no covered services.

Of the 5.6 million enrollees using covered services in July, approximately 600,000 persons or about 10 percent had used services with charges totaling $50 or more and thus met the deductible during the first month of the program's operation.

Use of medical services among the aged differs to some extent by age and sex. The CMS provides some evidence that the proportion using covered medical services increased with age—from 31 percent of persons aged 65–74 to 36 percent of persons aged 85 and over. A somewhat larger proportion of the aged women use medical services than aged men. There are, however, no material regional differences in the use of medical services.

Total charges of $167 million were incurred in July by the 5.3 million persons using covered medical services and for whom bills have been rendered or are expected to be rendered. This total represents an average of $31 per person using such services (table 2). As expected, when the dollar amounts are allocated to the deductible status of the enrollees, a different picture emerges. For the 4.7 million persons who had used medical services and incurred charges of less than the $50 deductible during July, the aggregate charges amounted to $57 million, or an average of $12 per person. By contrast, for the estimated 607,000 persons who had incurred charges of more than the $50 deductible during July, the average amount per person was about $181. On an aggregate basis, total charges for this group amounted to approximately $110 million.

For the first month of the program's operation, all but the first $50 and 20 percent of the remaining charges are potentially reimbursable, on the assumption that all charges are classified as reasonable by the intermediary.[3] On this basis, about $64 million or 58 percent of the total charges for the group of aged persons meeting the deductible in the first month are potentially reimbursable. This percentage rises somewhat in succeeding months as the same individuals continue to use additional medical services and the deductible amounts have already been accounted for. By the end of the third quarter of 1966, potentially reimbursable charges amounted to approximately $227 million.

The following tabulation presents the estimated charges for persons using medical services in each of the first 3 months of the program, categorized by their deductible status.

The use of medical services in August and September 1966 by aged beneficiaries of the medical insurance program remained about the same as in the first month of the program's operation. About 32 percent of the enrollees used medical services in each month. These figures are not additive because many of the same

[2] See "Enrollment in the Health Insurance Program for the Aged," *Social Security Bulletin*, March 1966, pp. 21–24.

[3] "Reasonable charges" are based on the customary charges for similar services generally made by the physician or other person, as well as the prevailing charges in the locality for similar services. They may not be higher than the charge applicable for the carrier's own policyholder for comparable services under comparable circumstances.

[In thousands]

Type of charge	July	August	September
Total	$166,867	$167,367	$164,993
Deductible not met	56,983	45,457	39,230
Deductible met:			
Total	109,884	121,910	125,736
Amount reimbursable	63,629	80,275	82,587

TABLE 2.—CURRENT MEDICARE SURVEY, MEDICAL INSURANCE SAMPLE: ESTIMATED AVERAGE CHARGE PER MEDICAL INSURANCE ENROLLEE USING MEDICAL SERVICES, BY SELECTED CHARACTERISTICS AND DEDUCTIBLE STATUS, JULY–SEPTEMBER 1966

Characteristic	Total [1]	Deductible not met	Deductible met [2]	
			Total	Potentially reimbursable [3]
July 1966				
Total	$31	$12	$181	$105
Age: [4]				
65 to 74	32	12	192	113
75 to 84	31	12	175	100
85 and over	28	13	132	66
Sex:				
Men	33	12	158	87
Women	31	12	201	121
Census region: [5]				
Northeast	31	12	195	116
North Central	32	11	181	105
South	30	11	191	113
West	34	15	148	78
August 1966				
Total	$31	$11	$113	$74
Age: [4]				
65 to 74	33	11	116	77
75 to 84	26	11	98	64
85 and over	42	9	144	94
Sex:				
Men	33	11	115	76
Women	30	11	112	73
Census region: [5]				
Northeast	32	11	116	77
North Central	31	10	119	76
South	25	11	90	58
West	40	12	129	88
September 1966				
Total	$31	$10	$82	$54
Age: [4]				
65 to 74	28	10	73	47
75 to 84	34	11	90	59
85 and over	45	10	106	71
Sex:				
Men	38	11	96	65
Women	27	10	72	47
Census region: [5]				
Northeast	33	11	85	58
North Central	31	10	84	54
South	30	10	89	59
West	30	12	63	40

[1] Based on number of enrollees using covered services, excluding persons for whom a bill is not expected.
[2] Based on number of enrollees for whom the first $50 of covered expenses have been met by the end of the month and for whom a chargeable expense has been incurred during the month.
[3] Excludes the first $50 and 20 percent of the remaining charges and assumes that all charges are classified as reasonable by the intermediary.
[4] Age attained in 1966.
[5] Based on mailing address of enrollee when selected for sample.

persons use services in successive months. In August and in September, as in July, there were indications of the increasing use of services with advancing age, and a somewhat higher proportion of women than men continued to utilize medical care services (table 1).

Total charges incurred in August and in September also remained at about the same level as in July—approximately $165 million or $31 per enrollee using medical services. When the enrollees and their incurred charges are distributed according to their deductible status, the picture changes significantly for each of the months. During July, approximately 4 percent of the enrollees had met the deductible and the amount incurred averaged approximately $181. In August, 6 percent of the enrollees had used some services and met the deductible by the end of the month, but their charges averaged $113. About 9 percent had used some services during September and met the deductible by the end of the month, and the average charge for this group declined to approximately $82.

This successively decreasing average charge for the enrollees using services in a given month who have already met the deductible is undoubtedly a function of the pattern of expenditures for medical services by aged persons. It is likely that initial large expenditures resulting from an illness requiring hospital care are often followed by additional smaller outlays for follow-up physician visits. Thus, the calculation of average charges in August and September among persons who have already met the deductible involves an increasing number of persons who have met the deductible in previous months and use little services in the month of calculation, and an increasing number of persons who have partially met the deductible in previous months and meet the deductible with relatively small charges incurred during the current month. In addition, there are some persons who may have met the deductible in July but did not use any services in the months following. Likewise, others may have met the deductible in August but did not use services in September.

A cumulative picture of the number and percent of the enrollees meeting the deductible by the end of each month is shown in table 3. An initial group of 607,000 met the deductible in July, and another group about the same size reached this amount by the end of August. By September's end, about 2 million persons, or 11 percent of the enrollees, had reached the deductible. The evidence of increasing use with increasing age continued to manifest itself.

At the end of the third month of program operation, there was no material difference between the proportion of men and women who had met the deductible. Regional variations were, however, evident. A somewhat higher proportion of the aged enrollees in the West (14 percent) than in the South (10 percent) had met the deductible by the end of September—a reflection perhaps of both the relatively higher utilization and higher charges in the West.

RELIABILITY OF ESTIMATES

Since the estimates are based on a sample, they may differ somewhat from the figures that would have been obtained if the same data had been collected for the entire universe of enrolled persons and the same collection procedures used. The data may also differ from the results of statistical compilation of data from the administrative records. As in any data collection, the results are subject to errors of response, reporting, and processing as well as being subject to sampling variability. On the other hand, statistical compilations of data from the administrative records may be subject to errors of omission or incompleteness as well as processing and, where sampling is employed, may also be subject to sampling variability.

The standard error is primarily a measure of sampling variability—that is, of the variations that occur by chance, because a sample rather than the whole universe was used. As calculated for this report, the standard error also partially measures the effect of response errors but does not measure any systematic biases

TABLE 3.—CURRENT MEDICARE SURVEY, MEDICAL INSURANCE SAMPLE: ESTIMATED NUMBER AND PERCENT OF ENROLLEES MEETING THE DEDUCTIBLE BY THE END OF EACH MONTH, BY SELECTED CHARACTERISTICS, JULY-SEPTEMBER 1966

Characteristic	1966		
	July	August	September
Number (in thousands)	607	1,198	1,978
Percent of enrollees [1]	3.5	6.8	11.3
Age: [2]			
65 to 74	3.2	6.8	10.7
75 to 84	3.7	6.4	11.6
85 and over	4.4	9.8	15.6
Sex:			
Men	3.8	6.8	10.9
Women	3.2	6.8	11.5
Census region: [3]			
Northeast	3.2	6.6	10.9
North Central	3.6	7.2	11.7
South	3.1	5.7	9.6
West	4.7	8.7	14.3

[1] Based on the estimated number of enrollees in the medical insurance program as of the beginning of each month.
[2] Age attained in 1966.
[3] Based on mailing address of enrollees when selected for sample.

in the data. The chances are about 68 out of 100 that an estimate from the sample would differ from the result for the entire universe, with the same procedures and methods used, by less than the standard error. The chances are about 95 out of 100 that the differences would be less than twice the standard error. The chances are about 99 out of 100 that the differences would be less than two and one-half times the standard error.

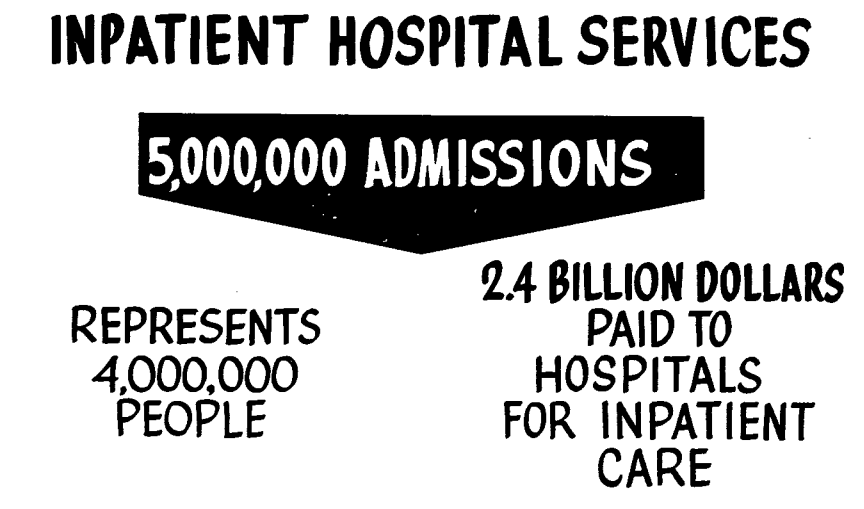
For this report, a group of items have been selected for which approximations to the standard errors have been estimated. Similar approximations of the standard errors of other estimates could be calculated. At the start of this statistical program, sampling variability estimates are shown only for some data in order to illustrate the range of variability in the basic data. In order to derive standard errors that would be applicable to the wide variety of items presented and that could be prepared at a moderate cost, a number of approximations would be required.

The necessary experimentation to enable the generalization to be carried out is under way. In subsequent reports, as soon as possible, generalized tables of standard errors will be provided.

The medical insurance sample of the CMS estimates that 1,978,000 persons had met the $50 deductible during the first quarter of operation. The standard error is about 125,000. The chances are 68 out of 100 that the result based on the CMS collection procedures for the entire universe would be between 1,853,000 and 2,103,000. Approximately the same number of persons met the deductible in July, August, and September. The estimate of about 600,000 for July or August has a standard error of about 65,000. The estimate of 780,000 for September has a standard error of about 80,000. It is estimated that approximately 5.6 million persons have been using services covered by the program each month. The standard error is about 180,000. Chances are about 68 out of 100 that the number of persons using these services lies within the range of 5.42 million and 5.78 million in each month.

The aggregate amount of reimbursable charges for the first 3 months of the program among the 1,978,000 who have met the deductible has been estimated to amount to about $227 million. The standard error is about $18 million. The survey has estimated that the average amount of total charges in September among persons using services and meeting the deductible by the end of September is $82. The standard error is about $11.

The estimates developed from the medical insurance sample of the CMS are based in part on the memory or knowledge of one person. The memory factor in data derived from field surveys probably produces underestimates, because the tendency is to forget minor or irregular items. Other errors of reporting may result from misunderstanding as to the scope of the program's coverage.



*INCLUDES ESTIMATED DATA FOR JUNE 1967

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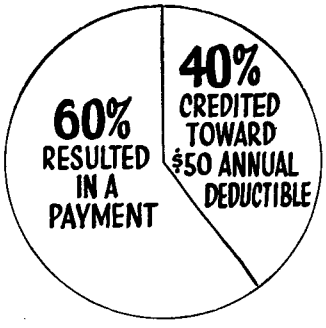
PHYSICIAN AND OTHER MEDICAL SERVICES

25,000,000 BILLS FOR SERVICES

CHARACTERISTICS OF BILLS PROCESSED

90% FOR PHYSICIAN SERVICES



640 MILLION DOLLARS PAID ON BILLS PROCESSED

• *INCLUDES ESTIMATED DATA FOR JUNE 1967*

EXTENDED CARE SERVICES

(EFFECTIVE JANUARY 1, 1967)

200,000 ADMISSIONS

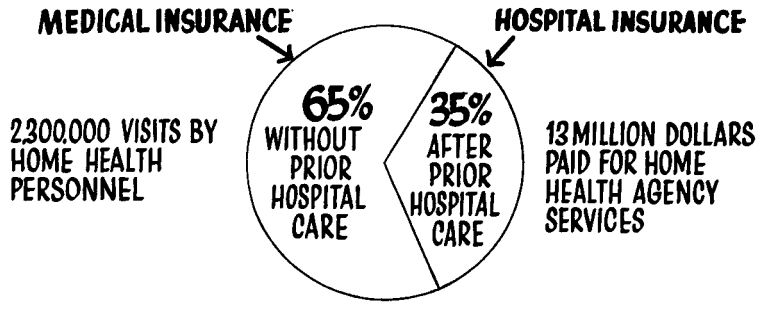
EXTENDED CARE SERVICES RELEASE HOSPITAL BEDS FOR ACUTE CARE

$60 MILLION DOLLARS PAID FOR EXTENDED CARE SERVICES

✱ *INCLUDES ESTIMATED DATA FOR JUNE 1967*

HOME HEALTH AGENCY SERVICES

230,000 'START OF CARE' NOTICES



• *INCLUDES ESTIMATED DATA FOR JUNE 1967*

OUTPATIENT HOSPITAL SERVICES

3,500,000 BILLS RECEIVED

1,900,000 BILLS FOR OUTPATIENT DIAGNOSTIC BENEFITS	1,600,000 BILLS FOR OUTPATIENT THERAPEUTIC SERVICES	$12 MILLION DOLLARS PAID TO HOSPITALS FOR OUTPATIENT CARE

ALL *OUTPATIENT BILLS, WHETHER FOR DIAGNOSTIC OR THERAPEUTIC SERVICES, RESULT IN EITHER A CREDIT TOWARD THE $50 PART B DEDUCTIBLE, OR A PART B PAYMENT IF THE $50 DEDUCTIBLE IS MET.*

* INCL. EST. DATA FOR JUNE 1967.

PROVIDERS PARTICIPATING IN THE PROGRAM

6800 HOSPITALS

MORE THAN 98% OF THE NATIONS SHORT TERM BED CAPACITY IS IN PARTICIPATING HOSPITALS

*INCLUDE ESTIMATE DATA FOR JUNE 1967

PROVIDERS PARTICIPATING IN THE PROGRAM

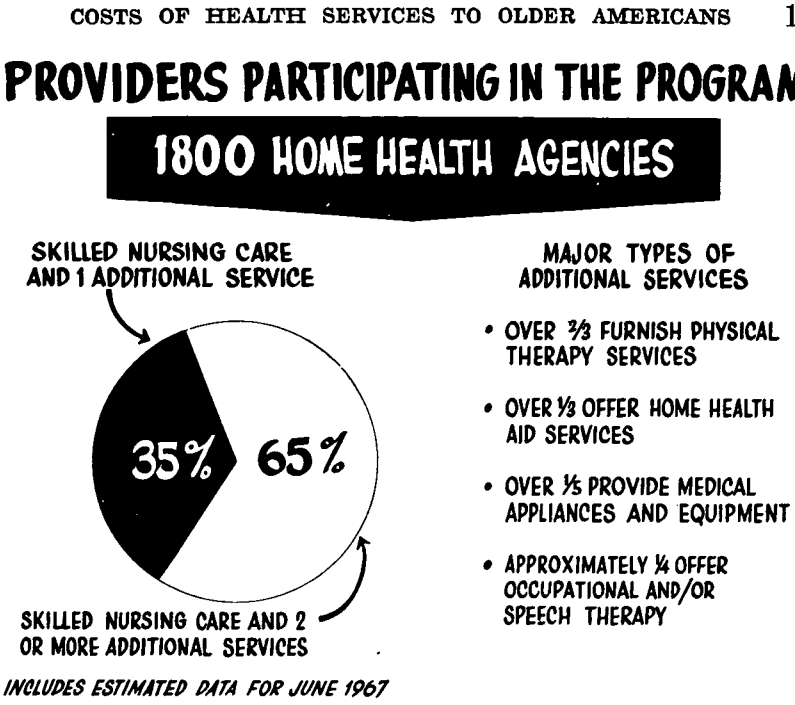
4,000 EXTENDED CARE FACILITIES

ABOUT ½ OF SKILLED NURSING FACILITY BEDS ARE IN PARTICIPATING EXTENDED CARE FACILITIES

281,000 BEDS

550 FACILITIES WITH OVER 30,000 BEDS ARE DISTINCT PARTS OF HOSPITALS

*INCLUDES ESTIMATED DATA FOR JUNE, 1967



E—STATEMENT OF WILBUR J. COHEN, UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE*

Mr. Chairman and members of the committee, I am pleased to be here today with Dr. William H. Stewart, Surgeon General of the Public Health Service to give the Department's wholehearted and enthusiastic support to the Partnership for Health Amendments of 1967, H.R. 6418, introduced by the distinguished chairman of the Committee, Mr. Staggers.

In 1936 Congress first provided, in the Social Security Act, a general health grant program to support any part of a State's public health program. Since that time the Federal government has continued to be one of the major financial partners in the nation's health enterprise because Congressional concern and public attention has been aroused by a variety of urgent, specific health problems. Federal support was provided in the form of earmarked grants.

The result, over the past decades, has been a salutary growth in health resources and some dramatic breakthroughs in health protection.

Thirty years of Federal-State cooperation in health programs has brought us to the point where the States can and should be given a larger role and a much greater measure of flexibility in planning and carrying out health programs. Two important changes in this direction were provided by the Comprehensive Health Planning and Public Health Services Amendments of 1966: first, a real opportunity and a mechanism for the States and localities to identify their own most urgent health needs and, second, a change in Federal funding to help them meet those needs.

Last year we appeared before this Committee in the closing days of the 89th Congress to request that the Congress enact those amendments into law. We asked for your quick action at that time because we felt that it was of great importance that the principle embodied in the bill, which has now become P.L. 89–749, be made part of the structure of our national health effort. Your action was timely. We are grateful for it.

President Johnson specifically recognized the importance of your action in his February 28 Message to the Congress on Health and Education; he said:

> "The Partnership for Health legislation, enacted by the 89th Congress, is designed to strengthen State and local programs to encourage broad gauge planning in health. It gives the States new flexibility to use Federal funds

*See reference on p. 4.

by freeing them from tightly compartmentalized grant programs. It also allows the States to attack special health problems which have regional or local impact."

This is the heart of the new law: *planning* for the efficient use of resources, and sufficient *flexibility* to use resources efficiently. We have as a Nation, Mr. Chairman, committed ourselves to promoting and assuring the best level of health attainable for every person in this country. The magnitude and complexity of that commitment requires that we marshal all our available health resources, public and private, in a vital partnership to achieve this objective. The bill before the Committee would continue and expand the new partnership which was created by the Congress last year.

In the intervening months, since you last considered the partnership for health, the Public Health Service and the Department have become more intimately acquainted with the possibilities and problems posed by this large effort. We have begun to lay the base which is necessary to move away from the restrictive effects of fragmented and outmoded patterns. We have begun the task of creating a new relationship which can enable every sector of the total health community to provide fuller service to our citizens.

The Public Health Service has been consulting with representatives of State, county and local governments; with university officials; with representatives of professional organizations such as the American Medical Association, the American Hospital Association, the American Public Health Association, the American Institute of Planners; and with many voluntary organizations which have a long-standing interest and involvement in health affairs. Some of them, for example, are the American Heart Association, the American Cancer Society, the National Tuberculosis Association. These meetings have done much to shape our initial thinking and indicate the direction we must take in launching this nationwide program.

Early in January, Secretary Gardner wrote to each of the State Governors and expressed his belief that P.L. 89–749 is one of the most significant health measures passed by the Congress.

The response from the States to the Secretary's letter has been most gratifying. The Honorable William L. Guy, Governor of the State of North Dakota and Chairman of the National Governor's Conference, wrote to the Governor of each State:

"This new health legislation could be a milestone in our continuing progress toward improved Federal-State relations."

Governor Guy wrote this to the President:

"When you signed into law Public Law 89–749, known as the 'Comprehensive Health Planning and Public Health Services Amendments for 1966.' you gave federal aid an historic turn for greater federal-State relations. The Act will now permit total comprehensive planning in the field of health."

The Honorable Hulett C. Smith, Governor of the State of West Virginia, wrote to say that "West Virginia is eager to take full advantage of the Comprehensive Health Planning and Public Health Service Amendments."

Governor Harold LeVander of Minnesota concluded his letter to the Secretary by saying:

". . . This program will undertake to assess the present level of health programming and health resources. This assessment, I am confident, will lead to improved and more efficient programs and to fruitful working relationships between the health consumer, the governmental, the private and the voluntary health agencies in our State."

Thirty-seven States, the territories, and Puerto Rico, each have already designated a comprehensive health planning agency. We believe that the remaining States will take action to designate an agency within the very near future. We are greatly encouraged, Mr. Chairman, by the very deep interest and marked enthusiasm which the States have shown in this new program.

Section 2 of the bill before you now embodies no major changes in philosophy, direction or emphasis from P.L. 89–749. It extends and expands the authorizations for grants for comprehensive health planning and services which were provided last year. The important innovations enacted last year are preserved in full:

the concept of comprehensive health planning to be undertaken by the States with Federal grant support;

the extension of area-wide planning of facilities to encompass all health services;

the training of the personnel necessary for these planning efforts;

the new program of flexible assistance through State formula grants, without categorical restriction, for the public health services the States need the most;

the broad project grant authority for the stimulation of new kinds of services, and for dealing with special types of problems.

The bill extends the authorizations for each of these aspects of the program through fiscal 1972. It would increase the authorizations for assistance to the States for planning activities, under section 314(a) of the Public Health Service Act, from the present $5 million to $7 million for fiscal 1968. It would also increase the authorizations for both formula grants under section 314(d) and projects grants under section 314(e) from the present $62.5 million to $70 million for fiscal 1968. Funds to support these increased authorizations are included in the President's 1968 budget request. Formula grants to the States in fiscal 1967, under the previous Public Health Service Act authorizations, were at a level of $55 million annually, and assistance under the project grant authorizations was at a level of $58 million annually. A large proportion of the funds authorized under the Partnership for Health Amendments for fiscal 1968 are likely to be committed by the States to programs approved and begun in earlier years. The $70 million authorization for fiscal 1968 will thus allow for only a modest expansion in these activities, and result in a roughly constant Federal share of the total cost.

There is little doubt that diversity of needs and resources extends down into the localities within the States; and the Partnership for Health recognizes this, both in the planning and funding of health services. Local planning is an essential base for the State-wide planning effort. Local participation and knowledge of the area to be served can best come from the area-wide planning groups. The provision in this bill that at least 70% of the allotments for support of health services shall be available only for services in communities is further evidence of the desire to move planning and programs closer to the people who are to be served.

The new project grant authority in section 314(e) is also broad and flexible. It will permit the development and initial support of health services and will make it possible to mount narrower, targeted attacks on problems of limited geographical scope or of special regional or national significance.

The combination of these two approaches, a highly focused developmental effort and flexible support for continuing service offers, we believe, a framework within which the comprehensive planning carried out by States and localities can be meaningfully translated into good health care.

The Congress has done much in the past several years to meet the justifiable expectations of the American people that this country can and will provide the best in health care to all its citizens. Medicare and Medicaid are major steps in removing financial barriers to health care. This Committee has recommended a series of laws which are building up the basic resources necessary to produce an adequate supply of trained manpower. Since 1946 we have been redressing imbalances and inadequacies in the supply and distribution of health facilities. And we have begun a program which will create a network of services designed to reduce the lives lost to heart, cancer, stroke and other major diseases. Each of these steps was important; each was basic. We have now reached a stage where harder tasks must be faced. We must find ways to make the total organization of our health effort as efficient as possible. The Partnership for Health is an indispensable element in reaching that goal.

HEALTH SERVICES RESEARCH AND DEVELOPMENT

President Johnson in his Health and Education message pointed out that despite a $43 billion annual expenditure for health and medical care our system of providing health services is not operating as efficiently and effectively as it should. We have done much to train the manpower, to build the facilities, and to pay for the services which the American people demand and require. We have not, however, done nearly enough to mobilize our universities, our industries, our private practitioners and research institutions to seek new ways of providing madical services and to hold down the cost of health care. Research and development can greatly improve the health services system. Yet today, the government-wide total investment in health services research amounts to less than one-tenth of one percent of our total annual investment in health care.

A major concern of the Department of Health, Education, and Welfare is to create a research and development program which will bring health services to a

level of productivity which compares favorably in efficiency and effectiveness with biomedical science, on the one hand, and with some of our most advanced industries, on the other.

We must accomplish this if for no other reason than that health and medical care prices are rising rapidly. Any reasonable forecast is that these prices will continue to increase for sometime into the future. Secretary Gardner recently transmitted to President Johnson a report on the problem, and the Department has called a conference on medical care costs, to be held in Washington, D.C. on June 27th. Experts from all segments of the health industry have been invited to attend and will search for the best ways to retard the rate of increase of the cost of medical care.

Section 3 of H.R. 6418 would give us the broadest, most flexible kind of authority to employ the Nation's best minds, wherever they are, to design the facilities, the information systems, the training methods, and the more efficient patterns of health services we must have. Much knowledge, and many new technological developments already exist and we can take advantage of them immediately.

An early step will be the establishment within the Public Health Service of a National Center for Health Services Research and Development. The National Center will be responsible for administering coordinated grant and contract assistance for research and development in the health enterprise, as well as for establishing and maintaining a flow of carefully evaluated research and development results to health service agencies and practitioners.

We must clearly identify the working, dynamic elements of health services. We must understand what they contribute to health, and we must select the critical points at which well-designed experiments will result in more effective medical results, greater efficiency in terms of dollar costs and other scarce resources, and greater availability of services to all of our people.

There are six major areas in which we plan to carry out research and development.

Medical services: the work of physicians, nurses and other health personnel as they engage in direct patient care in individual practice, group practices, hospitals and their clinics, nursing homes, official health agencies, and the patient's own home.

Instrumentation and automation of medical and other health services: the rapidly increasing use of electronic and other equipment to assist in diagnosis, patient monitoring and therapy, medical record handling, and overall control of medical care processes.

Facility design, organization, and operation of hospitals and other medical and health care facilities and their organization and administration.

Health economics: the analysis of the role of the health industry in the economy as a whole as well as cost of benefit and other studies of the efficiency and effectiveness of specific programs and systems.

Social analysis: the study of social and psychological factors influencing individuals and groups in their health habits and their use of available services, and the understanding of factors which affect the operation of health institutions and programs.

General systems analysis, organization, and planning: the application of systems analysis to the health industry as a whole and to its components, giving attention to the processes of health planning and organization in entire communities from a research and development viewpoint.

These six areas span all of health services. Obviously they cover an enormous network of scientific, technical, and behavioral activities. To work on one, or only a few of the elements would be futile—each aspect of the problem affects the other.

This is a research program in which industry and operating service programs have much to contribute, as do the universities, the medical and other health professional schools, and the non-profit research agencies. The Department and the Public Health Service will spare no effort to enlist the best thought, the most vigorous individuals and institutions and the best administrative methods in this cause.

CLINICAL LABORATORY IMPROVEMENT

Section 5 of the bill is the "Clinical Laboratories Improvement Act of 1967," recommended by the President in his Message to the Congress on Consumer Interests. It would authorize the Secretary of Health, Education and Welfare to

regulate by licensing clinical laboratories which operate in interstate commerce.

Everyday the lives of thousands of people depend upon the accuracy of the tests performed in such laboratories. Studies by the National Communicable Disease Center and others indicate that unsatisfactory performing is demonstrated by 10–40% of laboratories in bacteriological testing; by 30–50% in various simple clinical chemistry tests; 12–18% in blood grouping and typing; by 20–30% in hemoglobin measurements; by 40–80% in differential characterization of blood cells; and by 20–30% in measurement of serum electrolytes. There also exists considerable variation in results from laboratory to laboratory. This information indicates that erroneous results are obtained in more than 25% of all tests analyzed by these studies. Clinical laboratory testing is a large and rapidly growing industry. Virtually every person who seeks medical attention uses—directly or indirectly—laboratory services.

A significant share of those services is provided by laboratories which send both reports and materials across State lines at distances remote from the physicians requesting the analyses.

The problem of regulating the interstate operation of clinical laboratories is one which the States alone are unable to cope with effectively. In most States, there is no effective regulation, even of those laboratories which operate wholly within the State. The interstate clinical laboratory industry is potentially either a major resource for the improvement of our Nation's health, or a national health hazard, depending upon its performance and reliability.

This legislation is designed to assure both physicians and their patients that the work done by a laboratory of their choice will be consistent, performed under responsible supervision, and within established clinically sound procedures.

There are a number of other provisions in H.R. 6418; Dr. Stewart will deal with the remaining aspects of the bill. Thank you once again, Mr. Chairman, for the opportunitl to appear here today. I urge the Committee's early and favorable action on H.R. 6418.

F—SUMMARY NOTES OF CONFERENCE* ON MEDICAL CARE COSTS BY ROBERT M. CUNNINGHAM, JR., EDITOR, MODERN HOSPITAL, MCGRAW-HILL PUBLICATIONS

My assignment as general reporter for this Conference is to summarize the highlights of the panel discussion—a task that is actually less intimidating than it might seem, because as you may have noticed the Conference planning staff has provided reporters for all the sessions, and all the reporters have provided abundant notes; and so what we have finally this afternoon is—in effect—a summary of the summaries.

If it had to be reduced to a single sentence, which is happily not the case, I should say it has been the sense of the panel discussions that there are many promising means by which the end of retarding the rise of medical costs without damaging medical quality must be sought, and that all the promising methods that have been examined here require vigorous development by all the appropriate interested groups. As I listened to them, the panel discussions reflected the sense of urgency that was evident in the conference call and at the opening session.

It is interesting I think, and certainly indicative of the complexity of the phenomena you have been discussing, that the jurisdictional boundaries between the various panels represented here were not scrupulously observed. At times, in fact, the boundaries were invisible, as when on occasion the panels on community systems and prepayment seemed certain of just what needs to be done to reduce hospital costs, and the hospital panel prescribed the specific remedy for third party payments, and of course everybody had ideas on what to do about drug costs and physicians' charges—a circumstance that may prove only that there may be something to the proposition that Marshall McLuhan likes to repeat that we don't know who discovered water, but we're pretty sure it wasn't fish.

The hospital panel addressed itself initially to what it saw as the two significant dimensions of total hospital expenditure—the increase in the cost of a day of hospital care, and increased use measured in days. In the first instance, it was emphasized that cost-based reimbursement to hospitals is open-ended and has

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*Conference called by Secretary Gardner on June 27–28, 1964; Washington-Hilton Hotel, Washington, D.C.

been an effective invitation to increasing expenditures. The development of a satisfactory alternative method, it was pointed out, is enormously complicated by the fact that the end products of improved health and quality care have thus far largely defied rational measurement, but there was no substantial dissent from the view that alternatives must be sought and found that will furnish cost-saving incentives and stop rewarding, or ignoring, whatever inefficiencies may exist in the process. It is perhaps worth noting and remembering, however, that an administrator-panelist at one point in the discussion interjected the thought that there is indeed something worse than cost reimbursement, and that is below-cost reimbursement, a quaint practice that still persists on occasion in remote provinces like New York and Chicago.

Also, within the jurisdiction of the panel on hospital costs, there was general agreement that cost effectiveness can be improved—to whatever extent—by increasing productivity, or the ratio of output to input. Measures of output need to be related more closely to quality considerations and to appraisals of improvement in the patients' condition, and not just counted in numbers of patients and units of service, it was emphasized again; but even these comparatively simple-minded measurements are not always used as intelligently or as extensively as they could be to stimulate improved performance within institutions.

Economies can also be achieved on the input side through the more effective matching of skills and functions, it was suggested, and through the substitution of machine power for manpower. Traditionally, these processes have generally been initiated only by the forcing action of desperate manpower shortages at the higher levels of skill, but it has been proposed here that the tradition may be disregarded on occasion, to everyone's advantage.

In the hospital panel it was also suggested that one manpower resource that has remained largely untapped until now is the patients themselves, whose helplessness is often assumed, if not forced upon them, when in fact with some instruction and supervision many of them might safely and efficiently perform some routine procedures in their own care, with resulting economies of hospital manpower input.

There was general recognition that the hospitals system has done an unusual job in the face of rising demands which in many ways are controlled by forces outside the hospital itself, i.e., doctors, the prepayment system, and the community in general.

There was general and strong agreement that economies could be effected by providing a system of incentives and sanctions to the hospital system, as well as to the individual hospital operations.

It was recognized that in doing so hard choices would have to be made about allocation of limited resources and priority decisions among the many desirable objectives.

1. Incentives and sanctions to deal with:
   a. Institutions which provide efficient and measurably effective use of utilization review process.
   b. Institutions which show weekend utilization comparable with during the week utilization.
   c. Institutions which engage in shared activities with others—laboratories, laundries, computers, etc.
   d. Institutions which use drug formularies and generic drugs.
   e. Institutions which maintain high caliber cost records and demonstrate the use of effective cost control systems.
   f. Institutions which avail themselves of professional advisory and consultant services for more efficient use of hospital services.
   g. Institutions which use ancillary services like social services to plan for discharge and next steps for patients.
   h. Institutions which devise working departmental incentive programs which lower supply consumption and increase productivity.

2. a. * * *

b. Social security and HEW are urged to give recognition to the varied substantial economies in hospital days used in prepaid group practice plans. They have also demonstrated more efficient use of scarce manpower and ability to program comprehensive care. A recommendation was made that through legislation or regulation it be made possible for prepaid group practice plans to receive capitation payments for outpatient plus physician plus hospital plus extended care services. This would apply specifically to Title XVIII and Title XIX of the Social Security Act.

c. Incentives should be provided to hospitals which develop continuity of care, integrate obstetrical and pediatric units with other hospitals, integrate radiological and open heart surgeries, etc.

Sanctions would be provided to hospitals which provide duplicate and unneeded "prestige" services.

d. Incentives to be provided to hospitals which are prepared to provide comprehensive services to a defined group or a geographically determined group in the population.

3. There was recognition that among the incentives which could be included to both the hopital and the system were tax incentives, liberalized capital fund grants, structured reimbursement formulae. It was recognized that there were technical problems involved in this as well as value judgments. There was strong feeling that these technical problems should be reviewed by a small group of technically qualified people who should be able to develop experimental formulae.

4. a. * * *

b. There is need for strong encouragement of effective broadly representative areawide health planning agencies related to and supported by State franchising legislations. Many areas have no such services and in others they are in their infancy. Hospitals as well as the Federal Government are urged to support these councils programatically and with funds.

c. It was, however, emphasized that while areawide planning is an effective tool for economy and rationalization of services, it must be related to continuity of care and to standards which emphasize quality and provide ample room for innovation and experimentation. In some instances areawide planning has been used to freeze the status quo which should be antithetical to the basic purposes of such planning.

The panel on community health systems at the outset of its deliberations heard a detailed description of one such system which provides comprehensive health care services on a prepaid basis. Organized regionally, the system includes preventive, diagnostic, therapeutic and rehabilitative services as needed in the physicion's office, in the hospital, and in the home, delivered and paid for through three basic organizational units: the physician groups, the hospital system, and the prepayment plan. The essential element of the working arrangement of the system was described by the speaker as effective communication among the physicians, group, hospital and health plan managers and community leaders on day-to-day operating problems and long-range plans, and the results were listed as quality care, lower costs, and satisfaction of members.

Other speakers saw the community health system simply as a clearer identification of all existing community resources and the subsequent organization and utilization of them on a more effective basis. If a communtiy takes careful stock of the services provided by its health institutions, organizations, agencies, and personnel, it was suggested, it will very likely find that had there been more adequate standards and more stringent requirements, there would be fewer gaps in the total health care available to its people. The infusion of new federal funds would be welcome to ensure the optimum use of resources and thereby get the greatest mileage from the planning capacities of the community, but the panel appeared to agree that subject to broad, national performance specifications, planning decisions should be made on the local level, with emphasis on preservation of the innovative capabilities of the voluntary way.

Voluntary area-wide planning can be expected to bring progress in the reorganization of medical care, another speaker warned, but Great Leaps Forward are not to be anticipated. Systematic development must deal with the weight of tradition, custom, vested interests and the special type of momentum and vitality of established institutions. The real obstacles, this speaker declared, are lack of commitment to community-wide goals within elements of the system, lack of a tradition of trust and cooperation, lack of focus on systematic objectives, lack of mechanisms for orderly corporate planning, and lack of incentives for encouraging and assisting each element of the system to define an appropriate role for itself in relation to over-all goals and objectives. In overcoming these obstacles, it was suggested, the health planning agency will function most effectively if it does not seek to exercise direct controls but makes use instead of sanctions residing in other agencies. Why should a hospital or health agency which has *not* planned its future in terms of the comprehensive health needs of the community be entitled to accreditation, licensure, tax exemption, medicare funds, public welfare payments, a Blue Cross membership?

This morning's session took a more specific approach to the question of planning. In essence it did highlight the following factors. . . .

We do face a National emergency.

We do need a change in a number of areas, all of them relate themselves directly back to planning for community systems and the interrelations between problems of health and those of the total community.

There is general agreement that there are multiple causations and no single or simple solutions.

Some recommendations to meet the needs and effect some developments toward solutions were made. . . .

Mechanisms

Nation-wide support for Public Law 898–749 (Comprehensive Health Planning) and P.L. 89–239 (Regional Medical Programs) and encouragement for support in utilizing these two devices for developing mechanisms, separately and together, for planning.

The building into Titles 18 and 19 of the Social Security Act both incentives for planning and provisions for experimentation in reimbursement procedures by the Department of Health, Education, and Welfare.

Build into licensure and accreditation programs incentives and restraints which encourage participation in comprehensive planning by rewarding positive approaches and discourage the isolationist approach.

Encourage the development of the National Center for Health Services Research and Development.

Go forward with recommendation already made in the Gorham report for the implementation of group practice of all kinds.

Planning per se

The community planning process should be comprehensive and directly related to total community needs, of which health care is only one part.

We must continue to take advantage of our pluralistic approach, recognizing that no one way is best. However, there must be linkages among all planning activities.

There must be inclusion of the "right kind" of people in planning as well as the right kind of organizations, institutions, and agencies. In terms of people, there must be representatives of government at all levels, the voluntary sector, and particularly broad representation of all types of consumers—there should be a preponderance of non-health professionals.

There must be appropriate roles in planning at every level—Federal, State, regional and local.

The final responsibility for determination of the final plan and its implementation should rest at the local level.

A State planning agency must be strong. This strength can only be realized if there is a proper degree of responsibility and scope of authority, coupled with adequate and qualified staff.

All plans must have broad flexibility.

If the difficulty of measuring hospital productivity in relation to quality, or real health output, is formidable, the difficulty of measuring physician productivity is probably even more difficult—and yet the panel on physician costs considered that some improvements in productivity might be achieved by changes in the organization of medical practice and by development of some ancillary care specialists to render more of the services now rendered by physicians alone.

Chiefly, the opportunities for greater efficiency were seen by some panelists, and questioned by others, in the expansion of group practice, whose enlarged scale of operations could maximize the utilization of skills of physicians and other personnel and provide a base for diagnostic and other equipment without encouraging hospitalization.

Four types of group practices were described: those evolving from medical partnerships; those emerging at or near hospital facilities for purposes of convenience and efficiency; those created *de novo* by non-medical groups such as labor unions, employers and others, and those organized as medical school faculties have seen the necessity and opportunity to integrate group practice and medical teaching. A fifth type, described as a group practice "without walls", with physicians practicing in concert but not at a single location, was also mentioned as offering some organizational advantages.

The panel noted that the economic benefits, or putative benefits, of group practice have been visible to many observers for thirty years or more but the

growth of group practice over that time has been something less than spectacular—a phenomeon that was attributed in part to difficulties that have arisen on occasion in the relationship among physicians within groups, in part to misgivings about the physician-patient relationship in group practice, in part to the simple but important fact that many physicians unquestionably prefer to practice independently and believe they serve their patients more effectively that way, and in part to the fact that, given the limited supply of physicians and the abundant opportunities in private practice over these years, the possible economic benefit to society has not been a compelling inducement to the establishment or growth of group practice. In fact, it was noted, the rate of establishment of new groups reached its peak 15 or 20 years ago and has diminished since that time.

To stimulate the more rapid expansion of group practice, a number of the panel proposed revision of the Internal Revenue Code to permit private groups to offer retirement benefits to physicians and employees, and special tax consideration to aid the financing, building and equipping of group practice facilities. Education of the public, third parties and government in the efficiencies of group practice compared to in-hospital services was also seen as desirable.

The second broad avenue to greater medical productivity that was discussed by the panel was the development of new types of sub-medical personnel, described by one panelist as the civilian equivalent of the military medical corpsman. Some tasks commonly performed by physicians don't require the physician's prolonged and expensive education, it was suggested. These tasks can be identified, but the impact of any such substitution of lesser skills on medical licensure and malpractice responsibility would have to be carefully explored, one panelist warned, and the attitude of the consumer would certainly have to be considered.

One area of assistance that would not involve any such complications is the critical need for trained persons to handle the physician's mounting administrative load resulting from the multiplication of agencies supporting patient care. Business education for medical administrators should be expanded, it was proposed, so that physicians whose medical capabilities should be directed to patient care can be relieved of administrative responsibilities in medical school and hospital departments, group clinics, health agencies and research institutes.

1. There is a definite shortage of medical manpower which should be recognized.
2. This country cannot look forward to continuously depending on foreign physicians.
3. There is a need for bringing the poor into the medical education system.
4. There is a lack of health care which is not confined to the poor but is a growing problem with the middle class.
5. The present methods of funding lead to fragmentation (both governmental and non-governmental).
6. We need to consider the total set of systems that impinge on medical care in the United States. As the other systems are persuaded to take over elements that improve health care, you lower the cost of the health care system.
7. Doctors should always be the apex of health triangle. We should not be willing to wait for changes under duress. Doctors should be leaders. We should not wait for the crisis to be defined by others.
8. The number of physicians should be increased because (1) the need justifies the increase in the number of physicians and (2) as a matter of equity to the students since many qualified students are rejected from medical schools.
9. There is a need to have a definition of health and services.
10. There should be experimentation in education and the delivery of health care.
11. There is a need for support of students (medical and allied health).
12. Coordination of government and nongovernment services can improve the distribution of health care.
13. We need to study the ways in which the medical care system relates to all parts of the social system.
14. There is a need for more medical schools rather than larger ones.
15. If there are to be more monies they should be provided for improvement in the system through training, operational and administration research.
16. Highest priority should go to the training of people to get involved in the infra structure (the total systems structure).

The panel on the cost of drugs and pharmaceutical services agreed that these services should be delivered to the public at the lowest possible cost without

compromising quality, and that was about all the panel agreed on. The views expressed in the panel were varied, to state the proposition in the most conservative terms, as to whether costs can be reduced or held at current levels—and as to how these goals may be attained.

One of the speakers at the opening session of the panel suggested at the outset that the increased utilization of and expenditures for prescription drugs unquestionably resulted from increased availability of new pharmaceutical products. This is not to be condemned, he said, but it should be considered rather a positive factor and a credit to American medicine and pharmacy. The factors influencing the price of a prescribed medication, he continued, are the cost of the product to the pharmacist and the charge for the pharmacist's professional services; the selection of the prescribed medication is the sole choice of the prescribing physician. The speaker urged the adoption of the professional fee method of charging for pharmacists' services, which he described as essential to the expansion of prepayment programs for pharmaceutical services. He suggested a cooperative industry-wide research bureau to encourage continued product development and defended the patent system as an incentive for drug development.

In the ensuing discussion, a consumers' representative said the speaker's views presented only one side of a difficult, complex and controversial picture. There should be professional presentation on such questions as price differences within areas, he said, on price trends among generic and brand name products, and on differences in quality of generic and brand name products.

Pharmacists take issue with pricing differences for them compared to other drug purchasers, another panelist declared, suggesting that there should be more emphasis on the importance of direct pharmaceutical service to the patient and more recognition of the pharmacist's role.

The opening speaker today said more attention has been focused on drug costs than on any other segment of medical care costs, but there has been more heat than light. He described the argument that savings can be achieved through cheaper "generic equivalents" as spurious, saying the logical questions to be asked are: Equivalent to what? Equivalent on what basis? Compendia standards may serve as satisfactory minimum standards, but such laboratory tests do not necessarily detect the therapeutically deficient drugs. He said post-1962 drug regulations have increased drug development costs and reduced the number of new drugs introduced. Industry should seek more effective means of evaluating its promotional effectiveness and services, he said. More orderly pricing systems also would be desirable, but he saw no prospect of reducing manufacturing costs and added that any reduction in expenditures for drug research would be undesirable.

Much of the ensuing discussion concerned the questions of whether savings can be achieved by "generic buying" and whether there is assurance of therapeutic equivalency among various drug products. Survey results were cited by one panelist showing wide variations in drug costs among various municipalities and it was contended that demonstrable savings are achieved when drugs are purchased by generic name with competitive bidding.

Spokesmen for the drug industry emphasized that drug costs have remained constant in recent years while costs of other medical services were rising. This has been achieved through good management techniques and improvements in technology. Studies should be undertaken to determine therapeutic equivalency of drugs as the Gorham report on medical care prices recommended, one industry speaker said.

Another panelist cited a number of sources to the effect that neither official compendia nor Government agencies can offer the assurance now that drug products are clinically equivalent. He suggested that the studies are just now getting underway which will provide the capability of established clinical equivalency standards.

Two panelists commented that a useful dialogue had been begun in the panel discussion, and one of them added that the panel had at least identified many "definitional needs."

There appeared to be consensus that studies should be carried forward on the clinical equivalency of drugs as rapidly as possible. There also were expressions that a "credibility gap" now exists among various parties interested in drug quality and costs which hampers discussion of the issues involved. Some panelits cautioned that marginal economies should not be over-emphasized at

the expense of overlooking possible over-all improvements in medical and pharmaceutical services. The view also was expressed that while the formulary system may help reduce costs, it should not be so restrictive that an individual patient is penalized by paying more for a drug not included in the formulary.

In the panel on the cost and impact of third-party payment, the first speaker reviewed the advantages and disadvantages of the third-party system of payment in this country and suggested that there may be a strong case for the need for individuals to participate with their own funds under health insurance—that is, to pay part of the cost. This can be an effective means of checking and controlling the demand for health services, he said, adding that there may be much to be said for reimbursement of hospitals and physicians on a charge basis.

The present method of third party payment embodies serious misconceptions of the nature of medical care and its organization, another speaker insisted. He emphasized that you can't talk about cost of care without talking of the quality of care and defining care. The central issues of cost in health care are issues having to do with the nature of organization of medical practice.

We started out in health insurance with a "casualty insurance" approach, dealing with medical catastrophe, providing coverage of hospital care and surgical procedures, which tend to be well defined, "one shot" services. In this view, comprehensive care has to do with comforting and strengthening the patient, and the whole present system of third party payments is inconsistent with this type of care. Physicians can be much better remunerated for comprehensive care on a retainer or capitation basis than by separate fees for each service, it was proposed.

In the discussion, a panelist from industry thought the catastrophe element in surgical expense had been over-emphasized. The system grew up to meet health care expenses, and hospital and surgical costs were the most important ones, he pointed out. He liked the idea of a yearly fee or retainer which would be paid by the individual. We need control in prepayment, which is why we have fee schedules and have limited insurance in large part to hospital care and surgery—services that people generally don't like to have. One fault with our prepayment system is that it is organized around employment and leaves out those not regularly employed.

Unions don't like deductibles and co-insurance, it developed, and they have been mainly responsible for getting health insurance on a "first dollar" basis.

Several speakers made the point that it would not be possible or desirable to lower the total cost of or expenditures for health care, and that possibly we aren't spending enough. The job is to get better value for what we do spend, it was suggested.

The panel generally agreed on the desirability of alternative approaches and flexibility in prepayment programs. The methods of compensating doctors and hospitals might have to be radically altered if we want emphasis on continued, comprehensive, nonepisodic medical care, it was pointed out.

One speaker deplored the sale of insurance policies that don't give adequate coverage of hospital costs. This was explained by another panelist who said that some people didn't have the means to buy adequate coverage. Still another panelist proposed that government should help to provide good coverage for everybody.

A number of speakers expressed the need for more effective exercise of cost control responsibility by the prepayment insurance mechanism, and the need for controls on the insured consumer, including such controls as co-payment or co-insurance and deductible insurance. Others insisted that deductibles and co-pay features "put the patient back in the practice of medicine" and raise economic barriers to health care that will work hardships on many families.

Discussion was far-ranging. Among the points made for specific action were the following:

1. Half the states have legislation which prevent the development of group practice prepayment plans. The States should eliminate these restrictions.

2. Title 18 should be changed so that group practice plans could be paid on a combined basis for hospital and medical benefits. Under Title 19 the States should be encouraged to provide comprehensive benefits through group practice.

3. Either the legislation for Titles 18 or 19 should be changed or the administrative agencies should take action to permit more flexibility in carrying out these programs. Several panel members urged that the proposal in the Gorham report for development of a center for health services research and development should be implemented immediately.

4. The medical profession should be drawn into management and labor groups to consider problems at the local and national levels.

5. The Government should set minimum standards for what carriers do; there should be more Government regulation of carriers and more visibility of their actions to the public, perhaps through an SEC-type agency.

6. A proposal was made that the Federal Government should establish a coordinating advisory group or council with representation of all parties to help plan further action as a follow-up to the Conference and that the President should recommend to the governors of each State that they should establish similar groups.

7. One speaker said we accept the role of Government in providing health care for the aged but have given little attention to the role of Government in providing care to the whole population. He thought the present prepayment arrangements are completely inadequate to provide comprehensive health care for the whole population and we must think of a much wider role for the Government in providing such care.

8. There seemed to be a concensus on the urgent need for the encouragement of flexibility and experimentation. This requires action aimed toward this objective both by Government at all levels and private parties.

Now it is not strictly within the terms of my assignment to add any gratuitous observations to what has been reported from the panelists, but since there is ample precedent today—here and elsewhere—for the violation of boundaries, I am going to add an observation of my own anyway.

Unlike scientific medicine, organization of health service is a field that more than many others has been dedicated unflinchingly to the rediscovery of the wheel. Many of the concepts that have been discussed here such as incentives, and productivity, and group practice, and community health systems, and utilization controls—these and other organizational and procedural goals and methods have been lying around in plain view, some of them for 20 years or more, now and again being re-invented, and re-explained, and re-exclaimed-over as succeeding generations of physicians, administrators, economists, social scientists and journalists have entered or turned their attention to the health field.

As one who has observed and on occasion taken part in these periodic rites, I feel constrained to report two things that have seemed to me to distinguish this gathering: First, of course, it is taking place in a setting characterized by rising public expectations for health care and rising public demands for efficiency that are obviously not going to be put down by conversation, promises and timid experimentation, at a time when innovative legislation has provided at least some of the means for grasping the opportunities for improvement that have been examined here without being overwhelmed by the risks and difficulties that are unquestionably involved.

Second, this conference has concerned itself not just with restatements of problems and theoretical constructions of goals but notably with many recommendations for method, action and in some cases assignment of responsibility. That's what you came to do.

G—"The Basic Forces Influencing Costs of Medical Care"

A STATEMENT BY VICTOR R. FUCHS, PH. D., ASSOCIATE DIRECTOR OF RESEARCH, NATIONAL BUREAU OF ECONOMIC RESEARCH, AT NATIONAL CONFERENCE ON MEDICAL COSTS, JUNE 27–28, 1967, WASHINGTON HILTON HOTEL, WASHINGTON, D.C.

It is both gratifying and challenging to be invited to address such a distinguished assembly of health experts. Until quite recently, an economist was rarely to be found in the company of the nation's leading physicians, and on those few occasions, he was likely to be flat on his back with one or more of his vital organs exposed to public view.

It is my intention this morning to provide exposure of a different sort. The assigned question—"The Basic Forces Influencing Costs of Medical Care"—is one which almost every man and woman in this room would be prepared to tackle. My aim is to indicate how an economist goes about answering it. This is not just another way of saying that I will give you my opinions—I will do that also—but it is an attempt to take explicit note that economics is, above all else, a way of looking at questions. In Lord Keynes' words, "The Theory of Economics does not furnish a body of settled conclusions immediately applicable to policy.

It is a method rather than a doctrine, an apparatus of the mind, a technique of thinking, which helps its possessor to draw correct conclusions."

To be sure, even among economists there is not always just one way of looking at things. Winston Churchill used to complain that whenever he asked Britain's three leading economists a question, he received four different answers—two from John Maynard Keynes. Nevertheless, there is a common fund of concepts, a common core of analysis, that nearly all economists use. When, in the course of applying these concepts, my own value judgments or empirical estimates appear, they will be appropriately labeled.

The basic analytical approach is a consideration of those factors affecting the demand for medical care, and those affecting the supply. Demand and supply, the two magic words. Some of us, when visiting hospitals, have discovered that by putting on a white coat and talking rudely to nurses, it is easy to pass as a physician. To be mistaken for an economist is often even simpler. All one needs to do is nod gravely and say "demand and supply."

Definition of terms

Demand for and supply of what? I shall assume that medical care refers to the services rendered by physicians, dentists, and other health professionals, plus all the goods and services consumed in connection with their work, or upon their direction. Thus, the costs of medical care include the costs of hospitals, drugs, and the like. This lumping of diverse health services is a concession to convention and to the limitation of time. Ideally one should apply the demand-supply analysis separately to hospitals, dentists, drugs, and so on because the forces that influence the cost of one type of health service are often different from those that influence another.

What is meant by costs? At least three possible meanings can be distinguished. It could mean price, or cost of production, or expenditures. When people speak of the rising costs of medical care, they frequently are referring to rising expenditures, and this is the way I shall use the term this morning.

Expenditure trends

We all know that these expenditures have been growing rapidly. In round numbers, expenditures for medical care have risen from under $4 billion in 1929 to over $40 billion in 1965 and probably close to $50 billion in 1967. Even as recently as twenty years ago, expenditures were only $10 billion. Of course, expenditures for most other goods and services have also risen; it is therefore more meaningful for some purposes to look at the share of total spending allocated to medical care. This too has risen, from under 4 per cent in 1929 to about 6 per cent in recent years. Nearly all of this relative increase has occurred since 1947.

Before examining the factors responsible for this trend, it is worth noting that there is nothing wrong *a priori* with changes in industry and sector shares of gross national product. Indeed, such changes seem to be a natural concomitant of economic growth. For instance, the relative importance of agriculture has declined precipitously in most western countries. During the last half of the nineteenth, and the first half of the twentieth century, there was a significant rise in the relative importance of manufacturing. Now we are witnessing in this country the growth of what I have described elsewhere as the "first service economy."[1] If agriculture's share of GNP falls from over 9 per cent to under 4 per cent, as it did in the United States between 1947 and 1965, some other industries must show increases. There is no magic in the 4 per cent figure for medical care; it is now 6 and it could be 8 or 10.

Reasons for concern about costs

Why then should there be a national conference on the costs of medical care? Let me suggest three reasons for concern.

First, questions arise in my mind concerning the contribution that these increased expenditures make to health. Although we spend much more per person for medical care than any other country, the blunt truth is that we do not enjoy the highest health levels. On the contrary, many European countries have age-specific death rates considerably below our own. The relatively high infant mortality rate in this country is disturbing, and difficult to explain. The disparity in death rates for middle-aged males is even more shocking, and has more serious economic implications. In the U.S. of every 100 males who reach the age of

[1] Victor R. Fuchs, *The Growing Importance of the Service Industries,* Occasional Paper 96, National Bureau of Economic Research, Columbia University Press, New York, 1965.

45, only 90 will reach 55. In Sweden the comparable figure is 95. During this critical decade when most men are at the peak of their earning power, the U.S. death rate is double the Swedish rate, and higher than that of almost every western nation. It certainly seems legitimate to ask why. This is not necessarily with a view to spending less for medical care—I doubt if anyone can foresee a decline—but with a view to developing more effective use of the resources that we are now devoting to health.

A second reason why we should be concerned about medical care costs is the peculiar structure of the medical care industry. Most industries in the United States consist of profit-seeking firms actively engaged in competition with one another. The fundamental rationale of the American economic system is that the ope of profit (and the fear of loss) under conditions of open competition are the best guarantees of efficiency, an appropriate price and rate of output, and a fair return to the various factors of production.

The medical care industry is organized along radically different lines. Nonprofit operations are the rule in the hospital field; there are severe restrictions on entry and competition in medical practice, and advertising and patent control dominate the market for drugs. Thus, there is no *a priori* basis for believing that the prices and quantities of medical care approach those that would be socially optimal.

A third reason, it seems to me, is that a large and increasing portion of the cost of medical care is paid by third parties. In particular, the taxpayer is being called upon to pick up a substantial share of the bill. Because payment for medical care is increasingly regarded as a collective responsibility, it is natural and appropriate that there should be collective expressions of concern, such as this conference reflects, about the quantity and quality of medical care, and about its price.

These quantities and prices are determined by demand and supply. Let us consider each side of the equation in turn.

DEMAND FOR MEDICAL CARE

Economists say that the demand for any good or service depends upon relative prices, income, and tastes.

Price

How does price affect expenditures? Perhaps the most firmly established proposition about the demand for medical care is that it is relatively inelastic with respect to price. If the price rises relative to other prices, the decline in the quantity demanded will be proportionately less than the increase in price. The result is an increase in medical care expenditures. If, other things remaining unchanged, price rises by 10 percent and quantity demanded falls by only 5 per cent, expenditures will rise by approximately 5 per cent. Some studies suggest that the price elasticity of demand for medical care may be as low as .2, i.e., quantity demanded declines by only 2 per cent when price rises by 10 per cent. But present knowledge does not permit fixing a specific value other than to say that the elasticity is surely below unity.

An aspect of the price of medical care that is not widely recognized, is that it really has two components. One is the nominal price charged by the physician or hospital; the other is the value of the patient's time.[2] For instance, the nominal price of a visit to a physician might be ten dollars, but the trip to and from his office, the wait, and the actual examination will probably take an hour or more. This time might be worth more or less than ten dollars depending upon the alternatives available to the patient.

Once it is understood that the price of medical care includes both components, a number of interesting implications become apparent. Even when a sliding fee scale is not used, the total price of medical care tends to vary with earning power. The price is lower for retired people and the unemployed than for those with jobs, is generally lower for women than for men, and so on. Also, even when the nominal price is reduced to zero, as under prepayment plans or socialized medicine, the true price is not zero.

Income

One of the factors to be considered in any demand study is real per capita income. During the past twenty years this has risen by over 50 percent, and

[2] Gary S. Becker, "A Theory of the Allocation of Time," *Economic Journal*, 75, No. 299 (September, 1965), pp. 493–517.

there is no doubt that the demand for medical care increases with income. What is less clear is whether the demand for medical care is elastic or inelastic with respect to income, i.e., does a given percentage increase in income lead to more than, or less than, the same percentage increase in medical care expenditures, other things remaining the same. The question is only gradually yielding to attack as more and better data become available and analytical techniques are sharpened. Some recent studies suggest that the elasticity may be significantly below unity, and few investigators believe that it is greater than unity. At most, the demand for medical care seems to increase approximately in proportion to income. If this is true, we cannot attribute any of the increase in the *share* of total expenditures accounted for by medical care to rising income.

Insurance

A special factor that complicates the analysis of the demand for medical care is the growth of insurance and prepayment plans. Once a person is covered by such a plan, the effective price to him of additional units of medical care depends only upon the value of his time. It seems to me that this may explain a large part of the increase in the quantity of medical care demanded, and may also help explain the apparent insensitivity of insured consumers to increases in the nominal price of medical care. It is worth noting that hospital care has shown the most rapid rate of increase in expenditures, and it is hospital care that has been most thoroughly covered by insurance and prepayment.

The curious behavior of dental expenditures also offers support for this hypothesis. All the available evidence suggests that at any point in the time the demand for dental care is more elastic with respect to income than is the demand for physicians' services. Nevertheless, during these recent decades of sharply rising real income, expenditures for dental care have increased less than have expenditures for physicians' services. One possible explanation is the very small role played by insurance and prepayment plans in the dental field. Expenditures for eye glasses and appliances, and for drugs, two other components of medical care that are typically paid for directly by the consumer, have also risen much less rapidly than have expenditures for hospitals or physicians.

This should not come as a surprise. The advocates of insurance and prepayment had something like that in mind. They wanted to remove any financial barriers to obtaining medical care. But it is a basic law of economics that if you lower the price, the quantity demanded will increase. A critic of the British National Health Service put the matter cogently, albeit a bit strongly, in a recent issue of *The Lancet*. He wrote, "if taxi fares and meters were abolished, and a free National Taxi Service were financed by taxation, who would go by car, or bus, or walk . . . the shortage of taxis would be endemic, rationing by rushing would go to the physically strong, and be more arbitrary than price, and 'the taxi crisis' a subject of periodic public agitation and political debate." [3]

I am not suggesting that insurance and prepayment should be abandoned. But we do need to discover techniques, possibly such as coinsurance, deductibles, or experience rating, to check prices and expenditures without interfering with essential health services.

Tastes

All factors other than income or price that affect demand are put by economists in a catch-all category called taste. In the case of medical care, these would be the factors that affect the health levels of the population, and those that affect attitudes toward seeking medical care at any given level of health. Taste for medical care, therefore, would be related to: (1) demographic variables, (2) education, (3) envirnoment, (4) ways of living, and (5) the genetic stock of the population.

Research on these matters is only in its infancy, and there are few reliable findings to report. We know that an increase in the proportion of elderly people in the population tends to increase the demand for medical care, other things remaining the same. The effect of increased education is unclear. It probably leads to improved health levels, and thus less need for medical care, but may also lead to a greater demand for medical care at any given level of health.

Most observers believe that recent environmental changes, particularly the increase in real income per capita, have contributed to better health status. I think that this inference is incorrect. Some tentative findings from my research

[3] Arthur Seldon, "National or Personal Health Service," *The Lancet*, March 25, 1967, No. 7491, Volume 1, page 675.

suggest that the environmental and life-style changes of the past two decades have had either a neutral or negative impact on health for most of the population. One piece of evidence in support of this hypothesis is the stability of age-adjusted death rates in the United States in the face of large increases in medical care and improvements in medical science.

All these questions, however, are in need of more study. The National Center for Health Statistics is now developing vast new bodies of relevant data. I believe that a combined assault on these data by health experts and social scientists will yield information comparable in importance to that emerging from the laboratory in our continuing efforts to understand and improve the nation's health.

Accounting illusion

In concluding this discussion of demand, it should be noted that part of the observed increase in medical care costs is an accounting illusion. It does not involve any increase in real costs—only money costs. It is the result of an increase in the proportion of medical care produced and sold in the market, and a decline in the proportion provided outside the market by family, friends, and neighbors. Only the former is included in the GNP. A generation ago, a considerable amount of bed care, and associated services for the sick, were provided for at home. Surely there is relatively less of this today.

Some of the reasons for this shift other than increases in income and insurance coverage are: (1) urbanization, (2) the fragmentation of the family, and (3) the increased labor force participation of women. We do not know how much of the increase in observed medical care costs can be attributed to this shift; I believe that the amount involved is substantial. One corollary is that "home care" programs and other current plans to transfer costs back out of the hospital will reduce the money costs of medical care by more than they will reduce real costs.

SUPPLY OF MEDICAL CARE

I turn now to the supply of medical care. In studying the supply side of an industry there are three main elements to be looked at. The first is the supply of the factors of production—labor and capital—flowing into the industry. The second is changes in productivity, and the third is the degree of monopoly control, or other market imperfections that may influence the supply actually available to consumers.

Supply of productive factors

With respect to the supply of labor *to* the health industry, the crucial question is whether the industry has to pay inordinately high wages in order to attract an increasing fraction of the total labor force. In my judgment, the answer to this is "no." In technical terms, the supply of labor to the medical care industry is very elastic. This is true, incidentally, of most other industries as well. Except in the extreme short-run, the U.S. labor force is highly mobile and adaptable; studies of interindustry differences in earnings consistently refute the hypothesis that expanding industries must pay unusually high wages to bid away labor from other industries.

Between 1950 and 1960 medical care employment rose by 54 percent—compared with only 14 percent for total employment. Throughout the postwar period the annual rate of increase has been about 5 percent for medical care employment compared with a little over 1 percent for the economy as a whole. Despite this rapid expansion, wages for medical care personnel seem to have been rising at about the same rate as in many other industries. This last point has not been thoroughly documented, but is the most reasonable inference from the data available.

An analysis of the supply of capital to the medical care industry is much more difficult to undertake because most capital is used in hospitals, and most hospitals are nonprofit. Thus, the flow of capital is not determined by the rate of profit (as it is in most industries), but my government decisions and philanthropy. It is possible, however, to devise methods of financing and reimbursing hospitals that would make the flow of new investment more responsive to market-type mechanisms. The Soviet Union and other socialist nations have been attempting to do precisely this with substantial portions of their "nonprofit" economies.

Productivity

Changes in the supply of any good or service, in the sense of changes in the price-quantity relationships, depend primarily on changes in productivity. It is a commonplace to argue that productivity in medical care has advanced less rapidly than in the economy as a whole; but in the absence of reliable measures of the output of medical care this must remain a matter of speculation.

The development of such measures is an extremely difficult task because of our ignorance concerning the precise contribution of medical care to health. In addition, output is not limited to improvements in health but takes other forms including validation services and the hotel aspects of hospital care.[4]

There is some reason to believe that the available measures understate the true output of the medical care industry. A visit to a physician today is surely more productive than one twenty years ago, and this is even more true of a patient-day in a hospital. On the other hand, it is possible that many of the expensive procedures that are now part of "best practice" techniques are really not worth the money in the sense that their marginal contribution is small and the same amount of resources used in other ways would yield more utility to the consumer.

The common practice of reimbursing hospitals on the basis of their costs, as under Medicare and many other public and private programs, appears to be an open invitation to inefficiency. At best, the ability of hospital management to improve productivity is imperfect because of the independence of the attending staff. Under present arrangements, almost no one has any incentive to be concerned with the efficiency of the hospital as a whole.

Another weakness in the hospital supply picture is that, with few exceptions, each hospital is independently "owned" and managed. Unlike other industries where an exceptionally able manager gradually comes to exercise supervision over an increasingly large pool of resources through the growth of his firm, through mergers, and through establishment of branch plants, this pattern is absent in the hospital field. Also, it is much easier for inefficient management to remain in charge for long periods of time.

Physicians

The physician plays a key role in the supply of all medical care; his decisions and behavior affect almost everything else. Physician supply is now more specialized than formerly. This growth of specialization is often attributed to exogenously determined advances in medical science, but such an explanation ignores the role played by changes in demand. Two hundred years ago, Adam Smith observed that the division of labor is limited by the extent of the market. The relevant market for any one physician's services has grown tremendously because of the growth of income and population, the increased concentration in urban centers, and improvements in transportation. All these trends would lead to increased specialization, even if medical technology remained static. Moreover, given an increase in real income people want to buy more medical service for any given health condition. One way of buying more service would be to visit several different general practitioners, or to visit the same one several times. Alternatively, one can buy more medical service in each visit through the use of specialists. The specialist in medicine usually has more, not merely different, training than a general practitioner. The more valuable the patient's time, the greater will be the demand for "high powered" doctors. This demand-induced growth of specialization is thus a cause as well as a result of advances in medical science. Without a specialized practice, without the demand for specialized equipment and procedures, these advances would probably come more slowly.

Physicians have frequently been criticized because of their high earnings and their alleged desire to restrict their numbers. Such criticism, it seems to me, does not go to the heart of the matter. Most of the difference between the earnings of physicians and those of other occupations should not be attributed to their control over entry and competition, but to the long hours that they work, the lengthy period of education required, and the absence of pensions, paid vacations, and other fringe benefits. Moreover, physicians' earnings account for less than 20 percent of total health expenditures, and to the extent that they enjoy some monopoly return it could only be a small part of this fraction.

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[4] Victor R. Fuchs, "The Contribution of Health Services to the American Economy," Milbank Memorial Fund Quarterly, Volume 44, No. 4, Part 2, October, 1966, pp. 65–102.

A more valid criticism, it seems to me, can be directed against physicians for their opposition to changes in the methods of producing and financing medical care. The medical profession, or at least a significant and articulate portion of it, seems to believe that there can be rapid and far reaching technological change without disturbing the traditional organization of medical practice. This belief is irrational. One clear lesson from economic history is that technological innovation means organizational change.

Possibly the most harmful aspect of physicians' market control is the extremely narrow range of options available for someone seeking personal medical care. One bit of evidence is the size distribution of earnings in the entire medical care industry which can only be described as unnatural. Nearly all American industries have a distribution which reflects a fairly smooth vertical hierarchy of personnel. There are usually large numbers performing routine functions, and relatively fewer persons at each successive stage of increased power and responsibility. For instance, the *1960 Census of Population* shows that in nearly every industry the number of persons with earnings from $7,000 to $10,000 in 1959 far exceeded the number with earnings above $10,000. Only in the medical care industry, do we find almost a void in the $7,000 to $10,000 category; those above $10,000 are three times as numerous. Today the void is in the $10,000 to $15,000 range.

Whether consumers would use less expensive medical care personnel, if they were available, would depend upon a number of factors—the institutional setting and supervision, whether there is a financial incentive to do so, and so on. That it is technically possible for professionals with fewer than ten to twelve years of training beyond high school to render useful medical care has been repeatedly demonstrated in a variety of settings.

As some of my earlier remarks suggested, patients with high incomes, and patients with acute conditions would undoubtedly continue to seek the highest possible level of training and experience. But the demand for something less might be large in cases of chronic illness, or in isolated communities, or among those with low incomes. To say that everyone should get "highest quality care" is a counsel of perfection that presently deprives many people of the opportunity of getting even moderately good care. The natural conservatism of doctors, allied with the strong egalitarian drives of some social reformers, has served to limit the supply of medical care below that which would be available in a freer market setting.

New medical techniques

One special feature of the supply of medical care is the appearance of radically new medical techniques and procedures. Normally, when economists speak of the supply of a commodity they assume that the quality of the commodity remains unchanged. This is almost never strictly true, even for such staples as coal or wheat, but frequently the change in quality comes gradually, can be objectively measured, and an increase in quality can be thought of as a decrease in price.

In the case of medical care, some of the new procedures such as renal dialysis and open heart surgery are so radically different from anything previously available that they cannot conveniently be analyzed in this manner. Part of the increased expenditure for medical care is undoubtedly attributable to the appearance of these new techniques for treating conditions that simply could not be treated before.

CONCLUSION

Summary of the demand-supply analysis

What conclusions emerge from this analysis of demand and supply? By now it should be clear that cost is the result of many forces, that rising costs are not necessarily bad (or necessarily good), and that economists have some interesting questions to ask, but are far from being able to supply all the answers. Many of the estimates have a large range of uncertainty, but sustained scientific investigation can reduce that range and increase understanding.

If we take as our analytical task the explanation of why medical care now accounts for 6 per cent of gross product instead of 4 per cent, as it formerly did, the following developments all seem to have played a role:

1. An increase in medical care prices relative to other prices facing a relatively inelastic demand. These price increases are probably related to the institutional rigidities that surround the organization and production of medical care.

2. The growth of insurance, prepayment, and other forms of third party payment.

3. An increase in the proportion of elderly people in the population.

4. A shift from nonmarket to market production. If we measured all costs, the increase for medical care would not be as great as the GNP accounts indicate.

5. The introduction of radically new medical techniques and procedures to treat conditions that formerly could not be treated at all.

6. More tentatively, I have suggested that there may be greater need for medical care now to offset changes in the environment and in ways of living that are detrimental to health.

Two possible explanations that I believe the available evidence rejects are the rise in real per capita income, and the alleged rapid rise in wages for medical care personnel.

Suggestions for discussion

Before concluding, I would like to offer a few suggestions—suggestions that you may wish to consider in your panel discussions today and tomorrow. They deal with matters that affect the costs of medical care, but involve judgments about objectives and methods in fields where I can only claim to be an interested bystander. Perhaps they can be justified on the grounds that health, like war, is too important to be left to the "generals."

1. I begin with medical education. This priority is deliberate. Given the key role that physicians play in personal health care, in determining expenditures for hospitals and drugs, and in directing the work of other medical care personnel, it seems unlikely that significant changes can occur in medical care without changes in medical education. At the risk of some exaggeration, I would argue that the biggest shortcoming of medical schools is indicated by their *name*. If they were to transform themselves into *schools of health*—with all that such a transformation implies for attitudes, objectives, personnel, and curriculum, many of the other goals that will be discussed at this Conference would be much closer to attainment.

A "school of health" would have the twin objectives of training personnel and advancing knowledge to meet the health needs of the community. It would define these needs broadly, would be concerned with the future as well as the present, and would want to meet health needs at various levels. There would be several different "educational tracks" with some possibility of moving from one to another, and there would be a strong interest in continuing education. The aim would be to provide a continuum of trained personnel to deal with a continuum of health problems. Some students would be ready for professional careers with less preparation than is currently required. Others might receive even more training than physicians now do. Members of the last group would truly be "captains" of health teams—not only in name, but in spirit and in practice.

A physician emerging from such a school would take a broad view of his duties and responsibilities.It is not likely that a man so trained and so motivated would *want* to be a solo practitioner. Similarly it is unlikely that he would *want* to be paid on a "piecework" basis. He would expect, and would deserve, a good salary, but he would also want time to read and study, time to think and plan, and time to maintain his own physical and mental health. Far from regarding auxiliary medical personnel and new technologies as threats to his status or financial position, he would welcome developments that would permit the delivery of more medical care at lower cost per unit. Finally, his yardstick of success would not be the number of cases in which he personally was able to alter the course of events, but improvement in the health levels of the population that he and his colleagues serve.

2. My second suggestion concerns hospitals and has two parts. First, I would like to see widespread adoption of reimbursement plans that provide incentives for efficient operation. Such plans could establish target rates for each hospital, or establish fixed rates for groups of hospitals providing comparable service. These reimbursement rates would probably be related in some way to average costs. Inefficient hospitals, therefore, would be under strong pressure to bring their costs down, while efficient hospitals would find themselves with extra funds which they could spend for improving the range and quality of services offered. Such a system might well enlist the support of attending physicians. If the medical staff realized that by holding down costs the hospital would be able to buy

new equipment, or make other improvements, the hospital administrator would be in a much better position to obtain their cooperation. Reimbursement along these lines would facilitate another useful change—the development of hospital systems that include many separate and diverse types of establishments under common management. This would permit more able managers to exercise control over a larger range of resources and would also permit more efficient utilization of these resources within the system.

3. My third suggestion is to arrange for a minimum guarantee of medical care to every citizen through some sort of insurance or prepayment plan or plans. Most people can afford such plans; the minority that cannot should be subsidized by the government. Presumably this minimum guarantee exists now, because we are often told no person need go without necessary medical care. This may be true, but there is little merit in having this guarantee rest on the judgment and benevolence of physicians or hospital administrators. It should be a common charge against the total society. We have been moving in this direction, but on a hit or miss basis. We are now trying to care for the aged, for some of the poor, and compulsory insurance has been proposed for all wage and salary workers. This piecemeal approach is likely to be highly inefficient and inequitable. It is time this nation faced, in an adult way, its responsibility to assure some minimum level of medical care to all persons as a matter of right.

4. Having said this, I would also urge that we declared a moratorium on misleading talk about complete equality of medical care. This is technically not a realistic possibility, and in my view it is not a desirable objective as long as there is substantial inequality in the distribution of other goods and services. It would be most extraordinary if poor people, given an income subsidy, were to choose to bring themselves up to some common high level of medical care rather than to increase their consumption of a variety of goods and services. To arbitrarily impose this equality at the taxpayer's expense is to redistribute income in an extremely inefficient way. Moreover, insistence on equality may very well impede the development of the quantity and quality of medical care.

We can take a lesson from the field of higher education. In recent years there has been a tremendous increase in the demand for higher education, far greater than the increase in the demand for medical care. What has been the response of the higher education industry? On the whole, it has shown more adaptability and flexibility than has the medical care industry. There has been some crowding of existing institutions. There has been better use of facilities and personnel through trimester and quarter plans, and more intensive use of summer sessions. Some schools have expanded capacity. Perhaps most important of all, new institutions of considerable variety and scope have been created. In particular, one should note the growth of junior colleges.

One reason why higher education was able to respond so quickly is that the industry is not fooling itself with slogans about "equality" and "high quality for all." No one in education pretends that Smalltown Junior College offers as good an education as does Harvard. There is an attempt to assure that everyone who wants higher education can get it in some form, and to some degree, and this guarantee is probably more reliable than the one currently offered for medical care.

5. My final suggestion—almost plea—is for us to remember that what we are really concerned with is health—not costs as such, and not medical care as such. My reading of the health literature leaves me with the impression that the greatest potential for improving the health of the American people is not to be found in increasing the number of physicians, or in forcing them into groups, or even in increasing hospital productivity, but is to be found in what people do and don't do, to and for themsleves. With so much attention given to medical care, and so little to health education and individual responsibility for personal health, we run the danger of pandering to the understandable urge to buy a quick solution to a difficult problem. "Eat, drink, and be merry" runs the refrain. "Smoke two packs a day." "Engage in every physical and emotional excess known to man, for tomorrow you can come to Dr. Squash and have it all taken care of in two easy visits." (Some would add "at government expense.") Do we really believe that if only there are enough Dr. Squashes, or if only they practice in groups, everything will turn out all right? Let me express some doubts. I am impressed with Douglas Colman's recent observation, "Positive health is not something that one human can hand to or require of another. Positive health can be achieved only through intelligent effort on the part of each individual. Absent

that effort, health professionals can only insulate the individual from the more catastrophic results of his ignorance, self-indulgence, or lack of motivation." [5]

By all means let us discuss medical care. By all means let us discuss the costs of medical care. But above all, let us discuss them in relation to the more fundamental objective—better health.

H—"Organization for the Delivery of Care"

A STATEMENT BY ROBERT M. SIGMOND, EXECUTIVE DIRECTOR, HOSPITAL PLANNING ASSOCIATION OF ALLEGHENY COUNTY, PITTSBURGH, PENNSYLVANIA, AT NATIONAL CONFERENCE ON MEDICAL COSTS, JUNE 27–28, 1967, WASHINGTON HILTON HOTEL, WASHINGTON, D.C.

During the past year, I have been conducting an informal, unscientfic, unstructured, confidential survey. I have presented dozens and dozens of practicing physicians with the following hypothetical suppositions and questions:

Suppose this country faced a major national emergency like a long world war that required your region to contribute as many physicians, nurses, and other health workers as possible. Suppose further that you were placed in charge of the health services in your region and were assured of the complete trust and cooperation of everyone. Would you be able to contribute any of the region's physicians, nurses and other health workers for national emergency service, without impairing the quality of the health service provided in your region?

Every single individual whom I questioned believed that if he could achieve complete cooperation and commitment, health manpower in his region could be substantially reduced without impairing quality of care and without adverse effect on the people's health. The unanimity of response was striking.

Even more striking were these physicians' responses with respect to the amount of reduction in health manpower that could be achieved without reducing the quality or effectiveness of service. When asked to estimate the proportion of the region's health manpower that could be released for national emergency service, the answers varied from about ten per cent to forty per cent, with an average of about 20 per cent.

Equally as striking was the conviction of most of these doctors that the greatest proportion of health manpower could be spared among the most highly trained health personnel—physicians and nurses, for example, as contrasted with aides, orderlies and kitchen workers.

How would manpower reductions be achieved? As you might expect, there was a variety of responses, but there was a surprising consistency of basic themes:

(1) grouping physicians (and other practitioners) in organized settings and centralized locations so that they can make full use of lesser skilled but specially trained workers in their "office practices" and thus provide more service per physician,

(2) locating more physicians' offices at hospitals and removing the distinction between "office" and "clinic" to reduce physician travel time and to permit full use of the hospitals' manpower and technical resources without having to admit patients as bed patients,

(3) redefining many health service tasks so that lesser trained personnel can take them on, such as passing more professional nursing duties on to well-supervised practical nurses and aides, and increasing the use of dental assistants,

(4) permitting nurses to make house calls in medically supervised home health programs,

(5) creating closer linkages among related hospitals to permit grouping of maternity, open heart surgery, and other specialized low use services at fewer larger hospitals,

(6) encouraging all families to develop more efficient medical care habits by identifying with one nearby physician group for provision and supervision of all needed health services.

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[5] J. Douglas Colman, "National Health Goals and Objectives," speech presented at the National Health Forum, Chicago, Illinois, March 20, 1967.

Other ideas were mentioned less frequently: automation and computerization, self-help units in hospitals, intensified health education, multiphasic screening, etc. No one in the group suggested any lengthening of the work week.

Almost all of the physicians with whom I spoke focussed on the hospital as the key to manpower conservation. Almost all suggested grouping physicians at hospitals, and almost all pointed to the need to develop an interrelated network of smaller and larger hospitals. These physicians knew little or nothing about systems analysis, but all tended to think in terms of improved delivery systems as the key to manpower reduction.

How would my group of doctors go about organizing to bring about these changes so as to contribute health manpower to the national emergency? Almost all thought that they would work through the hospitals and their medical staffs or through the county medical societies. Some thought that they would start by drawing up detailed systems and manning tables for each hospital or county medical society to follow. Most, upon reflection, concluded that there were plenty of physicians and administrators in each community who would have as many ideas on how to conserve manpower as they had, and that detailed prefabricated plans were not necessary. All that would be required would be to assign specific responsibility in each community, and to encourage the leadership in each community to attack the problem in realistic ways.

Interestingly enough, many of the doctors whom I asked felt that the process of reorganizing to reduce manpower could produce improved quality with fewer health personnel. All agreed that since manpower is the largest part of health care costs, a 20 per cent reduction in manpower would result in reduction in the total health care bill.

In my informal, unscientific survey, I sometimes posed some final suppositions and asked one last question: Suppose the great national emergency was not a long world war, but the spiralling cost of medical and hospital services and the many unmet health needs right in your own region, the deaths and suffering that could be avoided by expanded and improved health service. Suppose further that the health workers that you could release for a great national emergency could be assigned right in your own region to work on reducing death and disability. *Could you deliver?* I wish that I didn't have to report that most of my group doubted that it would be possible, under current circumstances, to achieve the degree of commitment and cooperation that would produce results. At least, as a number said, "not in my lifetime".

I submit to you that any number of more highly scientific surveys of this type would document substantial consensus in the health field on two points. First, despite all the fatalism about inevitable costs increases, it is commonly accepted that costs could be reduced markedly without impairing quality. Second, the key to cost reductions is introduction of more systematic approaches to delivering comprehensive health services by grouping physicians and other practitioners in conjunction with hospitals and ancillary health personnel.

The time has come to convert consensus into operating programs that will bring results. What are the obstacles to achieving a more systematic approach? The lack of agreement as to which is the best way to organize the system shouldn't be a major obstacle because there is a wide variety of valid configurations, each of which could represent more systematic delivery of services and lower costs with better quality. The real obstacles, I submit to you, are the lack of commitment to community-wide goals within the elements of the system, the lack of a tradition of trust and cooperation, the lack of focus on systematic objectives, the lack of mechanisms for orderly corporate planning, and the lack of incentives for encouraging and assisting each element of the system to define an appropriate role for itself in relation to over-all goals and objectives.

In our extremely complex and pluralistic health care establishment, improved delivery systems will result from a refocussing of goals, programs, and interrelationships by every health agency, all up and down the line. What is needed is vastly improved planning by every health agency, in the framework of comprehensive health services for people.

The basic weaknesses, which can and must be overcome, are in the planning processes of health agencies. If the planning processes—the ways that health agencies define goals and objectives and devise programs to achieve their objectives—are strengthened, the delivery system will be strengthened. The problem isn't that the main health institutions are performing badly; the problem is that the medical care programs in a community are so rarely worked out in the

context of the defined needs of a defined community. The basic fault is in the planning process at each institution which programs health services. The solution is to improve the planning processes of all health units. I suggest that an orderly investment in strengthened planning processes in time could achieve the same impact on community health care costs as a great national emergency.

The Allegheny County approach

A demonstration of improving a community's system of delivery of health care by improving each health agency's planning process has been underway for the past seven years in Allegheny County, Pennsylvania, encompassing the greater Pittsburgh area. The results so far are not dramatic, but a great deal has been learned. The "process approach" is becoming increasingly understood and accepted, and there are indications that a foundation has been laid for more rapid progress in the future.

Ten years ago, Allegheny County's health services looked pretty good. Each health care unit was striving for best care for its patients, for self-sufficiency, for fiscal solvency, for expanded service volume, for modern facilities, for its share of the County's limited health personnel and dollars. Each was quite sure that what was good for the institution was automatically good for the community. This approach had produced rapid growth and fine results for many past decades when health services were so inadequate and so uncomplicated that problems of duplication and lack of coordination were unheard of. By the late fifties, however, some community and professional leaders were beginning to question whether this approach made sense in the rapidly evolving, highly developed, complex health care field.

The hospitals—the major health care agencies—were the first to recognize the problem. They began to perceive how poorly their individual planning efforts related to changing community needs and resources. They began to recognize that their individual uncoordinated planning efforts added up to less than the best health service, to pointless duplication and needless gaps, to waste of money and personnel, and to the very real risk of losing community confidence.

Let's take a closer look at today's hospitals. They are no longer simply edifices wherein sick patients lie in bed. They are no longer simply institutions that give doctors the tools to diagnose and treat certain kinds of illnesses. They are no longer simply the organizational entities that bring intra-professional discipline and education to doctors. They are all of these things, to be sure, but most importantly, they are increasingly becoming the key resource for community health services. They are the chief resource for organized medical care, the main focus for the technology and the group skills that are part and parcel of modern clinical medicine. They are the agencies with the strongest potential capability to create medical care programs that are directed at community health needs. More and more, however, people are questioning whether the traditional approaches to planning by the hospitals are suitable in today's scene. Planning at each hospital has tended to be facility-oriented and has only rarely engaged the full attention of the key professional component: the medical staff. Frequently, the planning has been sporadic and directed at short-range internally oriented goals. All too often the board of trustees has been preoccupied with means—construction and capital needs—rather than ends. Only rarely have administration, board, and medical staff been organized to carry on sound corporate planning for the hospital.

In 1960, our local hospitals stimulated the establishment of the Hospital Planning Association of Allegheny County, a non-profit community organization charged with responsibility for developing a flexible coordinated plan for hospital development. Prior to the formation of the Association, the hospitals were planning. The problem was not lack of planning. The problem was that the planning was almost entirely within an isolationist institutional framework, was not sufficiently responsive to rapidly changing professional and social forces, and only rarely included a systematic approach to setting goals and devising programs to accomplish the goals.

The Hospital Planning Association has been trying to provide encouragement, incentive, and assistance to individual hospitals in structuring planning processes to meet community needs and objectives, and to help hospitals to plan together in terms of comprehensive health service. The main emphasis has been to stimulate an effective planning mechanism at each hospital. The Association provides many kinds of assistance in the planning efforts of each hospital and other health agency (including groups interested in establishing new hospitals).

Finally, through a formal Approval Procedure, hospital capital proposals are endorsed by the Association board of directors, using criteria focussed primarily on the planning processes that produce the proposals.

The Association's criteria require that each hospital be established or expanded solely in terms of *community need* rather than the needs of the institution. Definition of community need requires a determination of *what people* the hospital is planning to serve, and *what services* it is planning for these people. Whether its programs are geared to primary health services or to specialized services, this requires that the hospital do its planning for a geographically defined community. The criteria require each hospital to delineate a geographic service area.

No one is suggesting that the hospital cannot serve patients from outside of its defined geographic area. There is no implication that the hospital should erect a Berlin Wall around its service area to try to prevent residents of the area from going to unrelated hospitals. Freedom of choice is preserved. But successful implementation of the hospital's plans should result in a higher and higher percentage of the hospital's patients coming from the defined service area, as more and more residents of the area identify with the hospital, its medical staff, and the inter-hospital relationships which develop.

What services should the hospital plan to meet the needs of the people in its defined service area? Here the Association's criteria provide a very simple and clear guide. The hospital should plan for *comprehensive* services. This includes *all* services: not only general medical and surgical, but also psychiatric, rehabilitative, social service, home care, extended care, preventive, diagnostic, emergency, other ambulatory, etc.

No hospital can *provide* comprehensive services. But each can *plan* in terms of the comprehensive health needs of its service area, both by direct provision and by making arrangements with other institutions. Effective and efficient arrangements to make available comprehensive care for the population of the hospital's service area is the ultimate goal. This requires that, in developing its plans, the hospital should give at least as much attention to the service it will *not* provide as to the services that it will provide. Only in this way can orderly systems for comprehensive care be assured for the people.

The Hospital Planning Association places greater emphasis on planning *process* than on planning *content*. Building programs and staffing patterns are treated as elements of implementation which flow out of the functional plans that emerge from efforts to meet the Association's basic criteria. If a hospital is organized to plan effectively, and if its plans are demonstrably couched in terms of meeting the comprehensive health needs of a defined population, the criteria have essentially been met.

A major challenge to the Association is the fact that most hospitals are not organized for a systematic planning process related to community needs. Active involvement and interaction of the entire hospital family, especially the medical staff, are required if the hospital is going to be able to carry on *corporate* planning which is responsibe to medical progress and which is based on viable goals.

Therefore, the key step is to achieve a viable organization of the planning process at each hospital. In Allegheny County, the hospital and medical leadership have decided that responsibility for the planning process at each hospital should be assigned to a new committee, called the Long-Range Planning Committee. This mechanism has since been picked up by many areawide planning agencies in the United States.

The Long-Range Planning Committee consists of representatives of the hospital's board of trustees, medical staff, and administration. Its task is very difficult and time-consuming, and requires staff support. In most hospitals, staffing can be provided by the hospital's regular administrative team, but three of our larger hospitals have now employed full-time planning directors to staff this committee. A fourth has sub-contracted with one of these large hospitals for planning staff services. Others have employed professional consultants to help.

Candor forces me to admit that progress has been very slow. Some hospital officials have had great difficulty applying the Association's concepts to their own institutions. There have been those who have rejected the Association's approach, or who haven't really believed that the Association was seriously committed to what it said. In seven years, two building programs have gone ahead without the Association's participation. The process of disseminating the

agency's viewpoint is a continuous one, requiring endless hours of meetings, conferences, and other forms of communications. Hospital Long-Range Planning Committees have tended to be preoccupied, understandably enough, with their own institutions' pressing building needs. They have frequently put off discussion of comprehensive care and the difficult issues involved in relating medical practice to institutional service in meeting community needs. It continues to be difficult for many hospital officials to understand why an institution with high occupancy, high standards of patient care, and a worn-out building cannot proceed to replace the old building without a lot of frustrating talk about goals and comprehensive care.

Moreover, an infrequently mentioned but widely recognized fact is that hospitals, in developing the instutional pride that underlies the pursuit of excellence, have tended to develop deep-seated distrust of their neighboring, "competing" hospitals. With a long history of competition for self-sufficiency among autonomous institutions, there is a legacy of misinformation, a lack of trust, and memories about apparent past immorality and double-dealing which cannot be overcome overnight.

The only answer to this problem is better communications within institutions and between institutions. Open communications can create conditions of mutual understanding and trust which will permit much more effective planning.

The Association's approach requires a great deal of patience and fortitude. When carried out aggressively, it is deeply disturbing to the community, the institutions, the medical profession, and the staff and directors of the Planning Association. Over time, however, ignorance, apathy, disbelief, and opposition have receded. The Association's Administrators' Advisory Committee has recently re-affirmed the planning criteria. Its Medical Advisory Committee has become deeply committed to and involved in the Association's activities. Both committees are currently working on more detailed recommended guidelines for use in applying the planning criteria. Some hospitals still want to build first and plan later, but they can expect little support from the two advisory committees.

Specific results are beginning to appear. One community hospital, for example, which had had difficulty in accepting the service area concept, is now working closely with its immediate community—a poverty area—and has just received a $1,800,000 federal grant for a neighborhood health center to be operated jointly with community representatives. A large center city hospital has shelved its plans to compete in providing specialty services with all hospitals in the area. It has recast its program to become a coordinated specialty resource to the community hospitals in a section of the region as well as a primary resource to a nearby poverty community. It is working to strengthen its neighboring hospitals through joint programs in specialty services. Other examples can be cited. Two hospitals have grouped their maternity services at one location. Four hospitals have formed a joint corporation which is now operating a central pharmacy service, a central clinical chemistry laboratory, and a joint laundry, each of which serves hospitals not in the corporation. Seven other hospitals serving another section of the region have recognized their community of interest and have formed a joint corporation for coordinated policy making, and for operating joint programs. In both of these corporations, the participating hospitals have not surrendered legal autonomy. But as they work together on common problems, they tend increasingly to adopt common or interrelated positions. The Hospital Planning Association assisted in the creation of a Regional Medical Program which is beginning to function to promote and fund cooperative arrangements in the fight against heart disease, cancer, stroke and related diseases. County-wide approaches to emergency care, to home health services, to rehabilitation services, and to mental health services are in planning. Several hospitals are developing innovative joint approaches to ambulatory services, social service, and radiation therapy. Physicians are becoming more deeply involved in planning at their own hospitals. Discussions concerning comprehensive care are becoming more common and less charged with emotion within hospital staffs and among groups of hospitals.

Implications of the Allegheny County experience

The Allegheny County experience suggests that delivery systems can be improved—with reduced costs for comparable service, or better yet, improved service for less than it would have had to cost—by concentrating attention on

improving the corporate planning processes of all health agencies. By holding each hospital and other health agency responsible for developing a viable and defensible community oriented planning process, the health care system can become more effective, more systematic, and more responsive to community needs and demands. Reduced costs and improved effectiveness will flow from strengthened planning at each level of operation.

Under Public Law 89-749, the Comprehensive Health Planning Act of 1966, every area can have a regional comprehensive health planning agency—backed up by a state comprehensive planning agency and by a strong federal commitment—to stimulate improved planning processes in every health agency and institution. This new law can have the most profound impact on the cost of delivering quality health care to people. The Allegheny County experience suggests some guidelines for this planning program.

(1) *Emphasize planning process rather than plans*

The comprehensive planning agency should not make plans for hospitals and other agencies. Rather, it should help operating health agencies to improve their planning processes.

A planning agency which attempts to plan for the health agencies risks the same reactions as parents who attempt to plan their children's lives: healthy but destructive rebellion, or unhealthy loss of capacity to change. Officials of operating health agencies are not children; they are mature, independent responsible people who have demonstrated great capability in achieving institutional objectives. With appropriate incentives and assistance in formulating broader goals and objectives, they are quite capable of planning sound programs in relation to community needs. The complex and delicate interpersonal and interagency relationships involved in implementing comprehensive planning require a commitment that can be obtained only if those responsible for the implementation are also responsible for the planning.

A comprehensive planning agency which concentrates its effort on review of building plans developed by operating agencies will also be of limited value. After an operating health agency has carried out the difficult and extremely time consuming process of developing a building plan, there is a sense of emotional involvement and commitment that permits very little outside influence. Unless the plans are patently absurd—they hardly ever are—it is too late to do much good.

Planning on a more or less systematic basis is a continuous process at each health agency. These processes—especially formulation of goals and objectives—must be strengthened. The primary job of the comprehensive planning agency is to help improve planning processes.

(2) *Require All Health Agencies to Plan Comprehensively*

Comprehensive planning agencies should attempt to improve the planning processes of *all* health agencies, not just the hospitals. While the hospitals are the key agencies in health care delivery systems, they must interact with a wide variety of other agencies which must also be engaged in planning in relation to comprehensive health services.

Especially important is attention to the planning processes of health agencies which are not directly responsible for patient care. Accrediting agencies, licensing agencies, financing agencies, educational institutions—all of these need improved planning processes that reflect a commitment to comprehensive care. A health care provider agency has difficulty planning in terms of comprehensive care if those agencies which supply it with capital and operating funds, with license, prestige and trained personnel do not reflect the same commitment. A hospital which can meet all the standards of license, accreditation, Blue Cross, Title XIX and Medicare participation has difficulty understanding why it must recast its goals and programs. Delivery of comprehensive health care as a goal must permeate the entire health establishment.

(3) *Make appropriate use of sanctions and incentives*

A comprehensive health planning agency will function most effectively if it does not exercise direct controls. The health establishment already has a great many agencies which exercise and respond to formal and informal sanctions and incentives. Many agencies which exercise sanctions on health agencies are in turn influenced by sanctions of other health agencies. For example, the hospital's power to grant or withhold staff privileges is a strong potential in-

centive and sanction on the practicing physician; the hospital, in turn, is subject to strong incentives and sanctions exercised by a wide variety of agencies such as the state Hill-Burton agency. All agencies should be guided by sound planning in exercising their sanction power—planning related to delivery of comprehensive health care. The comprehensive health planning agencies should strive to improve the planning processes of sanction and incentive agencies to help them to make maximum impact on improved delivery of health care services. Planning agencies should not usurp the operating responsibilities of these sanction agencies; rather sanction agencies must become involved in comprehensive planning themselves.

The greatest conceptual fallacy about areawide health planning today is that one form of sanction—control of capital funds—by itself can create more systematic planning. It hasn't worked anywhere.

Why should a hospital or health agency which has not planned its future in terms of the comprehensive health needs of people be entitled to accreditation? to licensure? to tax exemption? to all medicare funds (not just depreciation funds)? to public welfare payments? to Blue Cross membership?

All agencies which exercise sanction or incentive in the health field need to re-examine their programs and be guided to a strong commitment to comprehensive health care.

(4) *Determine priorities on the basis of innovation in delivering care*

Establishment of priorities is an inherent part of the planning process of any health agency. As planning processes of individual health agencies become more coordinated in relation to comprehensive health needs of the same people, many priority decisions will become products of inter-agency agreement. Agencies with operational responsibility for disbursing limited funds among different institutions will need to develop priority criteria relating to their own role in promoting improved delivery systems.

In the long run, determination of priorities will be one of the most difficult areas of planning and decision-making, because ethical considerations will be involved. In the short-run, and for a good number of years, most health agencies will have sufficient difficulty in re-focussing goals and objectives that priorities can be assigned to acceptable programs on a "first-come, first-served" basis. Innovative response to comprehensive health care needs of people can be the primary priority consideration. Overstructuring of objective priority considerations can be a stultifying force.

As with sanctions and incentives, a comprehensive planning agency without operational responsibility should not assume responsibility for determining priorities. It can advise on priorities. Even more important, it can help all health agencies and institutions to build into their planning processes priority considerations related to improved delivery of health care for people.

(5) *Avoid Overemphasis on Precision*

Health planning must be increasingly based on proven facts, and on ideas and programs that can be qualified, tested, and evaluated. But there is danger in over-reliance on precision. The current problem is not as much lack of exact knowledge about delivery systems as lack of commitment.

Precise quantification in the health field is difficult, expensive, and slow. Most basic concepts in the health field—for example, quality—have not yet been adequately defined or quantified. Yet, quality of care can be and has been improved, because of the deep commitment to it. Quality could probably be improved more efficiently if better concepts, definitions, measurements, and data were available. But we cannot and should not wait.

The same approach applies to planning for improved delivery systems of comprehensive care. We cannot wait for precision. The basic direction is clear enough to proceed simultaneously with efforts to improve delivery systems and to develop measurement techniques in a mutual feed-back process.

(6) *Coordinate Health Planning and Community Planning*

In the long run, the greatest potential for reduction of medical care costs probably lies in recognition that investment in other forms of conservation and development of human resources may frequently contribute more to human health than direct investment in health services. Investment in neighborhood development, housing, education, recreation, and welfare services are examples.

P. L. 89–749 goes a long way towards making the comprehensive health plan-

ning agency look beyond the limits of medical care, and on to environmental health, public health, and so on. It may be too soon to hope for, but we also need to relate comprehensive health planning to the planning which is directed at the total community. Close coordination of community planning and health planning—almost unknown today—may create a planning environment which will produce health care statesmen capable of deciding that application of all medical advances are not always in the community interest.

A FINAL WORD: PROGRESS WILL BE SLOW

Systematic planning by each institution and agency holds the answers to rising medical care costs. But patience and perseverance are required. Dramatic results may be hoped for, but should not be anticipated in short order. Systematic development must deal with the weight of tradition, custom, and vested interests, and with the special type of momentum and vitality of established institutions. The health field harbors an unusual mixture of sentiment, prejudice, and authoritative knowledge. There will be progress in the reorganization of medical care, but decades of development are not likely to be telescoped in one year. Everyone in the system is to some extent a prisoner of his education and experience. Everyone in the system can be expected to initiate or adapt to some change, but Great Leaps Forward are not to be expected. An entire system of health care will not be quickly converted to conform to models designed by the best planners. Facts and logic are not enough. To improve health care delivery systems requires a special logic that considers the stubbornness of men and policies and institutions, as well as the logic of rational thought.

I—Patterns of Utilization of Health Services by Older People*

(George A. Silver, M.D., Deputy Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare)

We are all aware of the dramatic strides which have been made in this country in the health picture of the entire population. It is the very success of modern medicine in preventing epidemics and curing or controlling diseases once usually fatal, that has brought chronic illness and the illnesses of old age to the fore as the major health problem of our time. Let me emphasize though that millions of older Americans enjoy relatively good health. Most of them can be almost as active as they were when they were many years younger and even large numbers of those with disabilities have learned to live with them, and accept their limitations.

Yet we must face the fact that the majority of the aged have become the prey of at least one disease in their lifetime that sticks with them as long as they live. About 15 million older Americans have at least one chronic condition, although it is true that less than one-half of those with a chronic ailment have some limitation on their activities. We all know that many of those with disabling illness might be in better health today if known preventive and restorative services had been promptly used. We do not know the causes and cures of all the diseases that come with old age. Until research efforts give us more information on the causes and cures of most chronic disease, we can only apply palliatives. Still, the most potent weapon against them is early detection and prompt treatment. However, too many of today's older people have not received treatment early enough.

Part of the problem may lie with the manner in which older people decide to seek medical care—the evidence shows a tendency to delay going to a physician until the later stages of a disease. The National Health Survey indicated that during the year ending June 30, 1964, one out of 4 people 65 or older had not been to a physician. But the entire responsibility cannot be placed on the aged; they have not always been made aware of the need for regular check-ups or the dangers of self doctoring or ways to avoid accidents. And we know that there is a tendency among many to treat themselves when they really need to see a physician. People often use medications which have worked on similar symptoms of neighbors and friends. Sometimes they wanted to avoid the cost—sometimes they were just afraid of treatment and hospitals. A large proportion of older

*Delivered at the 12th Annual Conference on Aging of the Western Gerontological Society, Monday, Sept. 19, 1966, San Francisco, Calif.

people are victims of poor nutrition because they are caught up by food fads or by poor lifetime food habits—some may suffer because they lack interest in eating, perhaps because they have to eat alone. Accidents, many of which are preventable, take a high toll among older people. They have almost twice as many home accidents as the average adult.

A good deal of the fault for these conditions has to be borne by physicians, communities, States, and the Federal Goverment. We have been slow in starting health programs for the aged. But recently enacted legislation should go a long way toward meeting many of these problems.

Medicare will modify dramatically the existing patterns of utilization of health services by older people and perhaps the entire population. I would like to present some important measurements of utilization of health services by older people as we move into the Medicare age.

Receipt of medical care in this country is obviously dependent on the social, economic and demographic characteristics of the population. If a person is aware of his illness and recognizes the need for treatment, if he lives in an area where medical care facilities are accessible, and if resources are available to pay for his care, then he is more likely to receive medical treatment than if he were living in less favorable circumstances.

HOSPITAL UTILIZATION

During the period July 1963–June 1965, the National Health Survey shows that hospitalization increased with advancing age, from 115 per one thousand people under 45 years to 186 per one thousand people 65 years and older. The length of hospital stays increased although the proportion of patients with surgical treatment decreased with the increasing age of the patients.

Among people 65 years and older the rate of hospitalization was higher among men than among women and rates of hospitalization in the Southern region and among non-farm residents living outside of metropolitan areas was higher than in other regions. During the survey period, the annual number of hospitalizations for the total population was 24,012,000. People 65 years and older accounted for 3,196,000 or 13.3 percent of these discharges; they account for only 9.4 percent of the total population. During the past 5 years the rate of hospitalization among persons 65 years and older has increased 28 percent.

Information on the relation between hospital utilization by older people in the various income brackets is equally significant. Among people 65 years and over, the highest rate of hospitalization was among those with family incomes of $3,000 to $4,000 and among those in the income group $10,000 and over. However, the length of hospital stay was considerably longer for the latter group (14.0 days) than for the former (11.0 days). Income of older people, then, has had a significant effect on hospital utilization in the pre-medicare age.

We also have information on hospital utilization related to the living arrangements of older people. Approximately one-half of the aged population is married and living with relatives (mostly married couples); one-fourth live with relatives but are not married (widows primarily); and the remaining one-fourth either live alone or with non-relatives. Among those 65 years and older, the rate of hospital discharges was highest (232.0 per 1,000 persons) and the hospital stay longest (19.7 days) among those living with non-relatives. This is so because this group tends to be older and there is need of more medical care.

Differences in the amount of hospital care for older people result not only from differences in age, sex, family structure, and income; they are affected also by characteristics of medical practice and the over-all supply of hospital beds, which in turn may reflect whether the area is rural or metropolitan. If hospital beds in a community are in short supply, the acutely ill with have first call on the available beds and hospital stays will be on the average shorter than if beds are plentiful. While we have known for years that much of the hospital stay for older people is unnecessary, that appropriate home care services are not only as effective as, if not more effective than, hospital services, and certainly more desirable from the patient's standpoint, home care has not flourished in this country. Now, with the introduction of Medicare, we are seeing a rapid multiplication of home health services. This will undoubtedly have an important and useful influence on hospital utilization by older people. And for the rest of the population as well.

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Utilization of nursing homes and related facilities

There is much less information about the extent of utilization of nursing homes and similar types of medical facilities by aged persons than there is of hospitalization. Most population surveys relate primarily, if not exclusively, to people who are not living in institutions. Over 600,000 persons aged 65 and older were in some type of institution at the time of the 1960 census. From subsequent data it has been estimated that some 23,000 non-hospital facilities with a resident capacity for 592,800 persons are providing or supporting services to chronically ill and aging persons.

Skilled nursing homes which provide skilled nursing care as a primary and predominant function total close to 10,000 with approximately 338,700 patients. There are about 11,000 other homes providing primarily domiciliary or personal care with 207,000 residents—but which may also provide some skilled nursing care. And there were some 2,200 residential care homes wtih 47,000 residents providing primarily sheltering functions but which also may provide some skilled nursing care.

Very few of even the best skilled nursing facilities provide restorative and rehabilitative services; although there is some evidence that physical rehabilitation for chronically ill bedfast patients over 65 might restore many to ambulation and partial self care, and some of those so restored would not require continued institutional care.

There is a rather grim picture in view of the fact that all of the patients requiring institutional care of this kind are not in institutions, and that a significant number of the beds that are available are not in institutions of sufficient safety or quality.

More skilled nursing home beds are becoming available and government help is increasing. Acceptable nursing home beds have doubled in the past 10 years.

The Public Health Service will spend $70 million in 1966, almost double the previous annual expenditures, under the Hill-Harris amendments to the Hill-Burton program. In the past 20 years, Hill-Burton funds have helped build 2,000 clinics and health and rehabilitation centers, and 350,000 hospital and nursing home beds.

Other Federal agencies are providing funds for the construction and expansion of extended care facilities. The Small Business Administration lends money to privately owned establishments. The Federal Housing Administration mortgage insurance programs covered 38,000 new beds in 1965 compared to only 200 covered just 5 years earlier.

The Area Redevelopment Agency also can make loans for private nursing homes in redevelopment areas.

It is hardly news to this audience to say that the very elderly predominate among the nursing home population. According to a survey some 10 years ago, of the 38,000 patients in nursing homes in some 13 States the average age was 80 years. More recent studies in Michigan (1957) and Pennsylvania (1959) reported the average age to be 76 and 80 years respectively. Data from a 1962 North Carolina study indicate that 66 percent of the patients were over 75—23 percent were over 85. A country-wide survey in 1963 gave an average age of 77.6 for persons in nursing homes.

Physician visits

Estimates derived from the data collected during the National Health Survey show that the rate of physician visits was 4.1 visits per person per year for people under 45 years, 5 for those 45–64 years of age, and 6.7 visits for those 65 years and older.

The proportion of total physician visits in the home has been decreasing with a compensating increase in the proportion of visits to the physician's office or to hospital clinics. This change in the pattern of utilization is true for people of all ages.

Among persons under 45 years the rate of physician visits increases with the amount of family income; however, for persons 45 years and over the pattern of physician's services is not so closely related to income, but the higher rate of hospitalization noted for persons 65 years and older in the income groups $3,000 to $4,000 and $10,000 and over is reflected in the comparatively higher rate of physician visits in these groups.

The impact of medicare on patterns of utilization

Probably no other piece of social legislation in the history of our country will have a greater impact on the patterns of utilization of health facilities by the

elderly than Medical, including Title XIX, the new medical assistance program.

Expenditures for health care in this country both public and private are increasing at the rate of about $3 billion a year. In 1965, the American people spent a total of $40 billion on health care, nearly 6 percent of the gross national product. Before 1970 this total will probably exceed $50 billion annually.

The combination of Medicare (Title XVIII) and the new medical assistance program (Title XIX) will help to bring about vast improvements in health facilities and their use in this country. Title XIX authorized increased Federal grants to the States to provide medical care to all people receiving public assistance and to others who are medically indigent. Title XIX requires that the States provide for the payment of many services that have not been provided by the States before. To receive Federal funds for the program, the State must provide comprehensive care and service to substantially all of its needy people.

This will include payments for hospital care, nursing home care, and physician services for those needy aged whose benefits under Title XVIII have run out. At no time, therefore, must the older person, sick and impoverished, fear deprivation of medical care because of financial need. Fifteen States and one territory have already obtained approval of their Title XIX plans and arranged by matching Federal funds. California can be proud of the dynamic leadership that made it among the first to participate in this noble social welfare and health program.

California's program of medical assistance is an exciting innovation in many ways. First of all, it attempts to remove the stigma of poverty in medical care from its program. A Californian eligible for medical assistance receives a green card, for all practical purposes a credit card, entitling him to the same services, the same doctor, the same hospital, the same nursing home as any other paying patient. His doctor, or hospital, bills the State and is reimbursed according to going rates even as the non-indigent patient pays the doctor or hospital the customary fees or charges. Two and a half million Californians are eligible for California's medical assistance program and already over a million doctors' bills have been paid. This is one quality medical care for all, equally, without regard to ability to pay. It is a landmark in American medical history.

California's efforts in this Title XIX program mark also the fulfillment of a philosophic dream—a true partnership of public and private interests for the benefit of all citizens. President Johnson said last year,

> Only through a creative and cooperative partnership of all private interests and all levels of government—a creative Federalism—can our economic and social objectives be attained. This partnership has written the story of American success and a new vitalization of this partnership and a new confidence in its effectiveness have produced the extraordinary economic and social gains of recent years.

And never has this been so clearly evident as in this partnership to improve the nation's health.

California's State government, its doctors, its hospitals, its health and welfare departments have written a bright page in our history. Title XIX has been the less well known section of the Medicare Act, P.L. 89–97. Through these efforts it may become even more significant.

But Title XVIII, the more familiar section, has also had an exciting impact. Since July 1, when the Law became operative, over 1,000,000 patients over 65 have been hospitalized, at a cost to the government of about $500 per patient. Half of these patients had no insurance previously. The experience of the aged under Medicare will be observed carefully. Ninety-seven percent of the short term general hospitals are participating, and only the handful that failed to meet civil rights requirements are not participating. Over 19 million people are eligible. The disastrous predictions of "mammoth traffic jams" never took place. America went from pre-Medicare to the new era in a quiet and orderly fashion. There was no more demand than in other years—only the quiet security of the aged who need no longer dread the economic impact of illness.

We will want to measure the results of these improved circumstances and the effects and by-products of Medicare.

We have heard a great deal about the shortages of doctors, dentists, nurses, medical technicians, professional aides, hospital beds and nursing homes. These shortages are real. But Medicare is not the cause of the shortages. The shortages already existed. The Medicare program only adds urgency to the need for both public and private action to relieve some of these critical shortages. In Califor-

nia, and in the country as a whole, legislation of the past 3 years, and pending legislation in the Congress, aim to provide us with more hospital beds, more doctors, more health service workers of all kinds. We have a generation of missed opportunity to catch up with, and we are on the way.

Other significant effects of the Medicare Law on the medical care for older people are inherent in the standards in the Law itself.

The utilization review committees provided for under Medicare will undoubtedly be a useful instrument in making more efficient the use of hospital services for older people, in fact, for the whole population.

Another of the important side effects of Medicare will be to highlight the need for area-wide community planning of all its health and medical care facilities and manpower. Communities must plan for adequate numbers of facilities with a full range of needed services. They must also design the facilities so they are flexible enough to get the most utilization from them as needs change. A comprehensive pattern of services must be integrated into the facilities. Cooperative arrangements must be developed to assure that community resources are used to promote quality care with the most efficiency and economy.

More widespread use of home health services will alter the picture of hospital and other institutional use dramatically. Medical care costs will change. Even as they are rising now, the more efficient use of hospitals and more appropriate use of facilities of all kinds may reverse this trend.

Specialized practice in geriatrics should become more remunerative under Medicare and this, in turn, should encourage more doctors to go into this type of practice. Undoubtedly, Medicare can be expected to accelerate the growing interest in the field of geriatrics. It will be easy now for physicians to carry out more fully their professional responsibilities for older people and older people will be less constrained in obtaining the care they need. By removing the financial barriers to high quality care the program will help to remove financial considerations from the patient's and physician's decision about what kind of treatment is necessary and what medical facilities should be used. Up to now, such considerations have in many cases prevented older people from seeking and obtaining the medical care they needed.

There will also be a stepped-up interest in the whole field of gerontology. As we gain more knowledge of the process of aging and the over-all health of the aged, we can relate this information to other aspects of living, improve the quality of care, and the quality of life for older people.

This needs to be accompanied by more emphasis on educational programs on aging. Colleges and universities are already adding courses on gerontology and directing more research to the process of aging. The Older Americans Act of 1965 provided, among other things, for a grant program to support training programs in aging. More can be done to encourage research and demonstration projects. Short in-service training programs and vocational training programs for auxiliary personnel who can care for the aged, such as home aides, should be encouraged. We will need more trained career personnel at all levels and from all disciplines to carry out programs designed for the aged.

CONCLUSION

With Medicare now part of our daily life, the organization and delivery of medical services to the aged will be changed dramatically in the years ahead, and with them the patterns of utilization will change.

As President Johnson said in signing the Social Secuirty Amendments of 1965:

> "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents."

It will indeed be interesting to attend such a conference as this a few years from now, to talk again about the patterns of utilization of health services for older people in this country. I'm sure that the story will be quite different—and far better.

Early in this address, Dr. Silver makes some good observations on the tendency of the elderly to stay away from doctors and medical services unless and until

they have a condition which has become serious. Inferentially, there is a plug for preventive health services.

Beginning on p. 221, there are some interesting statistics concerning hospital utilization. Utilization of nursing homes and related facilities is discussed beginning on p. 222. Statistics on physicians' visits are on p. 222.

The remander of the address discusses the impact of Medicare upon health services to the elderly. Since the address was delivered soon after eligibility for Medicare began, he could not say much about the effect of Medicare to that date, but he was very optimistic about prospective effects of Medicare upon health services to the elderly. Besides removing the financial barrier to utilization of health services, Dr. Silver thinks Medicare will have several important side effects:

1. The utilization review requirement will result in more efficient use of hospital services for the elderly;
2. Medicare will highlight the need for area-wide community planning of all health and medical care facilities and manpower, and will probably stimulate more and better planning of this type;
3. More widespread use of home health services will be stimulated;
4. Specialized practice in geriatrics should become more remunerative under Medicare and this, in turn, should encourage more doctors to go into Geriatrics.
5. There will be a stepped-up interest in the whole field of gerontology, resulting in advances and improvements in non-medical aspects of aging.

ITEM 2: EXHIBITS RELATED TO MR. WILLIAM R. HUTTON'S TESTIMONY*

NATIONAL COUNCIL OF SENIOR CITIZENS, INC.,
Washington, D.C., July 7, 1967.

HON. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly,
Special Committee on Aging,
U.S. Senate,
Washington, D.C.

DEAR SENATOR SMATHERS: During the course of my testimony before your Subcommittee on June 22, 1967, I was asked to submit data substantiating my assertion that U.S. prices for drugs are the highest in the world.

The examples cited below are taken from the 1961 report of the Senate Antitrust and Monopoly Subcommittee (Administered Prices—Drugs, Report No. 448, 87th Cong., 1st Sess.). As you undoubtedly know, this Subcommittee under the Chairmanship of Senator Estes Kefauver made an exhaustive examination of drug prices which culminated in the passage of the Kefauver-Harris Act of 1962. Data on foreign prices were secured through the State Department from American Consulates abroad.

The Kefauver report shows substantially higher prices for drugs in the United States as compared with other industrialized countries of the world. The following examples are typical:

1. Chlorpromazine, a potent tranquilizer used widely in American mental hospitals throughout the country. This product, marketed exclusively in the U.S. under the trade name of Thorazine by Smith, Kline & French, was priced at $3.03 to druggists (25 mgm. tablets in bottles of 50's). Rhone Poulenc, the French firm which originated this compound, sold the drug in equivalent amounts at $.51. The price in England was $.77; in Germany, $.97; in Belgium, $1.37.

2. Prochlorperaxine, another potent tranquilizer used widely in mental hospitals. This product, also developed in France and marketed exclusively by Smith, Kline & French in the U.S., was priced to druggists at $3.93 (10 mgm. tablets, 50's). The price in France was $.80; in England, $2.24; in Germany, $.80.

3. Tolbutamide, oral anti-diabetic compound. This product, sold exclusively in the United States by Upjohn under the trade name of Orinase, was priced to druggists at $4.17 (.5 gram tablets, 50's). Hoechst, the German firm which originated the compound, sold equivalent amounts in Germany for $1.85. The price in England was $1.87; in France, $2.04; in Belgium, $2.45.

4. Reserpine, a drug used widely in the treatment of hypertension and heart disorders. For this compound the Kefauver report compares the world prices

*See statement, p. 53.

of Ciba, a major Swiss firm which holds the patent on this purified form of rauwolfia, a product of nature used for centuries as a medicine in the Far East. Prices to druggists for Serpasil, Ciba's trade name, in the U.S. were $12 (1 mgm. tablet, 100's). For equivalent quantities Ciba charged in England $3.94; in France, $1.21; in Germany, $2.78, and in Belgium, $4.24.

5. Chloramphenical, an antibiotic controlled world-wide by patents in the hands of Parke Davis, an American firm. According to the Kefauver drug report, this company charged druggists in the U.S. $5.10 (250 mgm. tablets, 16's); in England its price for equivalent amounts was $2.67; in Belgium, $3.36; in Holland, $3.03; in Italy, $3.90.

More recently, data in this area have been collected and made public by Senator Gaylord Nelson, Chairman of the Monopoly Subcommittee of the Senate Select Committee on Small Business. This information disclosed during May and June of 1967 substantiates the continuance of higher drug prices in the U.S. as compared with industrialized countries abroad. The following examples may be noted:

1. Chlorpromazine continues to be marketed at a higher price in the United States than in France, where the drug was originated, as well as in other cities in Europe. According to the Monopoly Subcommittee, this drug, still marketed exclusively by Smith, Kline & French under the name Thorazine, is priced at $6.06 to druggists for 25 mgm tablets in bottles of 100. In France and England it is sold for $1.08; the price in Germany and Italy is $2.40.

2. Prochlorperazine, discussed above, also continues to be sold at a higher price to the American druggist than to the druggist in European countries. Smith, Kline & French sells its product for $7.86 for 10 mg. tablets in bottles of 100. An equivalent amount costs $1.75 in France and $1.95 in Germany.

3. Reserpine, the antihypertensive referred to in point 4 above, is sold to druggists in the U.S., under the Ciba trade name, Serpasil, for $4.50 for 100 tablets of .25 mg. This same Swiss firm sells the identical quantity in Berne, Switzerland, for $1.24; in Bonn, Germany, for $1.50; in Vienna, Austria, for $1.56; and in Rome, Italy, for $1.52.

4. Prednisone, a synthetic analog of cortisone used to control inflammation associated with rheumatoid arthritis, is marketed by various pharmaceutical firms. An international comparison of both Parke-Davis' prednisone, sold under the trade name Paracort, and Schering's brand of prednisone called Meticorten revealed that both these firms market their products at substantially higher prices in the United States than in a number of European countries. Paracort (Parke-Davis) sold to the druggist in the U.S. for $17.88, is marketed in London for $2.10 (5 mg., 100 tablets). Schering sells its Meticorten in the U.S. for $17.90 (5 mg., 100 tablets) while the same product in an equivalent amount and strength is priced in Berne, Switzerland, at $4.37.

These recently disclosed comparisons of drug prices in the United States and abroad substantiate the findings disclosed in the Kefauver report. Prices for drugs are considerably higher in the United States than in other countries of the world in 1967 as they were in 1962.

I hope that the example cited above will satisfy any questions you may have about my assertion that U.S. drug prices are the highest in the world. And, I am confident that your Committee will give full consideration to the serious issue of drug prices as they relate to the overall health problems of the aged.

Sincerely yours,

WILLIAM R. HUTTON, *Executive Director.*

[Enclosure]

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, INC., WASHINGTON, D.C.

Mr. Chairman, members of the Subcommittee: I am William R. Hutton, Executive Director of the 2,000,000-member National Council of Senior Citizens. I appreciate this opportunity to appear before the subcommittee.

President Johnson has called Medicare and Medicaid the most ambitious and formidable social welfare program to be undertaken by the American people in recent decades. All of us can understand that difficulties are inevitable in an undertaking of this vast scope and there are clearly many serious problems.

Members of the National Council of Senior Citizens do not spare themselves in recognizing that Medicare and Medicaid are doing more to break down the

barriers to adequate medical care for older people than any other steps that have been taken in the history of American medicine and in the history of our social legislation.

But it is precisely because we believe that the organization and delivery of medical services to every American citizen may be changed dramatically by the impact of these programs, that we are glad to submit the following observations.

Through its enactment of the Social Security Amendments of 1965 which included these important health programs, the United States Congress clearly recognized that the problems of medical care for the aged are more severe than for other age groups.

Though we are intensely grateful to Congress for the enactment of these programs, we have had plenty of opportunity during a full year of their operation to realize where they fall far short of the minimum that is needed to make good health a reality for many aged citizens.

IN THE NATIONAL INTEREST

Nevertheless, we want to emphasize that in our goal to seek a better life for all older Americans the National Council of Senior Citizens is extremely conscious of the national interest. This concept of seeking improvements for the elderly within the framework of the national interest is one, Mr. Chairman, which has brought recognition of our organization by the members of this Congress as a responsible voice of the elderly people of America.

We are desperately concerned about the health care needs of the elderly. We are just as desperately concerned with unnecessary, unrealistic, "runaway costs" which are forcing up the price of health care, not only to elderly people themselves, but for their sons and daughters and for their grandchildren.

Ever since the spring of 1965—when it became clear that Medicare was going to be enacted—the National Council of Senior Citizens has been warning Congress that soaring hospital costs and spiraling doctor fees pose a dangerous threat to the program.

We believe quite sincerely that this is currently an economic threat and not a political one. Something must be done to halt the rate of health cost increases. We must work to control costs and improve efficiency without sacrificing the quality of care. While to some degree this calls for the understanding and cooperation of the people who will use the care, it calls more seriously for restraint and judgment by those doctors who are wilfully and flagrantly raising their fees on the theory that "Uncle Sam can afford it" or who are inflating their fees because a patient happens to be privately insured.

NEED FOR BUILT-IN INCENTIVES

Though it is understandable that some hospitals which are belatedly meeting staff demands for needed increased wages are having to meet higher costs, it is also clear that there are wasteful and extravagant practices in many of our health institutions. Inside and outside of Government there is a great need for built-in incentives to control costs.

Mr. Chairman, in your Senate statement on June 7 announcing these hearings, you asked a number of questions to stimulate discussion concerning the organization of our medical services as they affect the elderly. I would like to group several of our observations under the topics prescribed by these questions.

Do many of our elderly face insuperable obstacles in obtaining needed health services?

I know that the committees of Congress appreciate the tremendous difficulties we experience in gathering accurate data on the invisible poor. As President Johnson pointed out in his message to Congress on social security, there are 5.3 million older Americans living in the squalor of poverty and obviously it is difficult if not impossible for many of them to meet the deductibles and co-insurance features of the Medicare law. The leaders of our over 2,000 affiliated clubs have told us they believe there are many older Americans in their communities who will not go to a doctor because of their lack of money.

Many aged sick would rather suffer in silence than admit they cannot produce the $40 for the first day of hospitalization, the intial $50 for doctor bills, or subsequent one-fifth of all doctor costs as co-insurance for medical insurance.

The people I am talking about, Mr. Chairman, include many proud Americans whose sweat and toil helped to make this country great. They don't wish to admit

their failure by throwing themselves on the mercy of the welfare people by taking advantage of Medicaid. It might be pointed out here, however, that only 29 of our 50 States have Medicaid programs in operation. Elderly poor in 21 States are out of luck insofar as meeting the deductibles and co-insurance features of Medicare are concerned even if they are prepared, in their desperation, to go the welfare route.

The truth is that the deductible and co-insurance features of the Medicare program merely discriminate against the elderly poor who need the most help. Any hospital administrator will tell you that deductibles and co-insurance are not necessary to control utilization and they certainly will not control abuses. People with plenty of money never have much difficulty getting into a hospital.

Frankly, the National Council of Senior Citizens fought against the inclusion of deductibles in the original King-Anderson bill, and after one year of their operation in the Medicare program we are even more convinced that we were right.

Our Medicare program is a program of social insurance but the use of deductibles and co-insurance comes strictly from the practice and thinking in commercial casualty insurance. The basic concept of fire, auto, marine, etc. insurance is the pooling of risks to protect against loss from undesirable and often preventable accidents. The deductible is promoted as a guard against carelessness—or paying the consequences.

But in today's world everyone requires health services. Modern medicine embraces preventive care and health maintenance as essential elements. The casualty insurance concept simply does not fit in a Medicare program established as an element of our social insurance system.

Now, Mr. Chairman, to answer another of your questions—"*Are rising medical costs causing special difficulties for the elderly?*"

Those elderly Americans who are fortunate enough to be able to pay taxes will, of course, have to meet their appropriate share of the Nation's precipitously rising health costs.

But, under the co-insurance features of the Medicare law, 20 percent of all doctor bills must be met by the elderly themselves. But nearly all doctors have raised their fees to aged patients—some have doubled or tripled their fees. Some of our elderly suffering in the most extreme cases are beginning to feel they are not much better off under Part B of the program (voluntary supplementary insurance) than they were before. They pay $36 a year in premiums, have a $50 co-insurance feature—and some doctors have double or tripled their fees!

At his recent press conference in connection with the first anniversary of the introduction of Medicare, Social Security Commissioner Robert M. Ball spoke of the possibility, starting January 1, 1968, of a substantial increase—perhaps 50 cents—in the present $3 monthly premium for the optional doctor insurance under Medicare because of skyrocketing doctor fees.

It was clear, months before the start of Medicare, doctors began jacking up their fees so they would not be caught with their fees down when the program began.

Some doctors have excused their fee-grabbing by claiming they charged the impecunious elderly reduced fees before Medicare and feel an obligation to charge them more now that the Government pays a major part of their doctor bills.

If this Robin Hood system of taxing rich patients for the benefit of the elderly poor was ever in general use by doctors it would seem that doctors, in all fairness, have an obligation now to lower their fees to the rich. Even though doctors no longer have elderly charity patients, we have yet to hear of one doctor who has lowered his fees.

Medical Economics, the chief journal devoted to doctors' incomes and financial practices, revealed in a national sample of 3,195 family doctors (general practitioners and internists) that since Medicare began, the median fee of general practitioners has jumped 25 per cent for the key category of office visits (the patient's follow-up visits after the initial contact). The median fee of internists is up 40 per cent.

A very interesting finding is that pediatricians' charges for office visits remained unchanged (the median figure was $5) during this period. Yet our population expansion is just as heavy among the very young as it is among our aged population.

DOCTORS CONFUSED

Under the fee-for-service system the accepted principle is that fees should be "commensurate with the services rendered and the patient's ability to pay".

Today, in millions of cases, the ability of the patient to pay has been reinforced, if not totally supplanted, by the resources of Federal and State treasuries or by Blue Cross-Blue Shield, or private insurance companies. This seems to have confused many of our doctors. They seem to want to charge what the Government can afford to pay, or what the insurance company can afford to pay.

The rising costs of health care are, of course, not merely limited to doctor fees. Walter J. McNerney, president of Blue Cross, has predicted the average cost of hospital care which he estimated at $54.05 nationally as of March, 1967, might go to $69.79 a day by 1970. At these rates few older people could remain in hospital one more day after their inpatient hospital benefits of 90 days run out.

Costs in extended care facilities are rising and our members report that the costs in the custodial care nursing homes outside the system seem to be rising right along with them.

To answer another one of your questions we would like to say we believe much has been done on a geographical basis to provide health care institutions under the program. However we are concerned that in many cases there has been a relaxation of the conditions of participation in some institutions. Introduction of the highly elastic concept of "substantial compliance" with conditions of participation gives cause for apprehension that the quality of care may be eroded in substandard and marginal facilities.

Before other Committees of Congress the National Council of Senior Citizens has highlighted what it believes are much needed improvements in the Medicare program so as to be able to deliver adequate health services to all older Americans. One of our major complaints is that while Medicare takes good care of the aged suffering from acute illness and requiring hospitalization, there is little help available for millions of older Americans suffering from chronic diseases. In this segment of our population the drug industry has bound a bonanza. Elderly people suffering from chronic ailments in a very real sense are captive to the drug industry because day in and day out they must take maintenance drugs for the treatment of chronic conditions which are an inevitable accompaniment to advancing age.

The high prices of prescription drugs constitute a problem of gigantic proportions. Frequently older people have to make a choice between needed drugs or food. But at the present time there is no other country in the world whose prescription drug prices are as high as those in the United States. Congress must find a way to provide the cost of prescription drugs—at least on a generic basis—under the Part B program dealing with supplemental insurance.

We believe, in fact, that Medicare will not adequately cover our older people until its provisions include wheel chairs, eye glasses, hearing aids, all surgical and orthopedic appliances, and all eye, dental, and drug needs as prescribed by a physician.

MAKE GERIATRICS A SPECIALTY

There are shortages of trained personnel in the medical and medical-related professions in all fields and particularly severe in fields that serve the elderly. Our population is showing marked increases at both ends—the very young and the very old. But after 50 years of struggle, baby care became a medical specialty and, in proportion, large numbers of each year's graduating crop of new doctors become pediatricians. At the beginning of this century there were only 3.1 million Americans age 65 or over. By 1980 we will have more than 25 million over 65. Not only is their number zooming but so is their proportion to the rest of the population. It is high time that geriatrics also became a specialty of the medical profession.

On of the greatest hardships under the current Medicare program arises from a doctor's refusal to accept an assignment of his medical bill. Social Security Commissioner Ball estimates 57 per cent of the doctors across the nation accept assignemnts at least part of the time. In some areas only one in three doctors do.

It is often all a low-income senior can do to pay the entire amount of his doctor bill in cash so he can get a receipted itemized statement of services performed by the doctors. For the elderly, the majority living on shamefully inadequate incomes, it is a hardship to pay for major operations and treatment out of pocket, then wait weeks or months for Medicare reimbursement.

The National Council of Senior Citizens has asked Congress to simplify collection of Medicare claims.

Congressman Al Ullman of Oregon, a member of the House Ways and Means Committee, has come up with a plan whereby the doctor would give his Medicare

patient an unreceipted statement of fees for service that conform to fees that are customary and reasonable. The Medicare payment agency would be empowered to send a settlement to the patient for transmission to the doctor.

This would provide an alternative to the present billing options, namely, direct billing which allows the doctor to charge all the traffic will bear, and assignment which limits the doctor to customary and reasonable fees as determined by the payment agency.

A resolution adopted at the National Council's recent convention calls for a system under which doctors send their bills to Medicare payment agencies as they presently do with Blue Shield plans or, else, allow the patient to collect on unreceipted bill as Congressman Ullman proposes. National Council members feel this will obviate the painful necessity of many seniors having to borrow to pay their doctor bills then wait long weeks for reimbursement.

These are problems that can be corrected by a vote in Congress—they will certainly not require the expenditure of Treasury funds.

The real challenge is the need for a radical reorganization of health care in the USA and that will take time. If the cost of Medicare and Medicaid is to be kept within reasonable bounds, hospitals and doctors must cooperate for maximum utilization of medical facilities.

No longer is it feasible for two hospitals in the same town each to install costly cobalt radiation units, for example, when both could use a single radiation unit.

More important, there must be an upgrading of medical procedures guaranteeing top health care for rich and poor alike.

We of the National Council of Senior Citizens agree with Dr. Peter Rogatz, director of the Long Island Jewish Hospital, New Hyde Park, N.Y. Writing in *Hospitals* magazine recently, he declared:

"It has been said many times that in the great cities of America, both the rich and the poor have access to the finest medical care in the world. The argument runs something like this: American medicine is the best there is. The rich of course can purchase it at will and, although the middle income family is sometimes caught in between, at least the poor can go to the finest hospitals, without charge, and receive the finest medical care avaailable.

"Well, it just isn't true. Our basic system for providing health services for the poor is a failure. We try. Our intentions are good but the results aren't. In taking an honest look at some of our comfortable assumptions, I believe that we, in the fields of health and social welfare, have allowed ourselves to accept a fictional view of some of our accomplishments.

"There is no doubt our medical schools and research centers are the best in the world and that our medical technology has made incredible advances year after year. And yet, within a few blocks of so many of our magnificent medical centers, there are persons in poor health, attended by doctors of questionable ability who are practicing indifferent medicine. . . ."

What Dr. Rogatz has to say about the poor applies especially to the elderly poor.

Medicare and Medicaid have set off a revolution in health care—a revolution that promises early prospects that this nation might soon be able to eradicate second-class care and bring us closer to the day when top-quality care will be available for all citizens—not merely those with plenty of money.

We of the National Council of Senior Citizens believe a nation whose gross national product is more than $700 billion a year should be able to accomplish this goal. However, we are pragmatists at the National Council and we are patient, but the sands of time are running out for our nation's elderly.

We therefore plead with Congress to assign its highest priorities to improving health care of the aged. The National Council of Senior Citizens seeks solutions to the problems of the aged not as a special interest group but as an essential element of the welfare and prosperity of Americans young and old.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
July 6, 1967.

HON. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate, Washington, D.C.

Dear SENATOR SMATHERS: Mr. Hutton's letter to Under Secretary Cohen was answered on June 26, 1967, to the effect that there seemed to be a misinterpreta-

tion of my remarks. The letter in reference is enclosed for your information and use in the record if you so desire.

Sincerely yours,

GEORGE A. SILVER, M.D.,
Deputy Assistant Secretary for Health and Scientific Affairs.

[Enclosure]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
June 26, 1967.

Mr. WILLIAM R. HUTTON,
Executive Director,
National Council of Senior Citizens, Inc., Washington, D.C.

DEAR MR. HUTTON: Under Secretary Cohen gave me your letter and asked me to respond, inasmuch as I am the one who presented the testimony you take issue with. I am having it delivered by hand, in order to be sure you have it before the Conference on Medical Care Costs, as you requested.

First, let me say that there is nothing in my statement that is in conflict with your position or that of Dr. Ross. Part of the statement submitted for the record reads:

"Although the price of drugs has not risen significantly in recent years, there are a number of reasons for concern about the cost of drugs. Prior to Medicare, average per capita drug expenditures by the elderly were about twice as high as the average for all persons in the population. Thus, the cost of drugs imposes a major financial burden upon many elderly Americans. Further, a large proportion of the total drug expenditures by the elderly are incurred by aged persons who are high users of medical care. For example, in 1962, 10 percent of those persons over the age of 65 incurred 40 percent of the expenditures on drugs by all persons over the age of 65. But out-of-hospital drug costs are generally not covered by health insurance."

Furthermore, in "Medical Care Prices," submitted for the record as an appendix, and from which our statement was drawn, a number of remarks cover this ground, for example:

"Drugs contribute to the high cost of medical care, although they have not contributed significantly to recent price increases.

"The use of drugs is increasing, and many consumers are conscious of an increased burden of drug expenditures not generally covered by insurance.

"Drug prices are higher than they would be if there were more vigorous price competition at either the manufacturing or drug store level. Advertising costs are high and doctors often prescribe costly brand name drugs when cheaper equivalents are available."

"Drug prices have not been major contributors to rising medical prices. The drug component of the Consumer Price Index increased 13.3 percent over the period 1950 to 1965, or somewhat less than 1 percent per year on the average. There was no appreciable change in the drug component of the CPI during the 6-year period ending December 1966. The prices of prescription drug items in the CPI (as contrasted with over-the-counter drug items) actually declined by 11.7 percent between 1960 and 1966.

"Industry sources give a slightly different picture. The average retail price per prescription, reported in The American Druggist, increased at an annual rate of about 2.3 percent between 1955 and 1965, and at slightly less than 1 percent per year between 1960 and 1965.

"The 'average prescription price' reflects the use of new drug products, and changes in the quantities and prices of drugs prescribed. In contrast, the CPI reflects changes in the unit price of the same or similar drug items over periods of time. It is difficult to adjust the drug component of the CPI for the rapid changes in the character of the drugs prescribed. By the time a prescription item is incorporated into the index, its price may have fallen to a lower level than in previous years. In the interim, newer drugs are being prescribed at a higher price level, and the drugs included in the CPI may not reflect such price movements. Most of the difference between the increase in the 'average prescription price' and the change in the drug component of the CPI can be attributed to the use of new and improved drug products and changes in the quantities prescribed."

In essence, we cannot quarrel with your argument that drug costs are a heavy burden to our older citizens. There was no intention on my part to minimize

this factor. When I said, "Drug prices have not been a major factor in rising medical prices," this referred to drug prices relative to other medical prices.

Sincerely yours,

GEORGE A. SILVER, M.D.,
Deputy Assistant Secretary for Health and Scientific Affairs.

ITEM 3: REPORTS SUBMITTED BY DR. RODNEY M. COE*

THE IMPACT OF MEDICARE ON THE UTILIZATION AND PROVISION OF HEALTH CARE FACILITIES: A SOCIOLOGICAL INTERPRETATION [1]

(Rodney M. Coe, Eugene A. Friedmann, Warren A. Peterson, Jack Sigler, Harold Saunders, Douglas Marshall, and Henry P. Brehm,[2] Midwest Council for Social Research in Aging, Institute for Community Studies)

The enactment of Public Law 89–97—the Medicare Act—in July, 1966, represents a dramatic innovation in the philosophy, scope and procedures for delivery of health care services to the aged population in the United States. As such, it affords a unique opportunity for social scientists to study the processes of social change that simultaneously permits the testing of hypotheses derived from sociological theory and provides information with an immediate importance for application to practical problems. This paper focusses on the development of testable hypotheses concerning the *utilization* of community health resources by older people and the *provision* of these resources by the community.

UTILIZATION OF HEALTH RESOURCES

Initially, our attention was drawn to the potential importance of this legislation by the early predictions—much publicized in the mass media—that local health facilities, especially hospitals, would quickly become swamped with requests for services. This prediction, of course, was based on a kind of "economic man" hypothesis that an increased ability to pay for health and medical care services (provided by Medicare) would lead to (cause) an increased utilization of the facilities and services by people eligible for Medicare benefits. This assumes that for the most part, utilization rates are determined by ability to pay. At a superficial level, some data would suggest that the hypothesis was valid. For example, utilization rates in terms of number of office visits, frequency of hospitalization, etc., do vary directly with amount of family income, i.e., the higher the income level, the greater the utilization (1, 2).

To suggest that this is the whole story, however, is to grossly over-simplify the problem. A considerable fund of research data points to other, more important factors related to utilization. Among them are the perception of illness and subsequent definition of symptoms as illness in need of professional services (3–6). These studies have consistently shown that the perception and meaning of experienced symptoms vary by such factors as age, sex, social class position, educational level, ethnicity, involvement in kinship ties, urban or rural residence, etc. Further, these studies suggest that the appearance of symptoms is not *always* defined as illness, or if it is defined as illness, it is not *always* seen as necessary or appropriate to seek out professional care. For example, some older persons may interpret persistent aches in joints and muscles, sore feet, generalized feelings of weakness as "a part of the process of growing old" and not as illness at all. If these symptoms are viewed as indicating an illness, they more than likely would be treated with home remedies or patent medicines of various sorts. If the individual's condition becomes incapacitating or otherwise prevents the person from engaging in important activities, then perhaps professional medical attention will be sought.

This brief characterization of illness behavior (7–8) and its relationship to utilization of health services suggests at least two opportunities provided by Medicare to answer questions relevant to sociological theory. The first has to do

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*See statement, p. 65.

[1] Revision of a presentation made at the meetings of the Midwest Sociological Society, Des Moines, Iowa. April, 1967. This paper was supported by USPHS Grant Number CD 00244.

[2] Washington University, Kansas State University, Institute for Community Studies, Institute for Community Studies, University of Iowa, University of Wisconsin, U.S. Public Health Service.

with shifts in norms defining appropriate behaviors; the second involves redefining a deviant role as non-deviant.

Normative Change

In the first instance, it is thought that the individual's decision concerning what to do about any symptoms he perceives is guided by norms appropriate to the groups to which he belongs. Thus, if his symptoms are interpreted as inconsequential or as "natural" (i.e., a normal consequence of aging) and appropriate behaviors are defined as ignoring the symptoms or administering self-treatment, that individual will not likely seek out professional care from community resources. It could be hypothesized, however, that one effect of Medicare (conceptualized as an increased ability to pay) will be alter the norms defining the appropriateness of seeking professional care for symptoms that had not previously been defined as illness or illness requiring professional care. If this is the case, the predicted increase in utilization would be expected to occur somewhat later. This, of course, is consistent with a general principle of social change, namely that normative definitions of behavior change more slowly than other elements, say, the acceptance of a technological innovation.

Deviant Roles

In a theoretical context, illness is viewed as deviant behavior insofar as the sick person is unable to fulfill his normal role obligations. The concept of the "sick role" has been described as the mechanism by which groups handle the illness behavior of a member of their group (9). The sick role is, of course, a social role in that it has certain rights and obligations and is related to other, complementary roles. An incumbent of the sick role is temporarily excused from normal role activities and is ordinarily seen as "not responsible" for his illness since disease is viewed as a natural phenomenon. At the same time, the sick person is expected to view his state of ill-health as undesirable and to "want to get well." That is, he should be motivated to return as quickly as possible to a state of being well. In this connection, the sick person is obliged to seek out and cooperate with competent helping agents in the process of recovering good health.

This conceptual framework has, for the most part, adequately explained much of the data collected in research on illness behavior in a group context. Yet there is a growing awareness that the assumptions underlying this conceptual framework are based on the characteristics of *acute* (and often, communicable) diseases, while an increasingly larger proportion of the diseases found in the population have the characteristics of chronic and degenerative diseases (10). Thus, the present conceptualization of the sick role as a deviant role may be inappropriate, i.e., chronic problems are not always incapacitating, thus the sick person may be able to fulfill most of his normal role obligations, at least part of the time. Moreover, it is unrealistic for the chronically ill person to expect to recover fully a former state of good health, but it is likely that he would require more or less continual medical surveillance and episodic treatments for the chronic condition.

Thus the sick role in the case of acute illness is regarded as deviant and the social system acts to separate temporarily the individual from normal role performances until restorative therapy can be applied. The case of *chronic* illnesses would require an entirely different set of definitions and responses because chronic illnesses, by definition, are more or less permanent, enduring conditions and, therefore, *normative* rather than deviant. This would require that the system accept and adapt to the long term limitations imposed by chronic illness of the individual rather than remove him until full capacity is restored; and that both the individual and medical care organizations become oriented to the types of preventive, rehabilitative and maintenance care which the management of chronic illnesses require. Thus, it could be hypothesized that another consequence of Medicare will be the development of a sick role that is defined as non-deviant and which imposes on the incumbent the obligation to seek periodic (and increasingly frequent) treatments from professional sources. At the same time, however, it allows the individual to participate in usual activities with some limitations of capacity. The implications of this hypothesis for illness behavior by the chronically ill and for patterning of medical care services for them are far-reaching and relatively clear. What is not so clear, but will bear watching is the relationship of the redefined "chronic" sick role to the previous one based upon the characteristics of acute diseases. Perhaps, the former will replace the latter. Perhaps, they will exist concomitantly. In addition, a non-

deviant sick role may also have consequences for attitudes toward the aged person on the part of adult children and other family members, health professionals and operators of health care facilities, and on the general population.

PROVISION OF COMMUNITY HEALTH SERVICES

From a theoretical perspective, the effects of Medicare on the provision of health services by the community may be viewed in terms of "institutionalization of need" (11). This is a complex process which, at the community level, involves studying the relationships among service agencies or organizations and interest groups in the provision of services and allocation of clients (patients). Although our prediction is that the need for increased services and facilities will occur after the redefinition of the sick role, the fact is that managers of present facilities are acting *as if* the need will appear immediately due to the increased ability to purchase medical care. That is, they are presently making decisions and plans for the future on the assumption that they are now unprepared to meet an immediate and large demand for their services. Thus, it is appropriate to study these changes in provision now as well as later.

The general question which may be posed is what happens to the community's health resources as a consequence of anticipated increased demand. Initially, it could be expected that communities may seek to (1) increase the types of services offered and extend the scope of present services; (2) shift the focus of present services to cope with the source of increased demand; (3) reorganize its resources to deal more efficiently with all the health demands of its population; or (4) effect some combination of these modes of adjustment. One hypothesis would be that most communities cannot now (1), expand their services, but will prepare to do (2), shift their present resources to cope with one set of problems at the expense of another. Eventually, however, it is likely that (3), reorganization will occur.

The rationale for this hypothesis is fairly straight-forward. It does not seem likely that any appreciable development of new facilities or expansion of present ones will occur immediately. In part, this is because it takes time (and money) to build facilities and recruit personnel to provide the services. More importantly, many facilities presently available are currently operating at less than optimum capacity. For example, the average hospital has about a 75% occupancy rate, thus could absorb some increase in patient load without expansion of physical facilities. However, many facilities do not provide services appropriate for chronic disease problems, especially hospitals geared for short-term care of acute diseases. Expansion of ancillary services for chronic or rehabilitation care is severely limited because of the shortage of trained personnel (12).

It seems more likely that health care organizations will adjust—at least initially—by becoming capable of shifting their present resources to meet the anticipated increased demand for long-term care services. There is some evidence that small (especially rural), acute hospitals become virtual chronic disease hospitals when their beds become filled with older, long-term patients (13). In any cases, it is expected that available resources will be employed as the need arises, but often at the expense of coordinated and comprehensive care.

Finally, in the long run, it is expected that much of the community's resources will be reorganized and more highly coordinated. In the first place, it is likely that new services will be developed which must be integrated into the pattern of existing services. More importantly, the management of problems of chronic disease requires teamwork by a wide range of expert personnel and demands coordination (and cooperation) if comprehensive care as envisioned under Medicare is to be effective.

Just how or in what order these processes will occur or how long they will take is, of course, an empirical question. It does seem likely, however, that the resources presently available to a community will influence the expected patterns of development. In other words, the size of the community, its present health resources and, perhaps, other attributes will be important factors to consider. In this regard, it seems imperative to study the local medical societies as the key to successful resolution of the allocation of resources. In studying these community processes in terms of social change, the medical profession becomes the key either to rapid and effective adjustment to pressures of demands or to a major block to innovation in the reorganization of medical care services.

EXPLORATION OF OTHER ISSUES

There are a number of issues with both theoretical and applied significance besides utilization and provision which are related to the enactment of Medicare. Limitations on space do not permit their full discussion here, but they can at least be noted.

First, there is the question of whether Medicare will act to increase the level (or quality) of care provided. That is, will patients who formerly sought care from faith-healers, chiropractors, and other sources of nonorthodox medicine now take their problems to physicians who are eligible to receive payment from Medicare vendors for their services? Again, the question relates to shifts in normative definitions of appropriate sources of help for health problems.

Secondly, will Medicare affect the ideological underpinnings of the delivery of health care services? Management of chronic diseases has largely occupied a residual category in priorities of profesional commitment. Will it now begin to assume equal status with the more traditional orientation towards treatment of acute problems? If so, there may be a subsequent redefinition of the objectives of long-term care facilities from custodial to a more therapeutic orientation.

Third, and also related to ideology, can it be expected that our basic philosophy concerning the payment for medical care services will change? Certainly it is unlikely that physicians will give less than their best to patients regardless of how they are paid for their services. Moreover, we are predicting a rational increase in utilization that, with coordination and planning, can be managed by the community. Thus, the major consequence of Medicare should be an increase in *availability* and *accessibility* of services for the aged population and it is, therefore, likely that the mechanism of subsidized care may be eventually extended to all population groups.

Finally, but not exhaustively, will Medicare effect an improvement in the physical (and, perhaps, mental) health status of the older age group? If so, the principles of more or less continuous medical surveillance and frequent treatment in the early stages of the disease process may have some impact on the demand for preventive medical care which, if extended to the general population, would benefit the nation as a whole.

NOTES

(1) Anderson, O. W., Collette, P., and Feldman, J. J., *Family Expenditure Patterns for Personal Health Services.* Chicago: Health Information Foundation, Research Series 14, 1960.

(2) U.S. Department of Health, Education, and Welfare, *Age Patterns in Medical Care, Illness and Disability.* National Center for Health Statistics, Series 10, #32, Washington, D.C., June 1966.

(3) Koos, E. L., *The Health of Regionville,* New York: Columbia University Press, 1954.

(4) Suchman, E. A., "Sociomedical Variations Among Ethnic Groups," *American Journal of Sociology,* 70 (November, 1964), 319–331.

(5) Freidson, E., *Patients' Views of Medical Practice.* New York: Russell Sage, 1961.

(6) Straus, A., "Medical Ghettos," *Transaction,* 4 (May 1967), 7–15, 62.

(7) Mechanic, D., "The Study of Illness Behavior: Some Implications for Medical Practice," *Medical Care,* 3 (January–March 1965), 30–32.

(8) Suchman, E. A., "Stages of Illness and Medical Care," *Journal of Health and Human Behavior,* 6 (Fall, 1965), 114–128.

(9) Parsons, T., *The Social System,* Glencoe: Free Press, 1951, esp. Chapter X.

(10) Zola, I. K., "Needed Problems of Research," National Tuberculosis Conference, Chicago, 1964.

(11) Peterson, W. A. and Zollschan, G., "Social Process in the Metropolitan Community," in Rose, A. M., (editor), *Human Behavior and Social Processes.* Boston: Houghton-Mifflin, 1962.

(12) Rice, D. K., "Organizational Patterns of Care for the Chronically Ill," Medical Care Research Center, St Louis, 1963.

(13) *Ibid.*

ITEM 4: MATERIAL SUPPLIED BY DR. MILTON I. ROEMER*

A—NEW PATTERNS OF ORGANIZATION FOR PROVIDING HEALTH SERVICES[1]

(By Milton I. Roemer)

(*Reprinted from* Bulletin of the New York Academy of Medicine, Second Series, vol. 42, no. 12, pp. 1226–1238, December 1966, Copyright 1966 by The New York Academy of Medicine)

The economic and legislative foundations of a steadily increasing demand for health service have been reviewed by other speakers at this conference. Even if medical technology had been standing still, the very volume of this mounting demand would compel us to find more efficient ways of meeting it through a given supply of personnel and facilities. But the vast growth of scientific potential has compounded the problem; the galaxy of specialized skills and instrumentation require organization if they are to be delivered at all. On top of this, the enlargement of democratic humanism has put further stresses on our health service system; expectations of more and more sensitive patient care have created—paradoxically to some—still further requirements for social organization of services.

These four sets of pressures—economic, legislative, scientific, and humanistic—have induced responses in the social institution of medicine in scores of ways. They can be classified, I think, in terms of five levels of medicosocial structure: 1) individual medical practice, 2) organized ambulatory service, 3) hospital organization, 4) interhospital systems, and 5) state and national governments. There is a stream of increasing social responsibility for health services along these five levels of increasingly collective action. Within each level, furthermore, there is evidence of systematization of health functions to higher degrees.

INDIVIDUAL MEDICAL PRACTICE

Despite the basic trends just outlined, at this point in history the prevailing pattern of personal health service in the United States is still the individual doctor in a private office. This is by no means true on a world scale, and the rate of change in the United States is rapid, but the independent private medical or dental practitioner is still the commonest model in the country. Yet, within this basic model, the evolutionary ferment is clear.

The general physician who practices in true isolation has become a rare bird. In the great majority of offices are medical aides, some of whom are registered nurses. The specialist may have a laboratory or x-ray technician or a physical therapist. Equipment may be elaborate and record systems well developed. The office assistant may take the patient's history through a standardized form, like the *Cornell Medical Index*. It is commonplace for several clinical rooms to be in use, so that one patient is being examined while another is disrobing. The telephone is, of course, a powerful channel to the patient at home. These and many other measures are forms of organization of the individual physician, whether in general or specialty practice.

The proportion of individual practitioners who share office suites is continually rising. A recent national survey by *Medical Tribune and Medical News* reported that 46 percent of doctors have shared office quarters, with higher proportions among the young, among specialists, and in the Western states. In the larger cities, office sharing is getting to be the general rule. Although patients and incomes are quite separate, waiting rooms, clerical files, laboratory or x-ray apparatus may be fully shared. Usually these shared facilities serve two or three specialists in the same field, sometimes in complementary specialties. If one doctor is away, his suite partner may cover for him. At a more elaborate level is the "medical arts building," where a score or more of independent doctors are served by a private laboratory, and perhaps an optometrist or physical therapist, in the same building. A pharmacy on the ground floor is an obvious convenience for patients. One study of such buildings in Washington, D.C., moreover, found 68 percent of the doctors in them to be in "associated practice," ranging from office sharing to full partnership.

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*See statement, p. 80.

[1] Presented in a panel discussion, Staffing for the Expanded Health Programs: Problems of Utilization and Supply, as part of the 1966 Health Conference of The New York Academy of Medicine, *New Directions in Public Policy for Health Care,* held at the Academy, April 21 and 22, 1966.

Aside from these physical forms of coordination of solo practitioners, there are functional relationships through a variety of influences. Attachment of the large majority of practicing physicians to one or more hospitals brings them into frequent contact with others. Channels of specialty referral develop through these connections. The medical society or academy serves a similar purpose. Postgraduate educational programs sponsored by voluntary health agencies or medical schools, as well as hospitals and medical societies, are further antidotes to isolation.

Thousands of individual practitioners spend some hours each week at part-time salaried posts in various organized programs. *Medical Economics*, the magazine, estimates that 65 per cent of practicing doctors have some such appointments in public health clinics, industrial medicine departments, Veterans Administration facilities, schools of medicine, voluntary hospitals, insurance companies, and the like. Another study of that magazine reports that about half of the 64-hour working week of the average practitioner is spent in activities other than direct patient care in his office. It is interesting to observe in the biographical notes of the *Directory of Medical Specialists*[2] the multitude of connections with organized programs that each diplomate proudly claims. The education of the physician, of course, is almost entirely carried out through such social frameworks. When the private doctor, furthermore, serves a patient with an industrial injury, a crippled child, a home-town veteran, or even a Blue Shield plan beneficiary—even though he holds forth in a single office—he articulates with an organized system of health service.

ORGANIZED AMBULATORY SERVICE

The impact of organization on the performance and behavior of the doctor is greater at the next level in our typology. When groups of three or more physicians form a team for coordinated services to the individual patient, the rationalization of medical and surgical specialties can be much greater. There are all degrees of group practice, and much depends on the range of physicians of different specialties involved, as well as the system of income sharing. A medical group can make fuller use of auxiliary personnel and expensive equipment. When group practice embodies a full sharing of earnings, the dysfunctional incentive to "hold onto" patients is replaced by uninhibited referral, but the opposite evil of excessive and expensive work-ups may result. When it is combined, however, with prepayment by a population, the economic incentive favors both economy and quality of care—as shown in several comparative studies.

The movement to coordinated medical teams for ambulatory patient care takes various forms throughout the world. In the underdeveloped countries it is the standard pattern in larger cities. The Chilean National Health Service provides ambulatory service through health centers staffed by a range of specialists and paramedical personnel. The polyclinics of Germany or the Soviet Union have long embodied this concept, as do similar facilities in Israel, Yugoslavia, or Japan. In Great Britain or Scandinavia, the multispecialty clinics are nearly always attached to hospitals, as in the outpatient departments in this country, but their services are, of course, not confined to the poor.

The growth of private group medical practice has probably been more rapid in the United States in recent years than is generally recognized. The count of organized groups by the U.S. Public Health Service in 1949—using the definition of three or more physicians with some form of shared income—found only 368 such entities. In 1959 the count was 1,546 such practices. But in 1965, when a national inventory of virtually all physicians was made by the American Medical Association, Chicago, Ill., it was revealed recently that 5,450 group practices were identified with about 26,000 physicians. This is about 15 per cent of all doctors in community practice. In the Western states, where traditions are younger, the growth of group practice is very prominent.

Programs serving special populations have developed teams of physicians for ambulatory care outside of private practice. The Veterans Administration operates free-standing multispecialty clinics in most large cities. Industrial medical care programs, since the pioneering of the Endicott-Johnson Shoe Corporation, Binghamton, N.Y., do likewise, especially in large enterprises such as public utilities or railroads. The ordinary public health clinic for children or mothers, for tuberculosis, venereal disease, or cancer detection is not to be overlooked in an

[2] Published for the Advisory Board for Medical Specialties, Inc., by Marquis-Who's Who, Inc., Chicago, Ill.

accounting of organized ambulatory services. And recently, the antipoverty program has broken precedent with establishment of comprehensive medical care centers in numerous blighted urban or rural sections.

The well-organized group practice clinic is able to introduce services difficult in a one-man office. Multiple screening procedures for early disease detection, handled mainly by paramedical personnel, are quite feasible. A visiting nurse, social worker, psychologist, or rehabilitation therapist, can be readily employed. Health education can be offered. The family physician, of course, can be backed up by appropriate specialists not only at critical stages of illness (common enough in solo practice) but all along the way. These more comprehensive services can be offered at lower costs because of economies of scale, although these savings are often translated into higher medical incomes rather than lower patient fees. The reality of the savings has been well demonstrated in the economic achievements of organizations such as the Kaiser-Permanente medical care plan.

Some of the larger ambulatory care clinics have sprouted branch clinics in metropolitan areas. The pioneer prepaid Ross-Loos Medical Group in Los Angeles, Calif., now has 12 satellite units. Branches are also being established by purely fee-for-service medical groups. In such clinic networks the scarcer specialists serve patients from any branch unit. Group practice is probably the most feasible way to adjust for the steady decline in general practitioners, while still meeting the psychosocial needs of patients. The recently proposed federal legislation for encouraging construction of group clinics through mortgage insurance and low-interest loans will, if enacted, doubtless accelerate the whole trend.

HOSPITAL ORGANIZATION

General hospitals served as a setting for systematic organization of medical care centuries before community medical practice. From the beginning, hospitals have brought together many types of medical workers and equipment. Since about 1900 the rate of hospital organization has accelerated everywhere.

The European hospital has always been essentially a public place, staffed mainly by physicians attached to the organization. We take this for granted in mental hospitals, but in other countries it has been the prevailing pattern for general hospitals as well. In the United States, the trend within general hospitals has been in the same direction, although the form taken is different. Departments and committees, appointment procedures and by-laws, clinical conferences and medical audits—all these measures of group discipline heighten the social controls in medical staffs. An increasing proportion of physicians working in hospitals are being appointed through some form of contract, under which their rewards come from the hospital organization rather than the private patient. These include not only radiologists and pathologists (about whom we hear so much controversy), but directors of medical education, researchers, outpatient department directors, and full-time members or chiefs of clinical departments.

Our own research in this field suggests that hospitals with a higher proportion of contractual physicians, even when correction is made for hospital size, are more likely to be providing the full gamut of services expected of an ideal institution. These hospitals are more likely to be offering education to interns and residents, to be doing research, to be engaged in preventive medicine (e.g., routine chest x rays), to be operating strong outpatient departments or coordinated home-care programs, to be admitting psychiatric cases, to be furnishing newer modalities such as intensive care or rehabilitation services.

The spectacular growth of hospital "emergency-room" services in recent years is an important straw in the wind of medicine in the United States. Relatively few of the patients coming to these units are genuine emergencies; they are mainly sick people who want attention and feel that the hospital—rather than a private medical office—is the place to get it swiftly and competently. Hundreds of hospitals with no previous organized outpatient clinics have had to set up special medical staff patterns to cope with the demand. In spite of the extension of the "free choice" pattern in welfare medical programs, the American Hospital Association, Chicago, Ill., reports total (i.e., both emergency and formal clinic) outpatient visits to have reached an all-time high in 1965. The rate of approximately 8,000,000 visits per month indicates that such services now constitute about 14 per cent of all doctor-patient contacts.

Here and there a full group-practice clinic is attached to a hospital, and some of the largest (such as the Ochsner Foundation Hospital in New Orleans, La.) operate their own hospitals. Private doctors' offices in a medical arts building near

the hospital or even in an attached wing are becoming more frequent. Large prepaid group practice plans, such as Kaiser-Permanente and those in Seattle, Wash., and Detroit, Mich., also provide comprehensive care through their own hospitals. Medical schools and their teaching hospitals have been slow to affiliate with health insurance plans, but the need for a balanced population to teach medical students properly is arousing increasing interest in such affiliations.

A major force for enriching the structure of medical staffs in hospitals has been the Joint Commission on Accreditation of Hospitals, Chicago, Ill. The requirements of the Council on Medical Education and Hospitals of the American Medical Association, for approval of internship and residency programs, has been another positive extramural influence. The quality of medical staff leadership itself, of course, can be decisive, and physicians seem to be increasingly sensitive to the responsibilities of such leadership. Medical performance is also influenced by a board of directors, especially if it is oriented by an imaginative administrator. Indeed, the whole temper of modern hospitals has been vitalized by the professionalization of the discipline of hospital administration.

The new Medicare law is confined largely to the aged and the indigent, but it has other specific implications for hospital organization. Aside from general certification—which should lead to an upgrading of customary state hospital licensure standards—the special requirement for a "utilization review" process will doubtless enhance medical staff self-discipline. The relatively generous support for "home health services" under the new law should stimulate the expansion of organized home-care programs based in hospitals and other agencies. While the focus of these programs has been largely on the care of chronic illness, their long-run significance may be greater by way of extending hospital influence over day-to-day community medicine in all fields.

It has become trite to say that the hospital is increasingly becoming the health center of the community, but the full significance of the statement is not always realized. It is not only the hospital's functions in patient care, professional education, and research that shape its central role. It is its capacity for *organizing* a symphony of skills around patients—both in bed and on foot—that gives it force in the total span of health service. This includes the ambulatory services generally and the preventive services. Such scope is seen more clearly in Chile, Brazil, the Soviet Union, India, or even Ethiopia, where the public health services and the ambulatory care services for a district are often headquartered at the general hospital. In the United States, such curative-preventive unification is seen only in 40 or 50 counties where local health departments and local governmental hospitals are under the same physical and administrative roof. But the movement in this direction is more than meets the eye, as the "public utility" character of hospitals, on the one hand, and the necessity of public health agency involvement in medical care, on the other, become more widely recognized.

INTERHOSPITAL SYSTEMS

More recent and more spotty than the increased organization within hospitals—but perhaps more important in the long run—has been the movement for enhanced relationships between hospitals. Within cities or larger geographic regions, these relationships have taken many forms.

It was the National Hospital Survey and Construction Act (Hill-Burton) in 1946 that launched on a nationwide scale the concept of planned hospital networks in geographic regions. As a device for alloting federal subsidies for needed construction, each new hospital as well as each approved existing hospital had to have its theoretical place in a system of "community," "intermediate," and "base" facilities. In such systems patients would be referred from the periphery inward and consultant services from the center outward. Every state drew its "master plan," and the maps enabled state hospital agencies (usually in state health departments) to make reasonable decisions on subsidized construction, even though day-to-day hospital operations rarely corresponded to the image of the maps.

In spite of the disparity between theory and reality in the Hill-Burton regional plans, the isolation and sovereignty of individual hospitals have been reduced in many ways. State hospital associations have brought administrators and trustees together to discuss common problems. Radiologists, pathologists, and physiatrists based at a large hospital often render part-time services in smaller hospitals nearby. Schools of nursing enrich their training programs by affiliations between hospitals and exchanges of students. Recruitment and training of per-

sonnel, bulk purchasing of certain supplies, negotiations with third-party payers (Blue Cross or governmental agencies), and other administrative functions are often carried out jointly by the hospitals in a region. Postgraduate education of medical staffs has been greatly facilitated. The most impressive demonstrations of such regional interhospital cooperation have been in foundation-supported programs radiating from Boston, Mass., and from Rochester, N.Y.

Within metropolitan areas, the tempo of interhospital councils has been higher than in larger geographic regions. Most of the nation's great cities have set up councils whose primary objective has been to exercise direct or indirect control over new hospital construction (independent of the Hill-Burton program), but usually bringing about other administrative liaisons as well. These metropolitan hospital councils are composed in a variety of patterns, representing different blends of large industrial donors, hospital administrators, medical leaders, Blue Cross executives, and so on. In the last few years, federal grants for "areawide planning" have given a further boost to these local efforts. Their long-run significance doubtless extends beyond the capital cost problem, which has usually stimulated them, toward genuine coordination of hospital services.

The advantages of large-scale operation have led to outright merger of several groups of hospitals in cities such as Newark, N.J., Wilmington, Del., and St. Louis, Mo. The administrative marriages of several pairs of voluntary and municipal hospitals here in New York City are well known to this audience. Within particular religious sponsorships— Catholic, Jewish, Lutheran, and so on—various forms of integration, ranging from simple cooperation to full merger, have been growing for years. The goal of these relationships is often to develop first-class centers embodying the ultimate in scientific technology, with or without medical school affiliation. The university medical centers, in the meantime, have also expanded, bringing under their wing specialized hospitals for children, for mental disorder, for chronic disease, for orthopedic conditions, as well as the older general hospital at the hub. They are offering an increasing range of postgraduate instruction to physicians practicing in the surrounding area. Professor Thomas McKeown of England has spoken of the "balanced hospital community" in which patients are flexibly transferred to the type of facility that meets their needs rather than kept in the one they happen to enter initially. This is basically the goal of any regionalized hospital system, but it is more readily attainable within a multidivisional medical center.

These varied expressions of interhospital cooperation have one thing in common, they embody an increasing organization of skilled and scarce medical resources to meet needs with optimal quality and economy. Whether the goal is achieved or not there is no doubt that some form of organization, as distinguished from sovereign individualism, is the path toward it.

The new Medicare law has two provisions specifically designed to promote further such interfacility relationships. The mandatory "transfer agreements" between extended care facilities and general hospitals, as a condition for participation, have been discussed by other speakers. The second provision is the assignment of a specific task of "coordination" to the state health agencies. This may be expected to encourage better relationships in the full continuum of health service, from organized home care through the intermediate levels to the complex medical center.

A more direct legal push to the interhospital coordination movement is given by the 1965 federal amendments on "heart disease, cancer, and stroke." The focus of attention in this law on the three leading causes of death in the nation is obviously only a means to the end of promoting "regional cooperative arrangements" between medical centers and peripheral hospitals for research, training, and "related demonstrations of patient care." I believe we may look upon this law as the 1966 approach, on a functional level, to the regionalization idea launched, on a structural level, by the Hill-Burton Act 20 years ago.

STATE AND NATIONAL GOVERNMENTS

Interwoven among the four levels of medical-social organization we have briefly discussed is a widening role for state and national governments. Within individual medical practice, the basic licensure laws exert their influence, as do the food and drug control laws, the malpractice statutes, and enactments such as the 1965 medical disciplinary measures in California. At the level of organized ambulatory service, government has been relatively timid, but we are now seeing

more interest on the part of Congress in bills to promote the extension of group medical practice. Senator H. A. Williams, Jr.'s new "Preventicare" bill on organized multiple screening centers is another augury. As in internal hospital organization, the impact of government has been extensive through the hospital licensure laws, the Hill-Burton Act, and the quality standards demanded of many programs for defined beneficiaries such as crippled children or compensably injured workers. At the level of interhospital networks, the influences of government have just been mentioned.

Beyond these four levels, national and state governments are influencing the ultimate patterns of health service in other far-reaching ways. The whole underpinning of economic support for health care—through general revenues or social insurance—means more than dollars. If due only to elevated utilization of service, the medical and hospital resources of the country are daily influenced by publicly financed medical care programs. Beyond the quantitative pressure is the impact of qualitative standards imposed on providers of service under these programs. Public agencies are, in effect, becoming a mentor to the patient in his choice of doctor or hospital "free choice" is being replaced by guided choice where technical sophistication is required for intelligent decision.

Government is also influencing patterns of care indirectly through its strong support of medical research. Advanced technology leads to changed social adjustments in spite of the usual cultural lag. Research on patterns of health service organization itself is also financed by government, and its impact may be seen directly in the fashioning of new programs; Medicare is one such product of years of data gathering and analysis. Government support of professional education, of course, has further influences on the quality of medical care.

The whole public health movement, in local, state, and national governments, also affects patterns of personal health service. Environmental prevention, of course, changes the spectrum of disease, reducing the infections and contributing to the higher burden of chronic metabolic disorders. Mass case-finding programs detect cases that are referred to personal physicians. Health education induces people to live hygienically and to seek attention for suspicious symptoms. School health examinations direct many handicapped children to the doctor's office.

Several governmental programs, of course, operate as separate and parallel systems of health services. The Veterans Administration, the Indian and merchant marine health service, the state mental and tuberculosis programs, the municipal or county hospitals for the poor—these entities maintain their own personnel and facilities. While these programs are often contrasted with the so-called mainstream of United States medicine, one must not underestimate their importance; they affect millions of people according to highly structured patterns of medicine. Whether the quality of care is conceded to be high, as in the Veterans Administration system, or low, as in most state mental hospitals, these programs are part and parcel of health services in the United States. They preempt a substantial sector of health needs into frameworks organized at both the ambulatory and hospital levels.

Beyond these various specific roles of government, there is a further over-all role of which we may expect to see more in the future. "Planning" is no longer a dirty word in our political vocabulary, and it is being undertaken increasingly by local, state, and national governments. It has been done for years in such fields as transportation, public power systems, city zoning, education, agriculture. It has been done informally by the more imaginative public health officials on problems of environmental sanitation, child health services, chronic disease control, accident prevention, or home nursing. Now we are coming to a time when the over-all planning of health services will probably be a designated task of government at all levels; a bill introduced in the U.S. Senate a few months ago provides for ear-marked grants to the states for such purposes. In some form or other, over-all governmental health planning is bound to arrive eventually.

SOME ISSUES

Several questions arise from this review of the five levels at which new patterns of health service organization are evolving in our society. I should like to close these remarks with consideration of just two of them.

One concerns the issue, alluded to briefly, of segregated medical care systems versus the "mainstream of medicine" approach. Segregated programs have often meant poor quality care, epitomized perhaps in the crowded public clinic for the poor. It is easy to see why clinic attendance has implied second-class citizenship

and why many organized programs have favored the use of public moneys to channelize patients to private medical offices. Such offices, however, are far from guarantees of good medical care; welfare clients with "free choice of doctor" may be badly served, as any physician in welfare medical administration knows. On the other hand, a public clinic may give first-class service if it is adequately staffed and supervised, as it often is at good teaching hospitals.

The dilemma, it seems to me, is not insoluble. Segregaton and mainstream patterns alike are poor if they lack resources and standards. Both can be good with adequate resources and standards. The segregated system, however, runs the constant political danger of weak economic support—hence meager resources. There are also undemocratic overtones. The task, then, is to move toward a single mainstream of personal health service for all persons in the United States, but to upgrade its quality continuously. This can be done only by ample economic support, sound technical organizations, and carefully supervised standards. Such influences will change the character of the mainstream while widening its encompassment.

The second issue concerns personal freedom of patient and doctor, which is so often alleged to be reduced by all the organization of health services we have reviewed. The burden of proof, it seems to me, is on those who repeat this cliché. It is hardly reasonable to express pride in the medical and health records of the United States and, in the same breath, to regret the social organization of the past and to oppose the social trends of the future. The scientific achievements of United States medicine are not matters divorced from social organization; they have been largely products of such organization. The reduced mortality and increased longevity are of similar derivation. The professional effectiveness of United States doctors, both in the quantity and quality of their output—not to mention their personal affluence is not independent of health insurance and public health and hospitals, but is largely attributable to them.

Where, then, is the loss of personal freedom from social organization? Is the child immunized in a public clinic less free because he is spared from diphtheria or poliomyelitis? Is the veteran served by a surgeon in a government hospital less free because the Veterans Administration requires that the doctor be board-certified to do the operation? In today's complicated world, one must conclude that organization is not merely consistent with personal freedom; it is a requirement for the attainment of that freedom. Others may argue the issue in other spheres of life, but in the health services the evidence is overwhelming. Social organization has moved us forward toward greater personal freedom. There are still many gaps and problems, but they will be resolved in the future as they have been in the past, by further organization of our resources in men, things, and knowledge.

B–Some General Considerations of Long-Term Illness From the Public Health Point of View*

(By Milton I. Roemer, M.D.[1])

Extent of the Problem

The successes of public health and the elevation of our standard of living have resulted in a high proportion of older age groups. The laboratory and clinical scientists are yet to tell us the many reasons for this, but that chronic illnesses do occur more frequently in the older age groups is perfectly obvious. The best data we have today on the extent of chronic illness in the population are the findings of the continuing National Health Survey.

Perhaps the simplest unit of measure of the problem of long-term illness is the one developed by the National Health Survey in terms of "restricted activity days." Examining a substantial sample of the non-institutional population in the United States, we find that there are for every 1,000 persons approximately 2,500 days of restricted activity per year with respect to circulatory disease, about 1,000 days for digestive disorders, 1,300 days for arthritis and rheumatism, 700 days for impairments following from injuries, 970 days for "other impairments," and 4,800 days for all other chronic conditions. These figures cannot be totaled, since there are duplications of more than one illness in the same person. However,

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*Reprint from The Gerontologist, Vol. 4, No. 2, Part II, June 1964.

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assuming an overlap of approximately 25%, we would come to a figure of about 8,500 days of restricted activity in the United States per 1,000 persons per year with respect to chronic disease. This is undoubtedly an understatement, since it does not include the institutional population. Another problem, of which the National Health Survey staff is very much aware, is the number of these who have died within the past year. There are also major omissions in the field of mental disorders. But even with this conservative estimate, at a figure of 8,500 days of restricted activity per 1,000 persons per year, the problem of chronic illness exceeds that of the aggregate of all acute illness.

As for the mortality as a measure of the extent of the problem, the chronic disease issue is far greater. Among the leading 20 causes of death, illness which during life was chronic accounts for something like 18 or 19 of the causes, depending upon how we classify a condition like pneumonia, which is often a terminal event in a chronic disorder. Accidents are almost the only cause of death of any significant proportions in the United States today which are not a chronic disorder, and in old people even accidents are often indirectly related to chronic illness.

The social problem of chronic illness is compounded by the fact that it not only affects many people and makes their lives difficult and creates burdens for those around them, but it constitutes a problem of high costs. The mere duration of the illness means long-term medical care. And so, largely because of its economic impacts, chronic illness has become a major medical-political issue of the day. Every significant political group in the country is debating ways of coping with the economic problem.

Much progress has already been made in coping with these economic aspects of chronic illness, through the extension of various programs of governmental or public medical care. The municipal hispital, the programs for crippled children, the Veterans Administration Service, the mental and tuberculosis hospitals, the vocational rehabilitation program, a major share of the medical service provided under public assistance, the largest sector of which is the old-age group—these programs are all largely oriented to meeting the economic costs of chronic illness.

Primary Prevention

From the public health point of view, we conventionally speak of various levels of prevention. One level is primary prevention. This means, in its original sense, doing somthing before the person has signs of illness. A tremendous amount reasearch is being done today on the ultimate instrument of prevention, the determination of etiology Epidemiological studies, both in the field and in laboratory investigations, are being purused rapidly with respect to heart disease, cancer, arthritis and other major chronic diseases.

In actual operation, there have been many accomplishments. The development of immunization against poliomyelitis has been a major success in the reduction, through primary prevention of paralytic polio, formerly a major chronic illness. The tuberculosis control program has likewise been largely successful in the primary prevention of this chronic disease, mainly through elimination of infectious cases by institutionalization. The same is true of venereal disease. For the last 6 or 8 years there has been a rise in venereal disease again, a relatively small rise if you take as your bench mark the situation 30 years ago. However, the general trend has certainly been a long-term reduction in acute cases and particularly the chronic sequelae of syphilis and gonorrhea.

With respect to cancer, we have learned an enormous fact in the association of tobacco and cancer of the lung, now the major cause of cancer in males. Far less has been done with this knowledge than many of us would like to see, but we have an instrument for primary prevention of cancer of the lung which can be more fully exploited in the years ahead. Some of the rarer cancers relating to occupation, in the dye industry and in other industries dealing with various hydrocarbons, have been successfully reduced by occupational hygiene. In the field of arteriosclerosis, we are on the verge of some type of consensus on etiology. The new knowledge about fat consumption and exercise may provide clues to measures for primary prevention of the major cause of death in the United States today, arteriosclerotic heart disease. There is certainly a tremendous amount of presumptive evidence that points to a combination of culprits: the fatty composition of the diet, the extent of exercise that a person engages in, the element of stress.

With respect to congenital defects, another major type of chronic illness, our knowledge of the problem of radiation has grown rapidly. We are certainly far

more cautious than in the past about use of man-produced radiation because of its possible effects in leading to congenital disorders the next generation.

As for chronic bronchial disease, bronchitis and emphysema, we certainly have accumulated evidence on the role of atmospheric pollution. We are beginning to do things in the field of smog control and on the general problem of atmospheric pollution which may have future benefits in the primary prevention of this type of disorder.

These are some of the direct measures of primary prevention. There are also many indirect actions which have probably led to a reduction of chronic disease. The general reduction in streptococcal infection because of drug therapy may well be responsible for the appreciable decline in rheumatic heart disease, once a major form of heart disease and now relatively uncommon. There has certainly been a reduction in osteomyelitis, which was a relatively common cause of locomotive disorder in past years, and in problems of mastoiditis and other infections. These complications caused by bacteria are less frequent today, largely because of the antibiotic drugs. The improvement of obstetrics and perhaps better prenatal care has led to a reduction of those congenital disorders associated with the birth process.

We have knowledge about obesity, which is not being very well applied. Some health agencies, however, are using education and special clinics to attack the problems of obesity with its associated diabetes, gall bladder disease, and, to some extent, cardiovascular disorder.

Early Detection of Disease

Unfortunately, much of what can be done today for chronic illness is not confined to primary prevention but must depend on a less direct method of prevention. It involves the early detection of the disease and the application of prompt therapy, on the grounds that if a disorder is detected early, its therapy can be more effective. Health departments and other agencies are doing a great deal about the early detection of diseases—diseases which might become chronic. The chest X-ray for tuberculosis and other conditions of the chest, including cardiac enlargement, is widely practiced. Case-finding methods for syphilis, of course, have been long practiced through blood tests, and examination of the blood and urine for glucose as an early method of detecting diabetes is widespread.

Cancer detection through formal clinics and through education of people—self-examination of the breasts in women, for example—has been widely extended. The extension of cytology for uterine cancer, the Papanicolau smear, and to a lesser extent the use of this technique on the sputum as a method of early detection of lung cancer, are important approaches. The early detection of glaucoma through examination of the eye pressure and through vision tests is another measure. Streamlined medical histories have been developed for simplifying the examination of large numbers of people, with respect to early symptoms of many chronic diseases.

These and other measures for early detection of chronic disorder require organization. One approach has been the use of multiphasic screening or combinations of various detection tests as a public health activity. Such programs are being practiced in industry and in many public health agencies.

The simple every-day practice of most hospitals, a work-up on all patients admitted, is a major measure for early detection of chronic disease. Almost one out of eight people enters a hospital in the United States each year, and among the older adult population the proportion is higher. The performance of a simple medical history, physical examination, and routine laboratory tests on these people constitutes a major approach to the early detection of chronic disorder. Payment plans, which are covering an increasing proportion of the population, also often provide encouragment for general medical examinations as a benefit of membership.

Prompt Medical Care

The next level of action against chronic disease from a public health point of view is the provision of early therapy. The procurement of medical care, following the detection of a possible sign of an illness, involves three sets of problems: cost, motivation of the patient, and organization of services.

To cope with the *cost problems* a great deal has been accomplished, although more remains to be done. The health insurance movement is a major contribution to the attack on chronic disease, by its effectiveness in easing the access of people to prompt medical care. It is a central feature of the public health approach to

the problem of chronic illness. In just the past 20 years, health insurance has grown to a point where over 70% of the American population is now protected by some form of insurance for hospitalization, and probably some 50% with respect to physician's care. In the rapidity of this growth, we have acquired types of health insurance that leave something to be desired in their concern for the qualitative content of the service provided. The largest form of health insurance in the United States today is that carried by commercial proprietary insurance companies, and this is a form in which the cost problem is met but with very little concern for the content of service purchased. We have a long way to go in improving the level of professional surveillance over the type of medical care that is financed by insurance programs.

Public medical care for the indigent, which is being improved and extended, is another way of coping with the cost problem of chronic illness. Probably the major political issue in the health field today is the problem of costs of hospital care for aged persons. We have had limited progress in the Kerr-Mills bill passed in 1960, but the issue is still very much alive.

Regarding *motivation*, we know that the problems of procuring medical care is not just a question of providing payment for services. People must be educated and motivated to use them. In many medical care programs, those for the indigent as well as health insurance programs, even when costs are met there are still many people who do not use the service. This may be a problem of education. It also relates to the physical convenience of medical care facilities, particularly in very large cities, where the task of intra-city transportation is great. It is also true, of course, in rural areas. Social scientists are doing a great deal to examine the feelings and attitudes of patients in the doctor-patient relationship. Most studies have shown that a major factor in the patient's willingness to see a physician, and his response to the instructions of the physician, is the patient's feelings about how the physician regards him as a person.

Regarding the *organization of services* for more effective application of therapy after the disease has been detected, we have seen tremendous progress in the field of medical services within hospitals. Hospital organization in the United States has improved very rapidly in finding ways to apply known techniques systematically. We see increasing use of consultations in general hospitals. We see many special measures like intensive care units, special rehabilitation units, more skillfully organized nursing services, etc. The field of physicians' self-discipline through medical staff organization in hospitals is receiving increasing attention. In the hospital setting, physicians are organizing themselves in a teamwork arrangement which is making possible a high quality of medical care.

Institutional care and rehabilitation

Next in the levels of prevention is the problem of the patient in whom primary prevention has failed, and in whom prompt diagnosis has not resulted in effective therapy, so that he continues with his chronic disorder and becomes confined to bed. Even at this stage, there is still room for some effective action from the public health point of view. Something can be done to reduce disability and to extend life. There is very rapid development of interest among general hospitals in special units for long-term patients. The Medical Care Research Center in St. Louis is conducting a major study on the details of long-term care units in general hospitals throughout the United States (see page 34). The "progressive patient care" concept of hospital organization has gained acceptance as a way of reorganizing according to the level of bed care or ambulatory care that the patient may need, rather than strictly according to pathological diagnosis.

Institutional care for those who do not need the active level of service of the hospital is being rapidly expanded through tens of thousands of nursing homes, convalescent institutions, and special wings of homes for the aged. This field has grown rapidly, however, that there is a woeful lack of quality standards in nursing homes, most of which, in this country, have proprietary management, but at least the problem has been recognized. There is now a new national association tackling this problem, in the same way that the hospital movement and the various professions have tackled the problem of standards and discipline in their own ranks.

As for other types of disabled patients, the hospitals have taken initiative in developing care for the bed patient at home. "Home care programs" are now part of the everyday vocabulary in the hospital field.

Many other forms of organized activity are coping with the problems of the bed-patient at home. The visiting Nurse Association, the homemaker services, the

extended bedside nursing services of the Health Department are all measures for providing more effective care of the bed-patient at home.

Finally, when all this has been done, we must still face the problem of rehabilitation of the disabled patient, to help him get back on the job.

Coordination

The panorama of activities which represent the public health approach to chronic illness involves problems that are enormously complex, administratively and economically, and also psychologically and culturally, and in every community the tying together of thes activities presents a large task of coordination. It is a task of bringing together all of the activities, public and private, including the voluntary health insurance movement, the governmental programs of medical care, the hospitals and the other voluntary agencies—bringing them together for a coordinated attack at all the levels of prevention of long-term illness that we have discussed. There are hundreds of councils and committees now functioning in communities to cope with the needs of the long-term patient. What is needed is a permanent, continuing, and well-staffed agency to concern itself with the coordination of these many measures of attack on long-term illness, and the logical agency to provide leadership toward that objective is the local Department of Health.

C—Health: Can We Afford To Meet the Needs?*

(By Milton I. Roemer, M.D.)

This paper was prepared for presentation at the Louisiana Conference of Social Welfare, New Orleans, March 19, 1964. The author is a member of the faculty of the School of Public Health of the University of California, Los Angeles.

Future historians, I think, will look back upon the nineteenth and twentieth centuries as the time when man was struggling to act upon the precept that he is, indeed, his brother's keeper. They will see evidence of this struggle in the great convulsions of international affairs and in the birth pains of a United Nations that is truly united and in the maturation of a world government. They will see it in the development of a vast industrial technology and system of agriculture, the products of which are distributed to meet the needs and reasonable expectations of people. They will see it in the gradual extension of education to whole populations, not only in the childhood years but throughout life, in order to enrich the meaning of daily experience. And they will see it also in the evolution of social responsibility for the maintenance of personal health and for its recovery when it is lost.

This evolution, which we see going on all around us, derives its impetus not only from the humanitarianism that the biblical prophets were teaching through Cain's ugly question. Its strength comes mainly from the growing realization that the personal welfare, indeed the survival, of each of us depends ultimately on the welfare of every other individual. This fact has been easy enough for even the most self-centered person to understand in regard to contagious disease; social action has been taken to prevent or control epidemics since man first recognized the process of contagion. Efforts to deal with mental illness followed recognition of the community hazards that may result from the behavior of psychotic persons. But social action has been increasingly taken to deal with the totality of physical and mental illness. It has been taken when the only impact of one person's misfortune on another's well-being has been through the vast and complex mediation of his living in the same society or, indeed, on the same planet.

SOCIALLY ORGANIZED HEALTH SERVICES

The forms taken by social action to protect or recover health have been of a bewildering variety. The organization of public health programs to cope with the hazards of environmental filth or squalor and to prevent the spread of communicable disease is only the most obvious type. Preventive efforts have also been launched in scores of other spheres: in the surveillance of expectant mothers to help assure healthy childbirth; in the prevention of accidents—now

*From the Social Service Review, September 1964.

the major cause of death for persons aged one to thirty-five; in the promotion of balanced nutrition, with all its secondary influences on health and well-being; in the achievement of mental and emotional harmony; in the prevention of congenital or even genetic disorders; in the avoidance of specific entrapments like those of narcotics, alcohol, or even tobacco; in the strengthening of human resistance to metabolic breakdown of the vital organs due to arteriosclerosis, cancer, or other pathologies.

Social organization has been as extensive, if less effective so far, in the application of scientific medical care when prevention has failed. In our free-enterprise society, no less than in the other political and economic systems throughout the world, it has taken two principal forms: organization of the patterns of economic support for personal medical care and organization of the manner of technical provision of that care. To finance care the social devices of tax-support, voluntary insurance, and philanthropy have been applied everywhere, at a generally expanding tempo. On the other dimension—the technical provision of service—we see increasing specialization, systematization, and group discipline to cope with the infinitely expanding knowledge and skills of science and technology. More and more services are being provided through hospitals and ambulatory clinics, through agencies and programs, as distinguished from the ministrations of the solo practitioner.

The effect of this increasing rate of social organization for both the prevention and the treatment of disease has been, without any doubt, to increase the years of healthy life enjoyed by people. We have paid some prices in terms of the aggregate burden of disease, because of the fact that people who are kept alive for more years eventually become prey to disorders that would not have occurred otherwise. But there can be no doubt that the organization of preventive service has reduced countless deaths and pains, and the organization of diagnostic and therapeutic service has made scientific skills accessible to treat countless maladies which would otherwise have been attended poorly or not at all.

PERSISTENT UNMET NEEDS

Yet, despite the great progress that social organization of health services has made possible, there are still enormous unmet health needs all around us. There are pains and hardships suffered because, within our currently available national resources, we have failed to apply the knowledge and skills that we already possess. We have not yet taken the social steps necessary to mobilize our resources for our own maximum personal good. Just a few examples are presented:

All the studies of mortality and morbidity made in America during the last forty years (and it was probably more strikingly so before then) have shown a generally higher burden among the lower income groups.[1] We know that this fact stems from many environmental and social factors other than health service per se. Nevertheless, the volume of medical services received by people bears generally an opposite relationship; that is, low-income families get less service, despite our extensive development of special programs for the indigent. That the poor among us are no mere handful is reflected by the fact that, in 1961, 32.5 per cent of all American families earned less than $4,000 a year—a proportion of poverty now dawning anew on our national consciousness. Adjustment to the higher illness toll of the poor has been somewhat better in the hospital sector, where illness is treated as a last resort, but the services of physicians, dentists, and nurses for the patient living at home become decidedly fewer, as one descends the income ladder. They tend also to become poorer in quality and sensitivity, more often involving the general practitioner than the specialist, the patent medicine than the scientific prescription. And, as we all know, these social inequities apply even more to American Negroes, whose handicaps in access to medical care compound social discrimination with poverty.

Aside from poverty as such, rural populations throughout America suffer numerous handicaps in their access to sound and scientific health service. Despite the steady urbanization of our country, service in rural areas is not a dwindling problem; in 1960, there were still over fifty million persons living in rural places (even by the more limited definition that counts suburbia as urban)—more than the total national population in 1880. Rural people have much

[1] U.S. National Center for Health Statistics, *Medical Care, Health Status, and Family Income: United States* (Public Health Service Publication No. 1000 [Washington, D.C., May, 1964]).

less access to medical personnel and facilities, less protection by health insurance, and weaker coverage by all sorts of organized health care programs than city-dwellers.

The aged, passing the sixty-five-year mark at the rate of about a thousand a day, are faced with the highest illness burden of all. Their physical and mental troubles come more frequently and last much longer. Yet these problems strike them at a time when they are least able to meet the blows, both economically and spiritually. Much progress has been made in helping old people cope with their problems through our national social security system and, for the very poor, through our federal-state systems of old age assistance. Recent federal legislation on Medical Assistance to the Aged (Kerr-Mills Act) has brought a little further help. The commercial insurance industry has been trying hard to extend coverage for hospital benefits to older people on an indemnity basis. Yet, in 1960, of the approximately $5 billion devoted to the health care of the aged, about three-fourths was spent by aged persons themselves from private resources.[2]

The mentally ill are still pariahs among us, if one can judge from the level of care being rendered in most of our mental hospitals. Despite great improvements, a vast realization that the psychoses do respond to an all-out therapeutic push, and the conversion of many backwoods asylums into active treatment institutions, most hospitalized mental patients are still treated by standards which—in the world of general medicine and surgery—would be considered primitive or even barbarous. Ambulatory treatment of persons with serious mental and emotional disturbances is still largely confined to a relative handful of the persons in need—largely in the uppermost income groups.[3]

Other long-term disorders, among persons of all ages, receive service far below our potentialities. A robust movement in rehabilitation and geriatric medicine has developed in the last thirty years, and the scientific literature is full of accounts of what can be and should be done. Yet most institutionalized persons with chronic disease are kept in small profit-making nursing homes, most of them totally lacking in rehabilitation programs, many without even a single registered nurse, and few with any organized medical staff supervision.[4] There is much talk of organized home-care programs, emanting from hospitals to serve the chronic sick at home, but hardly sixty out of the nation's six thousand general hospitals have established such programs.

For years, medical and public health leadership has advocated periodic health examinations of adults, no less than children, as a principal key to general health promotion. Such regular attention would facilitate not only early disease detection but also positive health counseling about a mode of life conducive to health. We do a great deal of propagandizing about such periodic health supervision, but the evidence is that hardly 20 per cent of our people actually get it. With expanded insurance and greater public sophistication, a rising volume of medical care is being obtained by the American population, but for most persons this care is hurried and episodic, rather than thorough and continuous.

One could catalogue other deficiencies in public health, industrial hygiene, hospital provisions, nursing service, accident prevention, and day-to-day medical and dental care, but this may be enough to indicate that there are still vast and serious unmet health needs all around us. Are these deficiencies necessary? Can anything be done about them? Could we afford the price of an optimal health program in every community, a program that would apply fully everything we know about the prevention and treatment of disease?

EXPENDITURES AND WASTAGES

In 1963, the United States population spent $34 billion, or 6 per cent of the gross national product, on all health and medical purposes.[5] This amount includes public and private expenditures and the costs of facility construction and research, but not of professional education. This expenditure, both in absolute dollars and as a share of GNP, has been rising gradually since 1930, when

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[2] Social Security Administration, *The Health Care of the Aged* (Washington, D.C.: Government Printing Office, 1962), pp. 33–34.

[3] Joint Commission on Mental Illness and Health, *Action for Mental Health* (New York: Basic Books, 1961).

[4] H. B. Spier, *Characteristics of Nursing Homes and Related Facilities* (Public Health Service Publication No. 930–F–5 [Washington, D.C., 1963]).

[5] "President's Message on Health" (excerpts from President Johnson's special message to Congress on health and medical care), *New York Times*, February 11, 1964.

data of this type were first collected. With this rise, more health services have been received by more people, more research has been done, and better quality personnel have been serving the population. But is this expenditure enough to do an adequate job? Should we be spending more, and could we afford it?

One would be hard pressed to specify a "proper" percentage of GNP to be devoted to health services. We do know that our expenditure is higher proportionately than that of other comparable countries, like Great Britain or Sweden, where the outlay is between 3 and 4 per cent of GNP. Yet, in those countries, the whole populations have virtually free access to medical care; they receive slightly higher rates of physican's visits and appreciably higher rates of hospital days than we do. There are certainly fewer inequities between upper and lower income groups than characterize the American scene. Still, there are many inadequacies in European medical service which could be corrected only if their economies could support a higher investment for health purposes.

Whether or not the share of our national wealth devoted to health is now optimal, it is quite clear that, while unmet needs abound wasted, a great deal of money is being wasted. In 1962, about $4.2 billion a year was spent on drugs purchased outside of hospitals. This amount constituted some 19 per cent of personal medical-care expenditures.[6] At least one-third of this amount, or about $1.4 billion, went for self-prescribed and patent medicine, the bulk of which was probably of little medical value. This is quite aside from large pharmaceutical company profits on the prescribed drugs and the many hundred million dollars (about 40 per cent of sales income) spent by the so-called ethical drug manufacturers on advertising and sales promotion. It is the patient, of course, who ultimately pays for this.

The medical cults still thrive in America. For the ministrations of chiropractors, naturopaths, and other "healers," Americans are squandering about half a billion dollars a year. The pity is that people of low income and limited education, who can least afford such waste, are most susceptible to the claims of these so-called healers.

Voluntary health insurance has brought enormous benefits, but our free-enterprise system, with hundreds of competing insurance carriers, the largest of them in business for profit, has exacted a high price for the protection. Quite aside from the medical expenses paid, the mere cost of overhead, reserves, and profits of private health insurance plans in 1962 amounted to over $2 billion.[7] Most of this went to commercial carriers. If the administrative expenses of American health insurance were at the level, for example, that has been achieved in the universal governmentally operated hospital insurance programs of Canada (about 3 per cent of premium income), this amount could be reduced greatly, at a saving of about $1 billion dollars a year.

The larger extravagances, however, are to be found, not in these tributaries, but in the central stream of American medicine. In this era of specialism, with need for elaborate equipment and auxiliary health personnel, the pattern of medical service prevailing in isolated individual offices is a technological anachronism. The duplication of office nurses, rented space, X-ray equipment, technicians, and record systems is a waste for which the patient must pay. Although they have been slowly growing, group practice clinics now involve only about 6 percent of American physicians.[8] Yet the great economies of this form of medical service organization have been amply demonstrated by the Kaiser Health Plan and many other programs of high-quality service. The advantages of group medical practice, moreover, go much beyond financial savings.

The fee-for-service system by which physicians and dentists are usually paid in America is associated with further extravagance. Its built-in incentives are all toward maximization of expenditures. When rates of elective surgery—especially for procedures which may be of dubious need, like tonsillectomies, appendectomies, and uterine suspensions—are calculated under conditions of fee-for-service, compared with salaried medical remuneration, they are invariably higher under the former scheme.[9] In a university teaching hospital, where fee

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[6] *Chart Book of Basic Health Economic Data* (Public Health Service Publication No. 947–3, Health Economics Series No. 3 [Washington, D.C., February 1964]), p. 7.

[7] In 1962 the premium income received by all voluntary health insurance organizations in the United States was $9.3 billion, while the benefits paid out were $7.1 billion (Health Insurance Institute, *Source Book of Health Insurance Data* [New York: The Institute, 1963], pp. 36, 46).

[8] *Medical Groups in the United States, 1959* (Public Health Service Publication No. 1063 [Washington, D.C., 1963]).

[9] Paul M. Densen, E. Balamuth, and S. Shapiro, *Prepaid Medical Care and Hospital Utilization* (Monograph Series No. 3 [Chicago: American Hospital Association, 1958]).

incentives are largely lacking, it is customary to find, on surgical tissue review, that not more than 15 percent of organs removed are non-pathological; in the typical open-staff general hospital, the percentage of unjustified surgery—on careful medical audits—is seldom this low. Every administrator of a medical-care program paying doctors on a fee-for-service basis can testify to the vexing problems of this payment system.

The free-and-easy operation of most health insurance plans has led to further extravagance. Physicians admit many patients to hospitals for workups that could be done more economically in clinics, simply because use of the hospital is convenient for the doctor and is covered by insurance. Most insurance is on an indemnity rather than a service basis, and many physicians inflate their final fees when the bulk of the charge is insured. There have been frequent appeals by medical leaders to refrain from this practice—in order not to discredit the whole voluntary insurance movement. With insurance income to buttress the financing of most general hospitals, extravagances develop, like selective-menu diets, corporation-type administrative salaries, and fat fees for fund-raising counsel or public relations consultants. Moreover, there is the mushrooming, in recent years, of small proprietary hospitals, providing a tidy profit for their owners by the simple expedient of accepting only paying patients and carrying none of the community responsibilities for long-term care, out-patient and indigent service, professional education, or medical research.

The above facts may be enough to suggest that within the $34 billion a year we are spending on health in America there is much waste. If this waste were eliminated, we could, within our current expenditures, do a great deal to reduce the many unmet needs reviewed earlier.

GREATER PLANNING NEEDED

Such a course of action would require a greater degree of planning and organization of all sectors of public health and medical care in America—more than we have so far been willing to undertake. Yet, as suggested at the outset, we have been clearly moving in the direction of greater systematization of both the financing and the provision of health services. If we wish to solve our problems, we must accelerate the rate of this movement.

The implications of such movement would be a greater shift of health activities to what Kenneth Galbraith speaks of as the public sector of the economy. Such a shift could mean, not only a reduction of extravagance and waste, a better return from our health dollar, but, I suspect, an enlargement also of the net share of GNP devoted to health. As public responsibility is more prominently assumed for the protection and maintenance of health, the value and importance of health benefits will be more widely appreciated. If, instead of 6 percent of GNP, it takes 8 percent or 10 percent to do the job, then why should this not be done? What is more precious than life itself?

Is this utopian naïveté? In 1961, we were devoting 10.2 per cent of personal consumption expenditures to clothing, accessories, and jewelry—pleasant purposes, of course, but much of it a commercially induced pursuit of the latest fashion.[10] Tobacco and liquor take almost the same share of our consumption dollar as do health services, and recreational expenditures about the same amount. One need not be a heartless kill-joy to question these proportions. The profiteering of the funeral industry has been recently documented in two important books, and who is to estimate the billions squandered each year on gambling, prostitution, and the illicit sale of narcotics? Most of this spending is done by persons least able to afford it. More respectable gouging of the poor is carried out by the loan companies on the main street of every American town, or the "easy credit" furniture and auto merchants who exact prices 25 or 50 percent higher than would be paid by the man with cash in hand. Then there is the $55 billion a year we are spending on military purposes, not counting $10 billion for interest on past military debts. It is more than a parlor game to calculate how many rehabilitation units or community mental health centers could be built and operated for the cost of one supersonic bomber.

There is no lack of economic resources with which to meet health needs in America, if we set out to meet them. It is a question of how we choose to use

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[10] U.S. Department of Commerce, *Statistical Abstract of the United States, 1963* (Washington, D.C.: Government Printing Office, 1963).

and organize our resources. If we choose to waste billions of dollars both within the health arena and in our total notional economy, we should be aware of the price we are paying in serious community problems and in personal anguish. If we want to shift our national patterns of spending and resource allocation, it will take more planning than preaching to accomplish it.

There are some, of course, who argue that pain and death are preferable to regimentation, for they fear that greater organization of our economy in general and our health service system in particular would mean an irreparable loss of freedom. This is a vast distortion, however, of the true meaning of freedom. We have built a great framework of public education in America—compulsory in its support through taxes and compulsory in its attendance by children—and it has enriched, not diminished, our freedom. Our social security system has enhanced our personal freedom in the later years of life by compelling us to save in the earlier years. Our public health system, with such compulsions as smallpox vaccination and pasteurization of milk, has helped to free us from disease, just as the workmen's compensation laws have helped to liberate workers from the hazards of industrial injury. A group-practice clinic frees the doctor from the preoccupations of the small merchant and permits him better to practice scientific medicine. The regionalized hospital system can assure the freedom of a country-dweller to get the scientific care he may need in an urban center. A flouridated water supply frees children from needless dental district and frees families from needless expenses.

SCIENCE AND LEADERSHIP

The path to freedom and to truth may be found more surely in the method of science than in that of tradition or faith or surmise. Yet scientific knowledge both about nature and about society itself has not yet reached the extent that all persons, or even the majority, can make the wisest decisions for their own good. Flouridation of the water supply is still submitted to community referendums, launched by public officials with a distorted view of the democratic process. More often than not, the people have voted against this safe and effective measure. Scientific medicine is still shunned by many in favor of quackery.

The task of leadership in a democracy, it seems to me, is to apply social measures for the benefit of people, based on the best knowledge that science has produced at a given time and place. The next year, the next day, science may yield a better answer, and then the policy must be changed. Within these limits, political and social leadership must be responsive to the will of the people. In the provision of health service, we have learned a great deal both technically and socially over the centuries, but we are far from applying all that we know. There are manifold resistances to the social changes that would be necessary to apply that knowledge, and the ultimate source of strength to overcome those resistances is the understanding of the people.

Social workers have a great role in increasing that understanding. They are carriers of a torch that is fed by a fuel of humanism—not just a merciful kind, with pity for the underdog, but a rational humanism that sees the importance of social responsibility for the personal well-being of every individual. They can help to advance the struggle of man to learn, in the achievement of health as in pursuit of other essential goals, that he is, indeed, his brother's keeper.

ITEM 5: MATERIAL SUPPLIED BY DR. GEORGE JAMES*

A—THE EMERGING MISSION OF THE NATIONAL HEALTH COUNCIL

(Inaugural Address by George James, M.D., President, National Health Council)

To some extent the National Health Council has become known as a sort of corporate representative of the voluntary health movement in the United States, and there is truth in this. But the real purpose and basic commitment of the Council is to promote health.

If the National Health Council is thought of as speaking for voluntary organizations waging war against specific diseases or collections of diseases, the image is incomplete. But I think in some people's minds there *is* a picture of the Council as representing a number of groups that are free and independent, not much in

*See statement, p. 71.

contact with each other and not only out of contact with government, but rather suspicious of it.

The fact is that if you consider the active members of the Council you quickly get a picture of the interrelatedness of American health effort and how we are all tied together. For example, the American Medical Association has as members doctors who conduct private practices, but it also includes many other doctors—some who are employed by government at various levels, and even some who are employed by pharmaceutical manufacturers. The American Nurses Association covers the whole field of nursing and that includes nurses in health departments, which are government, and nurses in voluntary health agencies, which are not. The Association of State and Territorial Health Officers is a voluntary group in that it is made up of men and women who have freely decided to keep it in existence and who choose its policies as they see fit. But in their daily work, these people are in government.

This broad spectrum in my view is one of the strengths of the Council. Through the individual members of its member organizations it reaches every part of the American health movement. Only by touching all these parts and dealing with all of them can we hope to be an influential generalist and an effective catalyst in health today.

THE PICTURE OF HEALTH TODAY

If we in the Council are going to do anything that makes any sense, we have to meet the needs of public health today and in the foreseeable future. We aren't going to be useful solving problems that don't exist, or that have essentially been solved already.

The nation, as you know, is experiencing an increase of population at both ends of the gamut: more youngsters, more old people. We have problems with the young, especially variations in infant mortality in different areas and we need much more effort in this field. But we already have a large number of sophisticated, well equipped and supported agencies and programs here. What really sobers us with its enormity and our unpreparedness is the medical problems of our older people. In my city we will have one million persons 65 or over in a few years and the nation will have about 25 million in this age group by 1980.

These older people are going to want all the benefits of first-rate American medical and health care for acute disease, when it is needed. But the great problem among them is chronic disease, very often half a dozen or more concurrent long-term diseases for which, as yet, we have no biologic cure but for which we do have treatment that can be effective in sustaining their precious independence and self-sufficiency.

I think I could convince you that if these older people do not get continuing care, then they are very apt to decline quickly and have to be put into hospitals or other institutions. The cost of institutionalization is high, however, and if it becomes the main instrument for care of the aged, the total expense will be so astronomical that it seems impossible to design budgets to include it. Estimated figures just for this city run to billions, rather than millions per year.

The cost of keeping people independent, of preventing their conditions from becoming crippling, is far less than institutional care, but even this costs money. And older people have less money than the average. There is a great deal of poverty among them, much of it brought about by illness; and there is a great deal of illness among them, influenced and promoted by poverty; a vicious circle if there ever was one.

When I say we don't have biologic cures for some of our long-term medical conditions, you will say: well, this is what we are looking for. We are looking for ways of curing arthritis and curing or preventing cancer and coronary heart disease. I believe that some of the organizations represented here will indeed contribute greatly to the solution of such problems some day, but these are complicated problems, likely to be overcome a little at a time, perhaps leukemia first, perhaps then another kind of cancer, perhaps over a period of many years, several others. But I think we must expect chronic disease to grow as a problem in the foreseeable future.

It is in this environment that all of our member organizations, and all their chapters, and all their people, and all their professionals and all their laymen and indeed, all of American health effort must function. I need hardly emphasize

what might happen to budgets and contributions if the problem of chronic disease is allowed to get out of hand. And, of course, it must be handled along with all the others, along with all we do in acute disease, along with our programs of immunization, environmental sanitation and all the rest.

Medical Care

Until research gives us preventives or cures, care is going to be the chief weapon we have to use against many of our worst medical conditions. The importance of care in public health is rather recent. In the earlier days of public health, we emphasized mass programs such as water purification, or one shot immunizations, in which we did help the individual but didn't come in very frequent contact with him. We still have those programs, but in chronic illness we have to deal with the patient very personally and frequently. There is no escaping it.

Chronic disease in an individual may require continuing care for 10 or 20 or 30 years. It seems to me inevitable that with the population growing, we are in a situation in which the amount of care per health worker (doctor, nurse, etc.) is going to be more than it is now. I admit that "amount of care" is an unsatisfactory term. What is evident is that continuing care for chronic disease tends to take more man-hours of work than quick, episodic treatment or prevention for acute disease. To keep up or to go ahead, we are going to have to become more efficient in our use of the resources we have. Today we have a situation where an indigent individual with four or five things wrong with him (not at all unusual in chronic disease in the elderly) may have to go to four or five different clinics for treatment. In a city like this it may mean a series of repeated trips of several miles: very difficult miles for an elderly man slowed up by arthritis, for example.

We have established six criteria for adequate health and medical care and I will pass over five of them quickly and talk a little about the sixth.

First, if it is adequate medical care, it must be available to everybody. From the public health point of view, we do not accept the concept of any group being left out. So-called "adequate care" that only a few can receive is of little interest.

Second, care must be of high quality, which means simply that professional competence is a prime element. It should be given by qualified people.

Third, prevention must be emphasized. Not just the traditional kind of prevention that comes from a vaccine, but prevention that involves early detection of disease so that action can be taken to prevent its becoming disabling, even if it cannot be cured.

Fourth, care must be patient-centered and family-centered. If we put the children one place for care and the father and mother somewhere else, we wind up by missing something and the quality of the care is reduced. We should not be concerned solely with fitting the patient into our medical system, we should be concerned with making that system adapt in new ways to these patients' needs.

Fifth, we must have continuity of care. We are suffering today from too much interrupted, disjointed medical care. Some is unavoidable. We know that about one out of five individuals in this country moves from his home county to another county in a given year. Usually his medical records don't go with him. When he gets to his new home, if he needs medical care, he has to start all over again. But even when people don't move, we chop up medical care. We give care to people on relief, and if they get off relief, which they try to do, they are often shifted to entirely new batches of doctors.

Sometimes we start a patient out with a private general practitioner. He may be dealt out to three or four specialists, winding up in the hands of a surgeon. Here again, complete medical records may not accompany him and a great deal of work is done over every time that does not have to be. What we need is for somebody to be in charge of the patient all the way through.

Sixth, we want comprehensive care. We want a patient to get all the care he needs whenever and wherever he needs it. If he receives treatment for diabetes we want that treatment to be comprehensive enough to discover tuberculosis if he has it; and if he starts with tuberculosis, we want the treatment comprehensive enough so that diabetes will be discovered and brought under care, if he has it.

Part of the lack of comprehensiveness in medical care has been brought about by dividing the individual into organ systems and then having payments made according to those organ systems. A separation of organ systems in a file cabinet

in Albany or Washington can mean that you have two separate institutions by the time you get down to the patient's level and he has to travel a long way from one to the other to get the care he wants. I don't at all deny the need for specialization nor the need to concentrate on certain specific conditions at certain times. Nobody can know all about medicine. We are all laymen about most of medicine.

If money is spent by government or by voluntary agencies for, let us say, the liver, I have no objection to its being earmarked so. But when that money gets to the level of patient care, then I say it must be spent as part of a total package whereby the patient gets comprehensive care that handles whatever his problems may be. Care facilities over-emphasizing single diseases are becoming old hat because today's and tomorrow's patients inconveniently don't restrict themselves to single diseases.

Most of you have read the report of the President's Commission on Heart Disease, Cancer and Stroke. I hope very much that the suggested program will help move us further toward comprehensive medical care. I am struck by the recommendation of a regional network of heart disease, cancer and stroke centers where clinical investigation, teaching and patient care will be brought together. Let us hope that these centers will provide us with new ideas on the interrelationship of our chronic diseases. I have no doubt that in the stroke and heart disease centers particularly, doctors will speedily find themselves dealing not so much with individual diseases as with different patterns of multiple problems in their patients and their families.

GOVERNMENT AND THE VOLUNTARY AGENCIES

A great deal has been written and said about the difference in function between government and voluntary agencies. It has become customary to say that government is both slow moving and threatening, and that voluntary agencies are both quick and reliable.

I don't know. Government can move pretty fast. Just you dare to distribute some thalidomide to the drug stores in New York and then see how fast government moves to get rid of it!

My own view is that within government health units, just as within voluntary agencies, there is not only room but a crying need for imaginative action. I think there has been imaginative action in both camps and to suggest that either group has a monopoly is foolish.

Some of the responsibilities of government are health programs for which, at least at the moment, there is not much fund raising potential. The voluntary agency is dependent on contributions and those contributions often depend on how convincing a picture is drawn of the problem being fought. Conditions which can be very specifically pictured appear to attract money more than collections of conditions. A great many health activities by government, such as assuring pure food, are not matters about which there is now public hue and cry, except when things go wrong. They have little present fund raising potential.

Neither government nor the voluntary agencies can operate on the basis of allocating money exactly according to a statistical estimate of the importance of a disease. This has never worked. In the first place, there is no agreement on relative importance. How many points do you assign disease A, which kills a lot of people but kills them quickly and quietly, as against disease B, which kills very few people but causes many man-hours of misery and crippling over many years?

It is true, even in government, that there are some diseases that people are exercised about that are not actually major problems. But the public considers them particularly ugly—I am thinking of rabies, for instance—and demands what might be called extreme measures against them.

Since we are dealing with human beings and working for them, we listen to these views. And a human being does have the right to make up his own mind about what he considers a bad disease, with or without statistics. In fact, his freedom to decide what *he* thinks is worth doing something about is a cornerstone of voluntaryism.

I want to say just one more thing about government and the voluntary agencies, something quite unrecognized. I think, by the general public. That is that the two groups work together over and over again. The New York City Health Department is working now with over a half dozen voluntary agencies that belong to the Council and works constantly with the professional groups among the active members. Government advisory committees are studded with scientists who serve the voluntary agencies.

In my view, the federal government has gone to great lengths to encourage *lay* participation in the field of health and *local* participation in the field of health. It has done this not only by tax deductions but it has repeatedly made grants to voluntary groups as, for example, to the National Commission on Community Health Services. I think the relationship between government and the voluntary agencies, admittedly sometimes difficult, is nonetheless flourishing and will improve.

Today with the growing significance of incurable chronic disease, we are realizing that any useful attack must be comprehensive and not narrowly specialized. Diabetes control, for example, requires the use of educational tools to motivate people to come for disease detection, home nursing to assist patients to give themselves insulin and test their urines, dieticians to help the patient regulate his diet, laboratory technicians to perform more complex analyses, and so on. So complex have become these programs that any given professional worker is a layman in more phases of the total effort than in those where he is an expert! What more proof do we need of the importance of lay participation in health programs, since the term "lay" truly includes all of us who picture ourselves as qualified professionals!

The fallacy of bigness

It is the fashion to sound the death knell of the voluntary health organizations that are involved in research. The claim is that with so much government money going into research, there must be little left for the voluntary agencies to do.

I don't agree with this. It seems to me we have been oversold on the fallacy that bigness is desirable. We have been led to confuse massiveness with effectiveness.

This is a little surprising, since the record of the voluntary sector of American scientific research is very good indeed. One need not go over the polio story again, nor review the very fine early work of the National Tuberculosis Association, especially in the Framingham project in Massachusetts. One could look at the histories of America's Nozel Prize winners, and one would find that the non-governmental side of medical research has acquitted itself very well.

Money does not always talk. Not to the extent that you can judge the relative merits of two research programs by their budgets. The great scientific discoveries of the future will come from individual minds, from the minds of what Sir C. P. Snow calls alpha-plus scientists.

The vast government programs are necessary. The nation does not intend to overlook their possibilities and hopes for their continued expansion. But the voluntary agencies have an important role to play. Their smaller research programs, easier to understand and to manage, often tailor-made to fill important gaps in more distantly controlled federal programs, can be beautifully controlled and highly productive. In the present state of science we have to continue and increase the huge federal effort, but there is a clear need for the sensitive, highly flexible investigation pioneered and continued so well by the voluntary agencies.

So I think voluntary organizations should divest themselves of their fear of smallness. It was smallness, audacity and mobility that sank the Spanish Armada and this approach may continue to sink some of our towering health problems.

The essential question to me is not whether a voluntary organization in a given field is necessarily better or worse than government in the same field. The question is whether we should let either side preempt a field, or might better agree that there is not only room for both, but need for both.

Accreditation and criteria

Much has been said about government controls, and about accreditation and criteria in the independent sector of American health effort.

Criteria pertain to membership in the National Health Council. We all want to maintain standards for our organization, and to admit only such member organizations as conduct themselves properly. The storm rages over what words like "properly" mean.

Certainly there are some groups in the country claiming to be professional organizations that most of us would not want to admit to the Council. There are some voluntary health agencies whose handling of funds is such that we might not approve of them.

It is the details that are hard to arrive at. I think, therefore, that we should all be grateful that the Council has come up with a set of standards of accounting and financial reporting for voluntary health and welfare organizations. I very

much hope that every member organization to which these standards are applicable will adopt them.

There can hardly be anyone here who has not read reports of irresponsibility among voluntary health agencies. In some cases there has been legal action and some people have been sent to jail. I make two points about this: first, it does not help us very much when an offending organization happens to be outside our membership. The bad operations hurt all voluntary health agencies. The damage does not stop at the line of National Health Council membership. The Council must be as much interested in the fly-by-nights as in its own members—perhaps more so.

Second, there is no such thing as voluntary health agencies operating without government control, if by control you mean a framework of law. Many states already require extensive financial reports on a county to county basis. In many areas one has to have a permit to solicit funds. In some places fund raising costs may not legally exceed a certain percentage of the contributions received. Practically everywhere, so far as I know, there are laws relating to misrepresentation. If you publicly raise money for disease X and spend it all on disease Y, you are very likely, at the least, to have to do a lot of explaining to the representatives of the law.

I don't think our position in the Council is or should be that we want the independent sector in American health to operate outside the law, beyond any control. To use one of the oldest, and maybe best, of the familiar analogies: it is not a loss of freedom when we are required to drive on the right hand side of the road. It increases our chances of getting from here to Chicago. A framework that will assure that voluntary health agencies show the same responsibility that a driver shows when he stays to the right should increase their productivity, not reduce it.

The problem is to achieve cooperation and assure responsible practices without giving up individuality and initiative—without cutting off the crisp wind of freedom that blows through the voluntary agencies. This is not easy to do, but neither is it impossible.

We should surely examine the proliferation of local laws and ordinances. It is as difficult for a national health agency to deal with these regulations as it is for the building industry to contend with thousands of codes. I know that the voluntary agencies would rather cooperate toward some reasonable national model state law in place of the increasing tangle of local restrictions.

If all agencies were responsible operations there would obviously be little need for regulation of any kind. One method that has been suggested to this end is accreditation, similar to the accreditation of medical schools and hospitals. This might be done by a special group developed by the National Health Council through its membership. Some have reacted privately, saying this smacks of vigilanteism, adding that if there is to be accreditation, it should be by government. But accreditation differs from the governmental mission of issuance of a license or a permit. In the health field accreditation has traditionally been a function of voluntary rather than government groups. The criteria for membership of the National Health Council already go far toward being a useful accrediting device. I urge that we build on this rather than try to start a new movement.

In any event, we cannot divorce ourselves from those in the voluntary field whose actions are less responsible than ours. And in my view there is much room for improvement, viewing the field as a whole. If all the voluntary agencies (and government, too, for that matter) were to run a tighter ship, our total achievement would surely increase.

AFTER THE NATIONAL COMMISSION

We are living through a revolution in medical and health care in the United States, in part because we have been living through the period of the National Commission on Community Health Services, sponsored jointly by the National Health Council and the American Public Health Association. The Commission grew out of the Advisory Commission on Local Health Departments, which in turn grew out of a conference some 18 years ago of which Dr. Haven Emerson served as chairman.

Then, as now, there was general agreement on one point: that people should get better health services. We thought then primarily in terms of providing adequate health departments because so many counties were really without public

health units. Today we have broadened our viewpoint. We are after adequate health services, and if they can be provided by a health department that's fine; and if they can be provided by someone else or a collection of someone else's, that's fine, too.

I don't know how many of you have seen the National Health Commission's work at a local level, but it is very impressive and the impressive thing about it is that it is really the work of local people. What they are finding out is motivating them to move ahead. If you would review, for example, the Lucas County Community Health Study in the Toledo, Ohio area, you would find that it is a fascinating thing, filled with facts not before gathered together. It is hard to believe that anyone could participate in such a study without being moved to action by its findings and, remember, these are the findings of the citizens themselves, not the professional health planners.

Interest and support for the Commission has come roughly half from government and half from private or voluntary sources. There are 21 community action studies and there are six task forces on environmental health, health services manpower, health facilities, organization of community health services, comprehensive health care, and financing health services. There is, of course, a great deal more.

The National Commission is now planning its 1965 National Health Forums which will be cosponsored by us as the National Health Council 1965 Health Forums. There are to be four regional forums, in San Francisco, Chicago, Atlanta and Philadelphia where the experiences of the study communities and the implications of the task force recommendations will be discussed.

There is no question that the National Health Council, as well as the American Public Health Association, as the original sponsoring organizations of the National Commission, will have their work cut out for them when the Commission ends in September of next year, a short 18 months from now. Whatever suggestions are agreed on, the job of implementing them will certainly fall on the members of the National Health Council and also of the American Public Health Association.

You will remember that when the National Advisory Committee on Local Health Departments was formed, its link to the National Health Council was purposefully made loose because it took controversial stands. The National Health Council itself does not take such stands because that is not its business. Its business, however, is to bring together people from all branches of our bustling civilization who very often don't think in the same way—who very often think exactly opposite—and in the productive discussion that results, to help get things started.

In the period after the work of the Commission, it will be the job of the National Health Council *not* to tell its member agencies what position they should take—they would react unfavorably to that anyway—but to help them in every way possible to show their own leadership.

I don't think we need to fear that nothing will be done as a result of the National Commission. Too many needs have been stirred up and illuminated, too many movements already begun, too much momentum already created. But unless the National Health Council acts skillfully, much *less* will be done than otherwise, particularly in areas where there were no local studies. If we can bring some of the enthusiasm that now exists in those communities to the others, we will have accomplished a great deal. Undoubtedly the implementation of the National Commission's recommendations is going to concern us greatly during the coming 18 months, and we will all be talking and, I hope, doing a great deal more about it.

Conclusion

That the National Health Council exists and continues to expand its influence is evidence of how much it is needed. Its member agencies, however independent, recognize deeply the need to reach out, touch each other and learn from each other. Let me just review briefly what seem to be areas in which the National Health Council has an emerging mission:

1. To bring together as a combination of catalyst, harsh irritant and house mother, the member agencies and sometimes others—agencies representing a great variety of effort and sometimes almost total disagreement on methods of accomplishing what needs to be done.
2. To promote a constant bubbling up and dissemination of truth, particularly the kind of truth that an organization needs to know about the field outside its primary responsibility.

3. To help educate those who work for voluntary health agencies so that they can do their job better. The program of the Committee on Continuing Education is a case in point.

4. To influence member agencies and thus, by example, all agencies, to higher standards and greater responsibility in the performance of their work and in the handling and accounting for their funds.

5. To give direct special help to voluntary agencies when they need it. This might be in a proposed merger of two or three organizations. It might be in helping to improve their accounting procedures.

6. To nurture the spirit of voluntaryism in the field of health. I consider this the most important. Part of the public rejoices at criticism of voluntary organizations because it provides an excuse for not giving. I think that voluntaryism is both tender and strong. There is nothing in our present system of government, thank goodness, to keep people from organizing if they are interested in a certain disease and want to do something about it. I hope nothing ever does prevent this. It is essentially an extension of the right of assembly in the First Amendment of the Constitution. But there are forces tending to make voluntary agencies into a repetition of a single image. These forces tend to reduce the influence of voluntaryism which ought to be promoted. I hope the National Health Council will do all it can to promote it.

Men can always invent a superstructure organization to gather together the various individual pieces of the independent sector of health and make them into some kind of unified whole. There are always those who wish to take over. This, however, is not the mission of the National Health Council. It does not seek to form all these groups into one block of concrete, but rather to provide the fertile soil where a large number of vigorous plants may flower gracefully.

It is perfectly fitting to talk about the role of the National Health Council, but for all of us the essence of being useful is that we recognize that the first aim is to serve the individual person in need, and that the role of the National Health Council or any other agency should flow out of that concept.

If we build around the individual every time, starting with him and his needs, we will do all right. If we become lost in problems of organization so that they occupy more of our time than consideration of the real objective, then we will not do so well.

In my own city we have a project in a low income housing development where a little clinic brings care to older people who are up and about and independent, but might otherwise be confined to institutions.

These are people with more medical problems than seems possible. It is a considerable feat to serve them properly.

But we have a little clinic and if you were to examine it you would find that in one way or another it is involved with government at three different levels and that a number of voluntary health agencies and professional societies are participating in it. And if all the rules of all these organizations and all their differences of opinion were written down and put in one place, it would be a tremendous pile of books. A pile dedicated to separateness, rigidity, red tape and legalisms.

But these various agencies, voluntary and governmental, have agreed that in this tiny pilot project, to set aside their rules and traditions and to start with the patient and meet his needs by whatever means possible. It is one of the most heartwarming and amazing things in all my experience in public health to see how, when this concentration on the patient is really achieved, the restrictive rules and regulations of these organizations and their defense of autonomy begin to fade away, and in a most human spirit, they cooperate in getting the job done without losing either their identity or their primary mission. It is this sort of thing, I think and believe, the National Health Council can achieve on a national scale. Just as the best of our voluntary agencies today channel the efforts of our most productive citizens by utilizing to the fullest their individual strengths while in turn strengthening each of them, so will the National Health Council be able to improve each of its member agencies and in the process continue to grow and develop as a powerful force for health progress. Operating not by law, not with the lure of money, not even by tradition, its power is at the very root of that which gives sustenance to the entire voluntary movement—the inherent desire of each man to strive for self betterment through the realization of his own strengths, his own interests and his own determination.

B—Medicare: What Else Do We Need in the Community?

(By George James, M.D., M.P.H.)

Sometimes the talk about Medicare reminds me about the way we talked about penicillin and syphilis a couple of decades back. Penicillin was so effective against syphilis that many thought the book was about closed on this disease. It has turned out, of course, that in recent years syphilis has risen sharply, especially in younger age groups. Penicillin is still effective enough; what was wrong with our calculations was that we forgot that no drug by itself accomplishes anything, that you have to find your cases of disease and track down contacts, and that you have to administer the drug in the right place at the right time. Human behavior and misbehavior are involved.

The coining of "Medicare" has given us a word that has the same misleading sound of finality that penicillin used to have in syphilis. No doubt many persons across the country are saying something like: "Well, it was a long fight, and perhaps we should have worked things out some other way, but what's done is done and the problem of medical care for older people has been settled." And, of course, it hasn't been settled. The fight for it has just begun.

The words that have been heaped on Medicare are certainly evidence that money talks because what we are doing is to provide payment for health services. Medicare hasn't built any hospitals and it hasn't added any nurses or doctors to the supply of health manpower. It hasn't developed any new vaccines or methods of treatment. People cared for under Medicare are cared for by precisely the same medical establishment that existed before Medicare.

But an influence on medical facilities and methods is sure to come as a result of Medicare. Whoever pays for large quantities of medical care can influence the quality of that care. This is true whether the purchaser is a government or an organization like Blue Cross. In New York City, for instance, the municipality buys a lot of hospital care and influences that care by insisting on certain standards. It can, for example, demand routine chest X-rays on admittance to hospitals for all city patients. Procedures established this way frequently wind up being adopted for all patients. There is little doubt Medicare can have a similar effect. In fact, the bill requires a review of hospital use, to be made by hospital staff committees or special outside panels. But, the actions of these panels are then to be reviewed by state agencies acting for the federal government.

The essence of the Medicare bill to me is that it is the first nationwide attempt, with any large segment of the free-living population, to implement directly the philosophy that everybody who needs care should get it. On a community level, we may have tried to get care to as many people as possible. We have emphasized child health services and even health maintenance for children. But across the country we have never taken any sizable group and tried to reach everybody in it with care for whatever might ail them.

In certain nonfree-living groups, we have brought medical care to all. We have done this for men and women in the armed services and, although inadequately, for persons in correctional institutions. But, the national attempt to provide services to more than 19 million elderly persons is revolutionary. We cannot quite say at this point that we are trying to provide *whatever* health services anybody needs because Medicare has limitations and was certainly written with existing medical facilities and present medical emphasis in mind. It is bound to change both.

It is inescapable that Medicare will focus a searchlight on the American system of health care as it now stands. We are saying to 19 million people "Come on in. We will pay the bills." But what are we asking them to come in to? We are asking them to come into our hospitals, most of which were designed for the treatment of acute conditions, not the kind of chronic disease that is particularly prevalent in old age. But Medicare does envision a rise in home care, and despite its limitations, Medicare seems to me at least a movement toward an open invitation to people to use our total medical care system, or whatever part they need, and have their bills paid.

Every aspect of our medical care system is going to be illuminated, and there is certainly going to be much more public criticism of our deficiencies in the near future than there has been in the past. Now, people are going to say that they have a legal right to adequate medical care and they are going to be very vocal if they do not get it.

Now, if Medicare is going to be a searchlight, what is it going to reveal? Some things it has revealed already. It has certainly shown us that while some people react almost instantly to an offer of care at government expense, others don't. We have had people rushing to sign up for the optional part of Medicare and others failing to sign up—members of the hard core that is so hard to reach in American medicine. We had people delaying hospitalization until Medicare went into effect. We have had the somewhat remarkable spectacle of public officials, entertainers, and volunteers trying to sell Medicare to the public. We have found out once again that having a program does not mean that the care involved and the people who need it will automatically come in contact.

But this is only the beginning of Medicare, the first contact, so to speak, between it and the public, as well as between it and the professions. What will we find as it goes along?

Certainly, we are going to find many hospitals overwhelmed with requests for the care of older people. Generally, in my view, these requests are not from people who don't need care but from people who need it very much, many of whom could not afford it before. The strain on services is going to be tremendous. Nowhere, are there enough hospitals in the United States to take care of the health problems of old age if we think of inpatient hospitalization as the main thrust of our effort.

After the first flurry about missing forms and lack of organization and as the problem of red tape dies down, I think we are going to take a deeper look at what we find and we are going to say: "We just can't keep up with this flood of elderly patients into our hospitals. Can't we do something to prevent their needing to be hospitalized?"

We do something already. We do give people smallpox vaccine and this keeps smallpox patients out of the hospital. We purify our drinking water and that keeps typhoid and diphtheria patients out of the hospital. But, if we think of preventive medicine in broad terms, we have hardly scratched its surface. In many of our elderly people, our problem is long-term disease for which we don't have a total preventive like smallpox vaccine. Yet, for many chronic conditions we do have treatment which, if early applied, could prevent such conditions from becoming seriously handicapping or requiring long stretches of hospitalization.

No doubt the life expectancy will further rise. But, we have a considerable challenge within the life-span as it is—some 70 years on the average but with very large groups reaching 80 and 90. We should look at this span and say: "Let's shorten the part of it during which the individual is unproductive and dependent."

There isn't much we can do to shorten childhood and the period of education. At the other end, however, we want to help our older people, to keep them functioning in society and to keep them independent. If we look at what makes old people sick, at what keeps them from remaining independent, we find ourselves pushed into a study of their lives before they became 65. When this happens, we repeatedly find actions that weren't taken that could have prevented their needing hospital care and kept them from becoming disabled.

We are going to find women in our hospitals with terminal cancer of the cervix who could have been cured if we had detected their problem early enough.

We are going to find people in thees hospitals needing amputations because, as diabetics, they acquired infections that got out of hand—a situation which could have been prevented by adequate foot care.

We are going to find people handicapped by coronary heart disease, although we know the toll of coronary heart disease could be drastically cut if we could get to these people earlier and convince them not to smoke cigarettes and not to stuff themselves with saturated fats and to take reasonable and regular exercise.

We are going to find many people whose ability to remain independent is fragile and who suffer from multiple chronic illness. They will have arthritis, bad eyesight, impaired hearing, and, perhaps, kidney problems. Whereas no one of their problems by itself may be serious enough to handicap such patients into dependence, the combination may well be.

We will find that many of these patients didn't get the care, the health maintenance, they needed, perhaps because the appropriate clinic wasn't open after they got through work or because they were grabbed, so to speak, by the kidney people and didn't really get to the arthritis clinic. Many patients are expected, because of organizational flaws in our medical system, to attend five or six different clinics; often, they give up.

So Medicare, at the same time that it directs attention to patients 65 and older, will eventually lead to public exploration on how they got that way. I hope this

will lead to our redoubling our efforts to provide the kind of community health maintenance services that now exist only as pilot projects.

For those who are already elderly, it is naturally too late for health maintenance in middle age or for heading off the cigarette habit in youth. We are going to have to take care of today's elderly as best we can, with whatever problems they have. Some, no doubt, will have acute episodes appropriate for hospitalization. Others we will keep in hospitals because there either are no other facilities or no adequate facilities to care for them. But mass inpatient hospitalization is so costly, not only in money but in the time of highly skilled and scarce personnel, that we will very carefully have to investigate other methods.

Particularly, it seems to me, we will have to enlarge our home care programs. We will also have to expand the provision of some kind of a minima level of medical care near where the older person lives, because often, even if he is able to live independently, he is simply too creaky to move very far very often to get medical attention. I think that expansion of care toward the patient through home services will in the long run cost us much less than the present emphasis on admittance to the hospital.

Some of the efforts now under way to supplement Medicare are well known. Blue Cross organizations in many states are arranging to meet some payments required of Medicare subscribers, including those for outpatient diagnostic care. In the main, however, I believe that what communities need beyond Medicare is what they have needed for some time, a rethinking and reorganization of their medical care systems. Among the changes called for are these:

1] Much more emphasis on the early stages of medical care, so that when the patient enters old age, he is in as good health as possible

2] A reduction in the emphasis on inpatient hospital care, coupled with a major expansion (and improvement in quality) of outpatient services; branch clinics, especially in areas where the percentages of older people are high; and home care services

3] A major overhaul and improvement of standards of nursing homes and, along with it, an overhaul in our thinking so that we begin to realize that often dependence in the older patient is reversible and, usually, vegetation should not be acceptable

4] An emphasis on comprehensive care: that is, wherever the patient applies for care he should be put in touch with all he needs for whatever condition or conditions he has

5] Greater emphasis on continuity of care—a prevention or elimination of the present tendency to transfer the patient from one jurisdiction to another, often without records

6] Increased recognition that the job of health care is so enormous that no one can now do it alone—neither government nor the private practitioner, nor the proprietary hospital, nor the voluntary health organization—and that we need all the varied resources that we have and must break down their isolation and get them working together.

I believe the beginning of a historic reorganization of our medical resources has begun. It seems proper to me that we now emphasize concern for the older patient with chronic disease but equally proper that a searching examination of health services for those below 65 has already begun. I am sure that this will lead us to an understanding that adequate care for the older person must begin in infancy and childhood, areas not now covered by Medicare. It is significant, perhaps, that the President has already proposed additional social security health benefits of the Medicare type for the dental care of children under six.

In any event, Medicare will surely ultimately result in far better health services than we now have, and the controversy it brings will be a major factor in that direction.

C—The Function of Health Facilities in the Total Medical Care Complex

(By George James, M.D., M.P.H.*)

The general problem of where health facilities fit into the total medical care complex, some of the major problems we shall have to face in coming years, and

*This article is based on Dr. James' talk at the annual meeting of the Conference of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities, October 14, 1965, in Chicago. At that time Dr. James was commissioner of health, New York City Department of Health. He is now dean of the Mount Sinai School of Medicine, New York City.

some of the attempts currently being made to determine the pattern desirable for future development comprise the substance of my discussion.

Foremost, we must acknowledge several highly significant factors concerning our medical care system. The system, as we see it today, developed in response to a need for health services. This need has been changing, and now it is changing with extreme rapidity and thoroughness. It is no longer an acute disease problem. It is no longer a curative medical problem. It is largely rehabilitation, limitation of disability for the aged, finding causes of disease, and getting people to live in a certain way so that they do not develop chronic diseases in later life.

For these needs, the present medical care system is not well oriented and, obviously, it therefore requires major adaptations. We cannot erase this system. If we had to do it over, I daresay we would end up with something quite different from what we now have. Since it is impossible to do it over, we must look to the system to develop that flexibility of approach and that attention to those needs which will lead to a future program.

Four stages of disease

I must start with epidemiology. It is convenient in discussions such as this to divide the natural history of disease into four stages. By "natural history of disease," I mean what happens with a given disease in a given patient, including the entire progress of the disease, all the many ways it develops in that patient, the period before it develops until long after it has ceased, and its effect on the patient. "Effect" includes all the short-range and long-range effects.

First stage. The first stage of disease is the period before the disease begins, the prepathogenic phase. What is important in this period are the factors which make a person more or less susceptible to a disease—the kind of cigarettes he smokes and the amount, the kind of ice cream he eats and the amount, his hereditary pattern, his occupation, many of his other health habits, whether he is immunized or not, whether he goes for routine medical examinations or not—all of the things that put a person in a higher or lower category with reference to the risk of getting a specific disease. It is interesting, in our present health programs and present national health status, that we are doing a relatively miserable job of considering these factors.

We cannot rest on our laurels for having conquered typhoid, diphtheria, and smallpox. These are not our problems today. A look at the 20 leading causes of death today reveals that we are able to effect a major impact against only a few. Considering what could be done about them, it is evident that we are not performing all the tasks related to the removal of risk factors. We have a big void in this field in our present medical care structure.

Also, the individual citizen is not much interested in removing risk factors. He feels no pain before the disease begins. He can read many advertisements telling him to avoid this and that, but he has less motivation to do so. He feels that no immediate medical payoff exists to motivate him to change his habits. The individual hospital or department that wishes to enter this field has a wide open territory that has been relatively unexplored.

Second stage. The second stage of disease relates to pathology subject to early detection. It is a period during which the disease process has begun but the patient is not aware of it. However, a disease can be detected by various tests. Here, too, the priority given by citizens is extremely low. People do not feel pain. They do not see the need to take time off from work, to travel long distances, to wait in clinics or the private physician's office to receive this medical care. Some of it is painful. Payoff, again, is far removed from the difficulty of seeking care during this stage of disease.

Surprisingly enough, this low priority for early detection is also the rule for medical care institutions. The hospitals give stage-two medicine short shrift in most cases, and I know no hospital that does as complete a job as possible. In New York City, where we have given a good deal of attention to this, we are now finding less than one-fortieth of our unknown diabetic persons. Less than one-fiftieth of the annual crop of unknown cases of carcinoma of the cervix are being detected. And we are still finding only one out of every two cases of infectious tuberculosis, despite having one of the most extensive and farflung, tuberculosis casefinding programs in the country.

Casefinding is a wide-open field—hospitals are filled with patients who have other undetected diseases.

Third stage. Stage three is the clinical phase, when the patient has accepted the fact that he is ill. He goes to the physician and says, "I have pain, I want

help." At this stage American medicine has been at its best, because people have always given clinical illness high priority. When they are sick, they demand care. We get into the trap, however, of equating need and demand. Need, as such, requires a more scientific degree of measurement than merely the fact that the patient demands it. But even in stage-three clinical medicine, we have difficulties. We fragment the human being and the human family into many specialties. We send him to one place for mental health, to another place for his liver, and still another for his heart and kidneys.

The accent in the third stage of medicine is on biological cure, and, for most of the chronic diseases which are major causes of death today, we have no biological cure.

Fourth stage. The fourth stage is that in which we have given up hope for biological cure and recognize that the disease is chronic. Here we hope for a different payoff. We have sick care, and we have social care which consists of disability limitaion and rehabilitation. Whereas a person may wish to give priority to social care because of his pains and aches, he finds it difficult to elicit an adequate response from treatment institutions. This is the kind of person we are remarkably skillful at keeping out of hospitals. This is the kind of person who ends up in a nursing home, and since the hoped for result is nonmedical, merely social, it is difficult to interest physicians in social care because they can't use their familiar medical techniques.

Now, these four stages of disease can be taken in one package. In my opinion public health, preventive medicine, and medical care are all one. I think that any distinctions we make in these three terms in lectures to students are purely transitional, reflecting the fact that we have not made sufficient medical care progress. If we had a truly adequate medical care program, they would all be the same. In effect, medical care, public health, and preventive medicine equally include anything anyone can do to interrupt the natural history of disease in favor of the patient. The interruption could be building hospitals, immunization, surgery, or health education. The fact that a physician is not always the best person to perform each aspect has disturbed physicians greatly. I think the goal must be—I know of none other worth taking—meeting the health needs of the nation. I don't see why we should reform this goal because a given profession finds it difficult sometimes to broaden its aspects and responsibilities. I feel that the medical profession will, and I think trends are being developed in this nation which indicate that it can. I think it behooves all, who are in a position to do so, to help out.

The "cut-finger" emergency. Let me tell you a little story. A woman comes to the emergency room of the general hospital at 3 a.m. with a cut finger, bleeding profusely, with a handkerchief wrapped around it. She is seen in a relatively short time by an intern. He washes the finger with antiseptic, drapes the lesion, sutures it, and bandages it. He then tells her to come back in about 7 days to have the stitches removed. In 1965, this is an example of high-quality medical care.

I hope by 1975 this will be used as a classic example of exceedingly poor medical care. If the intern had looked at the woman even casually while she was sitting in the waiting room, he could have seen her reading a magazine, holding it at arm's length with the hand that wasn't cut. So he missed an opportunity—not then but maybe later—to find out that her glasses were no longer helping her because she was suffering from the fourth stage of presbyopia. He could have easily rehabilitated her, perhaps thereby preventing her from cutting her finger again.

Then, if he had done a Papanicolaou smear, he may have discovered carcinoma of the cervix. And so he missed a good opportunity to practice the second stage of medicine for that disease.

Finally, if he had observed the woman further, he would have seen her lighting a cigarette with the butt of another. And so he missed the opportunity of practicing first-stage medicine for several diseases; carcinoma of the lung, coronary heart disease, carcinoma of the larynx, and emphysema.

What did he do? He treated her finger—the third stage of the disease, cut finger. He did nothing about treating a patient who may have been suffering from other stages of a flock of other diseases.

Quality Care

What, then, do we really mean by quality of medical care? We have defined the quality of medical care over and over again in a very limited way by saying it means that physicians giving medical care to an individual patient must

possess the appropriate skill. Hence, a practitioner who performs lung surgery should be a competent chest surgeon and a diplomate of the American Board or the equivalent. This is only one of several aspects of quality of medical care. I believe that other aspects are equally important.

First is continuity of care. Ideally, the patient should be treated by the same physician or group of physicians, or at least a continuing medical record should follow that patient throughout his life.

Second would be attention to the total patient rather than just his chief complaints. We have been practicing too much "chief complaint medicine" in the United States. The patient who comes for medical care is a patient at various stages of various diseases, and it is up to us to set up some kind of a regimen for finding them and doing something about them. Incidentally, unless we can develop some such regimen for picking up first-stage and second-stage problems, we are going to miss a great opportunity to do a tremendous amount in the attack on the major chronic diseases.

Parenthetically, some physicians have argued with me that our knowledge of first-stage and second-stage medicine is not that good. We don't have absolute proof that highly saturated fats in the diet raise cholesterol levels and lead to fatal coronary heart disease. We don't have the data to prove beyond all doubt that obese persons have a tendency to get diabetes and that if they lose weight this tendency is reduced. We don't have absolute proof that cigarette smoking causes disease, and so on.

In reply to the doubters, I say that they have been guitly, as have many of us, of double-standard thinking. When a patient comes to the physician in the third stage of a disease, the physician undertakes an enormous amount of effort and medical activity. The scientific knowledge upon which much of this medical activity is based is equally deficient in final proof.

We are not yet certain that dicumarol will prevent coronary heart disease and stroke. The medical care we give coronary patients (oxygen, supportive measures) has not proved tremendously effective. And I will say that case for case, point for point, lesson for lesson, the efforts we can make in the first and second stages of chronic disease can hold their own very well with respect to scientific proof as compared to the things we do in the clinical stage. Of course, the difference is that the patient does not demand services during the early stage, which suggests, perhaps, some ways of engineering such services a little differently.

Returning to the measurement of quality of medical care, another aspect is medical care which should be patient centered and family centered. Family-centered care provides an opportunity to bring a large number of people into medical care. When they are brought in, their first and second and fourth stages of medical problems can be tackled. These problems are not great enough to motivate the patient to seek care, but in this family arrangement, the opportunity arises to provide it.

The last aspect of quality of medical care is one which practically no medical care institution in the country can meet. In the future, a medical care institution will be measured by its abiilty to serve the unmet medical care needs of its community. In other words, if in the community around a teaching hospital a large number of people need care for any stage of a disease but are not getting it, then the medical care of that institution cannot be rated as being of high quality.

I think Hill-Burton is a community concept all in itself. I think medical care legislation, public health services, all of the things that deal in medicine and health today shall push more and more toward this community concept of medicine. Ideally, medical care institutions would feel the responsibility for patients who live in the area but don't come to them. They should feel this responsibility as strongly as they do toward the patients who do come to them.

Fallacies in the System

A number of things could be called evidences of maladaptations in our present health facility arrangements. The following are but a few of these evidences.

The unadmitted patient. First is the fallacy of the unadmitted patient. Some patients don't go to a hospital because they don't want to. Others don't come because hospitals are remarkably skillful at keeping them out—drug addicts, alcoholics, the aged, and the so-called crock. "Crock" is an interesting term for an uninteresting patient. But what is an uninteresting patient? He is one whose illness is so complex that we are unable to solve it. Therefore, we place the blame on the crock rather than on our failure to help him.

The ambulatory patient. Next is the fallacy of the ambulatory patient. Ninety percent of today's care is given to vertical patients. Yet in a great many institutions the finest physicians perform only on horizontal patients, and they are relieved of the responsibility of participating in ambulatory care.

The emergency patient. The third fallacy deals with the emergency room. This is the fastest growing source of medical care in many areas of our country today. It meets a tremendous social need. Yet the emergency room, while it is capable of treating patients with cut fingers and broken arms, is incapable of taking care of persons with chronic heart disease, chronic diabetes, nephritis, stroke, and so on. However, 30 to 40 percent or less of the patients coming to emergency rooms are true medical emergencies. Most of them require long-term continuous comprehensive fourth-stage medical care.

The undiagnosed patient. Another fallacy is the undiagnosed patient. In episode after episode, a patient goes to a clinic which specializes in one organ and he develops major pathology in some other organ. The clinic which has been responsible for this patient has been so interested in one disease, one organ, that it has not fulfilled its responsibility for the total patient. Our hospitals are filled with undiagnosed patients, undiagnosed in terms of other stages of other diseases.

Precursors of disease. Lack of treatment of the precursors of disease is another fallacy. If a patient in the medical care system is a heavy smoker, this is a far more serious disease than most of the conditions that might have brought that patient to the hospital in the first place. To what degree do we accept this responsibility? To what degree do we even follow up in this regard?

Hospital competition. The sixth fallacy is a familiar one—the extra staffing of institutions, the competition between hospitals. One person in New York City made the astute observation that there are three places in Lower Manhattan where the medically indigent patient can have open heart surgery, but there is no place where he can have his teeth fixed. We are approaching the time when there will be almost as many cardiac surgeons in New York City as there are patients needing cardiac surgery. There are, of course, definite values to this situation. Maybe it will be the answer to coronary heart disease some day, and I would not in any way cut back on the training of an adequate number of cardiac surgeons.

But there is an equal responsibility to look at total medical needs in the community. If the needs include dental care, then this care should be provided. If each institution duplicates and develops extra staffs, this interferes with its ability to devote its attention and resources to meeting other needs.

Fragmentation. We have fragmentation where integration is needed. One man, aged 76, was told to go to 10 hospital clinics. This old man was far to sick to go to 10 hospital clinics, so he became an uncooperative patient. However, if he hadn't been an uncooperative patient, he would have died, because it was quite beyond his physical capacity to go to a hospital miles away, sit in a waiting room for long periods of time, spend hours in line at the pharmacy for drugs, and go from clinic to clinic. What happens to such patients? They end up in nursing homes.

The nursing home. A nursing home is in itself an enormous fallacy on our medical care system. Here we find patients with diseases so complex and so difficult to solve, that instead of giving them top priority for our best research and medical brains, instead of bringing them into teaching hospitals in large numbers, getting our best scientists to study them and work with them, we do the exact opposite—refuse them admission, get rid of them as quickly as we can, and put them in a nursing home where they get some of the worst medical care of which we are capable.

Concentration on acute cases. The concentration of medical care institutions on the acute and clinical illnesses, again the third stage of medicine, is fine. But, the unmet need in our country today is the chronic illnesses which are not acute and often not clinical.

Denial of staff privileges. A curious fallacy is that of the individual physician who is most interested in comprehensive family medical care. He is the general practitioner. We have so arranged our society of medicine that he is the one person kept at the longest arm's length from our best medical care facilities. In my city, for example, few general practitioners are admitted to the best hospitals. I am not for one instant suggesting that we lower the standards. I am merely pointing out a fallacy of our present arrangements for medical care.

The one person who is interested in integration, who is trying to tackle the first, second, and fourth stages of medicine, is the one kept farthest from the best health facilities in the community.

Dr. Robert Haggerty, professor of pediatrics at the University of Rochester School of Medicine, last summer looked into the practice of general practitioners and found them undertaking an amazing amount of the first, second, and fourth stages of medicine. I don't know whether this is true throughout the nation, but if it is, then perhaps the general practitioner may not lack a future, because he is meeting a problem which may not be met in any other way. And one of the major questions in the future is how to bring this interest of the general practitioner into the best medical facilities we have. I am not saying that the existing general practitioner is the best one to do it, but I am saying he is serving some purpose, which is not integrated with the rest of medicine.

The community hospital. We definitely have a lack of responsibility for community problems. One of my stories in this regard is that when I asked the staff of a local hospital in New York "How would you like to move more toward being a community hospital?" the director of internal medicine gave me a fishy stare.

The director said, "What do you mean by a community hospital?"

I said, "Well, there is no time to give you a long, prepared talk. I will tell you in just two sentences: There are diabetics in New York City in the area around your hospital. We in the health department will find the diabetics through a detection program and when we find them we will turn them over to you for treatment."

Whereupon he became completely horrified and said, "Well, I have enough diabetics."

I said, "Well this is what I mean by a community hospital. Let me go one step further. Suppose we say there is a 50,000 population in your hospital area, and, with normal detection yields, suppose we find 1,000 diabetics that need a workup. Maybe we can do this workup on an outpatient basis with doctors who are related to your staff, but who would work in clinics in our own district health center. Then we would find among the 1,000 diabetics 50 with flame hemorrhages of the retina, with neurological disease, and some who do not respond to insulin."

"Oh," he said, his eyes getting big. "I am writing a paper on that. That is just what I want." Well, how does he expect to get these patients unless we can develop some major community programs in his area?

So, it is possible to develop a partnership and let the profession of internal medicine have what it wants, and then use a little bit of its prestige or influence to help the health department or cooperating agency develop its part, and together we have a community program.

We certainly have lack of feedback from the community. I have seen hospitals developing highly specialized programs when communities around them were crying piteously for a totally different kind of program. One hospital, the Gouverneur Hospital in New York, did a small study on the needs of its community and found an enormous need for dental care. Together, we moved in with extra services and developed a dental care program, which has become the most popular program in that institution. Not that popularity is the final answer. However, there was a need, and lack of feedback through the years had allowed this institution to undertake other programs without any concern for dental care. This hospital was ready to build a new cardiac surgical wing and had never before been interested in the real needs of this area.

The teaching hospital. Another fallacy is provided by the teaching program of the teaching hospital. What is the teaching hospital teaching? In Boston, Dr. Kerr L. White demonstrated that 700 of 1,000 adults became ill within 1 month. Of the 700, only 1 was admitted to a teaching hospital. Therefore, medical students were primarily being taught by observation of only 1 of 700 sick persons out of a population of 1,000. This is hardly medical education in terms of what illnesses people have and the current major health problems and needs.

The proprietary hospital also poses a problem in many areas where some of the most highly qualified physicians are weaned away from the teaching hospitals to proprietary institutions, which generally have lower standards for education and training.

Control of hospital admissions. The last fallacy on my list, which could have been much longer, is that of the control of hospital admissions by residents. Few professors will battle the resident on this point. Of course, the resident should have the teaching material he needs, but the present admission policy of teaching hospitals is a fallacy in terms of the health needs of the community.

The Goal

What can we do to reach the goal of universal access to high-quality, comprehensive health and medical care? Ten years from now, perhaps I could say only universal access to medical care, because by then perhaps all of the other adjectives would be understood. But they aren't yet.

This goal is not controversial. Everybody wants everybody to have all the care he needs and wants it to be comprehensive care. How we reach that goal is what causes all of the bitter arguments.

One step is to improve access by removing barriers. The major barrier, removed partly by Federal Government, is the financial barrier. Medicare is largely a minimal program. It does provide services at minimal cost for a group of people who found it difficult to get this care before.

But there are many more barriers other than economic. There are geographic barriers. There are educational barriers. We have found, for example, when a clinic is open from 9 a.m. to 4 p.m. that is is very difficult to get working people to go to it. That is why they go to emergency rooms at 3 a.m. If you expect mama to come, you must realize that she can't until she gets somebody to watch her children. If you can arrange a family clinic and invite the entire family to such a clinic at 7 p.m., then perhaps they would be more likely to come. Some of the demonstration programs now underway indicate that this is true. When services are arranged to accommodate the patients, the response is much greater.

In the past we have provided services and then tried to educate people to use them. This is good, but then the unmet need must be studied. If persons are not using the service because their motivation with respect to this pattern of care is not sufficient then we try more education. We have a girl known as a social worker. Once I defined a social worker, at a meeting of about 2,000 of them, as a girl who tries to fit a square patient into a round program, because what the social worker does is try to guide the patient through the maze of existing facilities.

But why don't we try another approach? Why don't were arrange some of the programs to fit the existing motivations of some patients?

New York City's cervical cancer program illustrates this point. We opened a clinic in one area and mostly Jewish women attended. Very few had cancer of the cervix. We then moved the clinic to the Harlem area. However, most of our patients were still Jewish women—they simply stayed on the subway a little longer to get to the clinic.

Let's face it, in Harlem there is a struggle for existence, and here the need to have a Papanicolaou smear receives very low priority. Eventually, we opened a routine detection service for hospital admissions. All the women in this area, when ill, were admitted to two hospitals. We saved more than 300 lives through this little program alone in just a few years by arranging the service to fit the existing motivations of the patient.

In attempting to reach the long-range goal, we have to go through certain intermediate steps. What intermediate steps should we use? Let's admit first of all that the goal as I have presented it is a good one, that the facilities, the hospitals, are good ones, and that they are operated by sensitive, flexible people who would like to reach that goal some day.

How do we go about effecting improvements? How do we get hospitals to adapt? The hospitals will not ordinarily adapt themselves—they have to be pushed or they have to be pulled. They can be pushed by some rules and regulations, and that has to be done gently, but firmly.

For example, in New York City, we have said to hospitals, "If you wish to be paid by the government for care of medically indignet patients, you will have to do certain things which provide high-quality medical care. Otherwise, we are very sorry but we can't give you the $36 or $40 per day." Few hospitals in New York would care to lose this source of income. What we need in this country, in my humble opinion, are more programs which offer bonuses to those institutions willing to develop new and progressive demonstration-type programs which will feed back into the institutions and reshape them to meet health problems, present and future, along the lines I have mentioned.

We have used a particular technique in New York City—we have our own little National Institutes of Health. Eight million dollars per year are awarded for research, and a group of scientists organized like the NIH study sections and councils recommend how it should be allocated.

We gave a large amount of money to a study group at Cornell University which conducted a medical care project for a welfare population. As soon as families

were admitted to public assistance, they were called in and given a complete medical workup. They were seen in the outpatient department. They were followed on the wards. They were seen in nursing homes, and they were part of the regular home-care continuation program. In other words, they were given comprehensive, professionally competent fourth-stage medicine. We couldn't force them to come in, but between one-half and two-thirds did. Why the others did nt come in is another problem for later attention.

During the operation of the project, Cornell, for the first time, had to have signs printed in Spanish placed in the waiting room. This was a new population entering the institution and presenting new kinds of needs. Physicians at Cornell were now able to study health needs that existed in their area. Also, from the data on use, the people in this area rarely use home care services. They prefer to go to the clinic with their families to see the physician who is following them on a continuation basis. A study is also being made of the costs of the project.

A similar, but less costly, program was undertaken at St. Vincent's Hospital in New York City. This institution was given a small grant, and its staff approached the feedback and adaptation mechanism a little differently from Cornell's. They started with selected patients in the outpatient department. For some persons they had records, for some they did not. But they put the pieces together from the hospital records and manufactured a family record. Then they invited other family members to come for a medical examination, and thus they created a special family clinic. The program has had an enormous effect on outpatient care at St. Vincent's, and the staff has seen the value of such a program.

One institution is studying emergency room admissions to see to what degree these patients can be placed in a medical care system, doing more with them than merely pushing them through the revolving door and getting them out. This institution is also working with the health department on a number of joint clinics.

Another institution has investigated the prevalence of neuromuscular disorders in an area of New York City to determine what could be done to rehabilitate persons with these disorders. It is also studying whether rehabilitation services for stroke patients early in the course of the disease can prevent the disease from getting worse in terms of the rehabilitation potential.

One hospital opened a small branch clinic in a housing project having 1,500 elderly, medically indigent residents. Two internists who staff this clinic are able to prevent the need for 90 percent of the patients to attend the hospital clinic 4 miles away. This plan offers an enormously greater opportunity to reach aged patients, and it is bringing service to the patient in a most effective way.

A voluntary hospital in New York City is teaming up in a comprehensive program with a city hospital and the departments of health, mental health, and welfare. The director of the hospital is responsible for all of the health, hospital care, welfare medical care, and mental health care for more than 150,000 persons in Lower Manhattan. The attending staff of private physicians are caring for the patients who can afford private care, and the clinics are treating patients who are medically indigent. One of the first things the director found necessary was a number of satellite clinics. Although the number of outpatients tripled within 1½ years, the project still is not reaching enough of the 150,000 people, and the director plans to open branch clinics.

One of the interesting byproducts of the projects in New York City is the development of positions in hospitals for experts in community care, and a large number of hospitals are now doing this. This is of particular interest because in this way the hospitals can recognize their responsibility for the unmet health needs of the community.

Finally, a word about categorical versus general approaches. In the past we have taken the viewpoint of an agency, a facility, or a profession. What we have to do is look from the patient's standpoint. The person who can teach an 11-year-old not to smoke is much more effective in the control of lung cancer than the chest surgeon. I think we are going to live with categorical specialists and categorical approaches for a long time. I think this is good and it is necessary, because we certainly want to know more and more. But on the other hand, at the point where the service reaches the patient, let us learn how to develop the ingenuity to integrate and coordinate our efforts around him.

APPENDIX 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

WORCESTER, MASS., *June 18, 1967.*

DEAR SENATOR SMATHERS: Thank you for inviting me to share my experience in the study of "the organization of health services today, and to determine whether our methods of delivering such services are raising costs to the elderly, or depriving them of even the opportunity to receive such services."

Primarily my statement is the result of personal experiences in the private practice of medicine. My observations are also derived as a member of a community hospital with teaching services for house officers, residency programs and a nursing school. At a community level I have also been Chairman of the Committee On Aging, Community Services of Greater Worcester, Inc., which participated in the seven (7) cities Ford Foundation Project on Aging.

I am the Founding President of the Age Center of Worcester Area, Inc. This is a central non-profit agency devoted to development, implementing, and giving services to the Older American in the areas of information and referral, craft shop outlet for people to sell their creations, and a senior service volunteer corps.

For the past three years the Age Center has carried on a Nursing Home project with the aid of a U.S. Public Health grant. As Project Director of this project, we have attempted to study the effect of special consultative services in nursing homes.

I am also a member of the Subcommittee On Aging of the Massachusetts Medical Society.

The Worcester area has over 30,000 men and women 65 years old and over. This is over 10% of the total local population in the Worcester area.

I must again emphasize that my statement is entirely personal and specifically that derived from the local situation.

It is nearly a year since Medicare was launched, but the anticipated rush of patients never occurred. As the President of the American Medical Association has recently stated in effect, that doctors in hospitals are finding it less difficult to live with Medicare than they expected.

The question of our "rising medical costs causing special difficulties for the elderly" as far as I can determine, they are not. The only area that costs may cause difficulty are in the matter of drugs. For the most part, though individual drugs may be high and require purchase by the Medicare patient, this is not a severe obstacle. A Medicare patient requiring drugs which he is unable to pay for can receive them as the result of special plans developed by Roche & Co. a pharmaceutical manufacturer, as well as others, or with the help of the Medical Assistance Plan which is still in effect.

Medicare does not cover glasses for reading.

There may be difficulties in Medicare in the areas which it does not cover such as dentistry, hearing aids, cost of a wheel chair, or protheses. Medicare does pay for drugs that have to be injected.

Thus far I have noted very few Medicare patients who have been unable to afford the system of the "deductibles". This might possibly cause a special difficulty for the elderly, but in the Commonwealth of Massachusetts with its organization of MAA, Blue Cross-Blue Shield Medex I-II-III, assignment of fees by the physician to the State Street Trust Co. as a result of a plan of the Massachusetts Medical Society, as well as private carriers, this difficulty has been fairly overcome.

The second question, "Do many of the elderly face insuperable obstacles in obtaining needed health services?" There are no insuperable obstacles in obtaining needed health services if the community is sensitive to the elderly in their midst, and has attempted to organize its social and medical agencies so that attention can be given to locating and getting the elderly to the sites of the health services.

In the Worcester area the Age Center has focused its work on this through its referral center. The Social Security office, Blue Cross-Blue Shield office, those

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industries which allow their personnel sections to continue to advise their retired employees on insurance matters, are other sources of helping the elderly obtain needed health services.

Perhaps one of the areas, the lack of generalists in the practice of medicine is slowly being felt not only as far as the elderly are concerned, but in the overall population. It is just as frequent in the elderly as in other age groups for them to seek a practitioner of medicine to fit their self diagnosis.

In regard to the question, "Are present health services remote geographically and sociologically from many of our older persons?" Not in this area. However, it may be necessary for a knowledgeable individual or agency to personally escort the older person to that service.

The question, "Are present Medicare and Medicaid policies intensifying old problems in the organization of health services or causing entirely new problems?" In my observation there are two parts to this answer although I have not been exposed except in one case to Medicaid. My experience in that one case would indicate that until State Senator Beryl Cohen's Committee reported on the unwillingness of state welfare departments to acknowledge or provide Medicaid, there was little effort made to implement Title 19.

Present Medicare and Medicaid policies possibly are intensifying old problems in the organization of health services or causing entirely new problems.

In this regard I would refer to a special article titled: "Challenge of Surgery", George R. Dunlop, M.D., in the New England Journal of Medicine, March 30, 1967. In Dr. Dunlop's Presidential address delivered at the annual meeting of the New England Surgical Society, Portsmouth, New Hampshire, September 21, 1966, he focuses on two moral issues American's face in their exploring adventure with Medicare.

The concern in the first place is with house staff training as the number of "charity" beds shrink because of Title 18 and 19. A suggestion is made for the establishment of special "team" specifically to care for Title 18 and 19 patients. The envisioned team would include a house staff with special prerogatives for care, and attending physicians who provide especially close supervision. Secondly, Dr. Dunlop calls for authoritarian reprimand for over utilization and bed wastage.

Everett Shocket, M.D. of Miami, Florida, has protested vigorously and logically to this concept in a letter captioned "Training an Authoritarian in Surgery", in a letter to the New England Journal of Medicine, page 1263, June 1, 1967. Dr. Shocket objected to segregation of Title 18 and 19 patients from other patients because they are poor. His second objection is against regimentation and authoritarianism as a means of solving over utilization and bed wastage.

Undoubtedly there is intensification of old problems in the organization of health services or causing entirely new problems.

Perhaps one of the most significant is the development of authoritarianism within those private groups which have been bitterly opposed to Medicare, and to which Dr. Shocket has revealingly alluded to in his letter to the New England Journal of Medicine.

Present Medicare policies regarding the approval of extended care facilities are causing difficulties in almost all the questions to be discussed in your June hearings.

There are many adequate extended care facilities that can never simulate a hospital. It is hardly believeable that even the "accepted" extended care facilities can be a small hospital, with all the difficulties which will be discussed in your hearing. "Approved" extended care facilities have become difficult to enter if the patient requires a great deal of care; even with the extra payment provided by Medicare for extra nursing service.

It is difficult to see how the elderly requiring nursing home care can afford $5,000 or more for annual cost of nursing home care when this is more than they probably could have earned in any one year of their earning years.

The subject of Home Health Care and Nursing services is also a difficult one to analyze. Worcester is fortunate in that the Visiting Nurse Association is organizing these services. However the dilema of the shift of responsibility from the home to hospital or extended care facility will have to be solved.

Rehabilitation and physical therapy facilities require greater development. Here again, personnel shortages, new and wider concepts of treatment and financial aid are needed.

"Are shortages of trained personnel in the medical and medical-related professions especially severe in fields that serve the elderly?" Definitely. They are specially severe in fields that serve the elderly. This has called for training programs to develop geriatric aids, volunteer corps, to operate in health services. The establishment of in-service training programs in hospitals and in extended care facilities. The Age Center of Worchester, with the Girls Trade High School and other educational facilities has attacked the problem. It is beyond the scope of the present facilities and funds presently available for the purpose to successfully cope with it.

There is a great deal to be done other than to repeat facts such as those which are quoted from Professor Milton I. Roemer, University of California, Los Angeles. This involves private continuance as well as more, not less, sensitivity to the elderly in their midst.

It involves care on the part of the government not to reduce its efforts because of the financial burdens imposed by the world situation. It is imperative that the experience of physicians as well as workers in other fields who have an interest and experience in the areas of health posed by the questions asked by Senator Smathers, shall not be buried by those who oppose the concept of Medicare and Medicaid simply because of a reputation which is still perpetuated against those who are said to have had, and still have "funny ideas about Medicare".

Finally, I would like to direct attention to a special article in the New England Journal of Medicine of April 2, 1964 titled: "Leadership in American Medicine", by John G. Freymann, M.D. When it appeared it made a stir, particularly in the medical academic community. Dr. Freymann contended in his article that only a "Third Force" in American medicine could restore the constructive organization and inspired leadership in the voice of American medicine, the American Medical Association.

The "Third Force" is defined by Dr. Freymann as "this new generation of particularly well educated physicians practicising outside univer-centers. . . ." "Nevertheless, with one foot firmly based on advanced training in scientific medicare and the other on private practice outside the academic sphere, it bridges the gap. (I.e. Between "town and gown", a categorization Freymann disliked.)

Freymann voices the hope that as the result of the "Third Force", "with so many brilliant men among its members the medical profession should not have to abandon direction of its destiny to outside forces." This concept is excellent as far as it goes, but one more step is needed if leadership in American medicine is to become effective. It is the need for the individual physician as well as the local or district medical society to join in intimate community effort to improve Medicare which has meant so much to the millions of Older Americans.

In this regard I can highly recommend the recent work of Robert Morris and Robert H. Binstock of Brandeis University, with the collaboration of Martin Rein (Columbia University Press, 1966) titled: "Feasible Planning for Social Change," critically reviewed in the New England Adage, January-February 1967. The collaborators discuss ways as the result of the experiences drawn from the records of the 3 year study of demonstration projects in Community organization for the elderly conducted in 4 of the 7 cities financed by the Ford Foundation project on Aging. They contend that it is necessary to overcome the wastes of enormous amounts of funds, and professional and citizen man-hours in social welfare planning as it is commonly conducted. These remedies are proposed: 1) differentiation among the planning efforts according to the types of changes sought. rather than to the social conditions under consideration; 2) systematic analysis of the factors that make the feasibility in various different types of planning.

The Subcommittee Hearing on Costs and Delivery Of Health Services to Older Americans is commended for its efforts to "improve understanding of present inadequacies or difficulties in providing health services to the elderly and also to suggest actions that may be needed to solve present problems." It is hoped that its ongoing future efforts which are necessary will be most successful.

Sincerely yours,

SAMUEL BACHRACH, M.D.,
Project Director,
Age Center of Worcester Area, Inc.

DOVER GENERAL HOSPITAL, INC.,
Dover, N.J., July 11, 1967.

Hon. Senator HARRISON A. WILLIAMS, Jr.,
U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: Many thanks for your kind letter of July 6th. It is with real pleasure to forward to our good Senator George A. Smathers the literature that you so kindly asked my permission.

I want you to know you are always at liberty to use any and all literature that I may send you as you so see fit.

Wishing you well, with kindest regards as ever.

Sincerely,

C. T. BARKER, *Director.*

[Enclosure]

DOVER GENERAL HOSPITAL, INC.,
Dover, N.J., June 7, 1967.

NORMAN H. TOPPINGS, M.D.,
President, University of Southern California,
Los Angeles, Calif.

DEAR DR. TOPPINGS: I read with interest in The Week For Hospitals, Volume 3, No. 21, dated May 26, 1967, of the American Hospital Association, as per photostatic copy attached, that you have been named General Chairman of the National Conference on Medical Costs to be held in Washington, D.C., on June 27th and 28th.

As a Hospital Director interested and concerned about both good health care, as well as reasonable cost, and living within the framework of a hospital for over twenty years, one can hardly believe that the cost could skyrocket so rapidly and the changes that have developed in the health and hospital field. In my opinion, some of the changes have been good and some have been very, very bad.

Referring to hospital cost even before, and now that we have in effect Public Law 89–97, as of July 1, 1966, the following are a few of the main factors to control hospital cost, and it is not easy, mainly because hospitals are never closed. We render service around the clock. Also, personnel, supplies and equipment must be available within minutes. Therefore, controlling same is not easy, as well as far too often personnel are being paid and nothing being produced or services rendered. Hospital Directors' hands are far too often tied by the authority of the Board of Trustees that does not live that closely with hospital problems and cost. Likewise, the medical profession is not an easy group to control on a reasonable and honorable basis. Great cost involves:

(1) Unnecessary duplication of paper work that has grown rapidly in the hospital field. Paper and reports do not cure the sick and injured.

(2) Pilferage is a main factor to be controlled in the nature of a hospital service.

(3) Waste, likewise, is a factor of high cost that must be controlled, and is not easy for many reasons.

(4) Getting an honorable day's service from each employee for their salaries paid.

(5) Controlling the medical profession is a costly factor and not an easy one and great cost is involved because of the medical pressures, far too often poorly evaluated on the part of hospitals or properly authorized people.

(6) Patients being admitted to hospitals because of health insurance and/or other third party insurance that ordinarily would be taken care of at home. This is a great convenience for the patient, the family and the physician, but we must realize it is costly. Also, the general public today is demanding hospital care because it is a convenient factor, again for the family, with everyone working and no one at home to even take a little time or give a little attention to someone that may not be feeling up to par. Here again, if this is the type of hospital care and service the general public is demanding, we must realize it is going to be costly, unless it is controlled in a strong and honorable manner.

(7) The medical profession practicing on the heavy side of legal protection at the expense of the hospital, the insurance company, the patient and now the taxpayers, with Medicare.

(8) The medical profession is not hurt financially or responsible for financing hospital care. Therefore, they are not concerned about cost.

(9) The medical profession having no control and not being able to control within, with the attitude that you must be a physician to make decisions. A lay

person is pressured far more by the medical profession than any other profession that I can think of along life's way.

The above statements are not made in an unkind or derogatory manner. We have been floundering around for years and constantly criticizing hospital cost. Yet, too few people will speak the facts. The other is there is only a limited amount of people in the health field that will have the opportunity of knowing the cost problems involved.

The medical profession is a great one and certainly one of the most important to our way of life. Yet, we have our problems in controlling our health cost, with the largest percentage being controlled by the medical profession because of some of my opinions that I have already mentioned.

I further question if Boards of Trustees have out-used their usefulness, as in years gone by hospitals were established and it was the responsibility of Trutees to formulate policies, as well as find ways and means of financing the service to the patients. This meant that great interest and efforts had to be put forth by Trustees in raising sufficient funds, as well as greater interest in policy making for the financial protection to the patients, as well as responsible for good patient care.

Within the last decade, health insurance has grown by leaps and bounds, as well as other insurances of a growing nature, of compulsory compensation insurance, as well as local, state and federal aid in many directions. Liability insurance has grown far greater than history has ever known. We have gone through a long period of years where the economy of our great nation has been favorable for the earning power of our people, which all spells out that the health cost to our patients, community and nation has now reached a new plateau of financing, which has meant, to a large degree, that cost has been allowed to skyrocket, with Trustees not being concerned about raising funds.

We have further overlooked, in my opinion, that hospitals today are big business. Anyone selling to hospitals is selling at a profit, whether it be equipment, supplies, medicine, maintenance and repairs, etc. Employees today in hospitals are now earning a fair and more reasonable, justified salary equal to other walks of life in the categories of the many types of business that are placed under one roof of a hospital. Other benefits, likewise, have been granted to the employees, which they are well-deserving of, provided the service is rendered honestly and faithfully in their responsibility to the patients, the staff and the hospital.

Unfortunately, we have been unable to organize and operate hospitals with the same business-like manner that we find in other industries because of the few reasons I mentioned earlier in this letter. Also, in the hospital and health field, it is the opinion of the medical profession that great advancement has been made in research, equipment and treatment, which has brought about costly equipment, costly technicians and personnel to understand and use same.

It is further my opinion that much of the so-called advancement is questionable to the cost involved to the average person. The light that I am trying to reflect at this time is whether or not we are allowing any and all hospitals of a general nature to become experimental, diagnostic or research centers in treating the sick and injured, and are we getting away from the down to earth, right to the point illness of our patients and cure them so that they can return to the every-day way of life of caring for themselves and families? Is the common illness and quick return to the cure overlooked? Have we turned too strongly to research and specialties? Are we lowering the standards of every-day medicine, or are we giving the best of care to the every-day patient?

We now have with us Medicare, Public Law 89–97, which was passed by the 89th Congress on July 30, 1965 and became effective July 1, 1966. Here, too, I question if we are going to lower the standards of medical care to a group of people under 65 that must and should be in good physical condition to maintain their own livelihood, families, etc., and to have the health to work, produce and pay the necessary taxes to care for our citizens 65 and over under Medicare.

With the growing percentage of Medicare patients being admitted to general hospitals, I am concerned about this most important point. I am in favor of Medicare. I am in favor of caring for our senior citizens. I am in favor of anything that is good for the people of our nation, provided it is done on an honorable, reasonable basis, in fairness, as much as possible, to all, although I am strongly of the opinion that we have fallen short of providing sufficient facilities for caring for a large percentage of our Medicare patients of a nursing home nature, more so than a general hospital.

Medicare now faces hospitals with the following problems: The nursing profession discouraged and becoming more so in caring for elderly people, more of a nursing home type patient than a general hospital, keeping them clean, feeding them, great patience that is needed in encouraging them patient-wise, in giving medications, keeping them under control of falling out of bed, falling out of chairs, etc. These patients are not general hospital patients and the nursing profession is being lowered because of the morale. The cost is great.

Also, hospitals are now faced with general facilities, such as x-ray, medical laboratories, other trained technicians, such as electrocardiograms, electroencephalograms, etc., for patient care, which would be of value to the medical profession in ordering to restore health to the younger to return to their way of life, as I have spelled out previously in this letter.

Medicare patients have become costly patients to general hospitals by occupying beds that are only limited to nursing care. It is true that we have established throughout our nation screening committees, as well as utilization committees of the medical profession. Here again, I question throughout our nation the real effect of these committees, in action, and it is further my opinion that unless the people serving in the hospital field are given authority in controlling many of the factors of hospital cost and procedures and unless we in the hospital field are given honorable and cooperation support by the medical profession, unless the general public realizes that health care is costly and that hospitals should operate and care for the sick and injured and not be used to the large degree of making it a convenience for the patient and family to be cared for in general hospitals rather than at home, unless the general public realizes that luxuries within hospitals must be curtailed and accepted by the general public, we have nothing else to look forward to than higher health cost. Unless a miracle should take place that the authorities and responsible people running and controlling hospitals, the medical profession and the general public were to work as a team in an acceptable, honorable fashion, much can be done to control health cost and still have good health care, or we will continue to be faced with high health cost.

The other is if our law-makers are sincere and concerned about Public Law 89–97 and our health cost, they will provide sufficient funds to build nursing and convalescing homes to be run under the supervision of a general hospital, where great economy can be used in still using the laboratory, x-ray and other facilities of a general hospital, when needed for Medicare patients in a convalescing nursing home type facility; not on a profit basis. I have reasons to believe that this would be the greatest answer to good patient care of the Medicare patient at a more reasonable cost to our taxpayers and patients cared for in general hospitals. I would challenge this thinking. Also, if we fail to accept the above, I personally feel we must look to some drastic action in order to correct the health cost without lowering the health standards.

Dr. Toppings, you have before you a most important and serious assignment, and I offer to you my fullest support and best wishes that you find some of the answers that we need to our way of life of good health care at reasonable cost.

I am attaching some literature which spells out some of my thinking and experience in the hospital field, if you care to review same.

Also, I would be most appreciative to receive a copy of the report concerning the National Conference on Medical Cost of June 27th and 28th in Washington, D.C., when same is complete.

Thanking you for your time. Wishing you well with the utmost success in your assignment as Chairman of the National Conference on Medical Cost.

Sincerely yours,

C. T. BARKER, *Director.*

ROSSMOOR-CORTESE INSTITUTE FOR THE
STUDY OF RETIREMENT AND AGING,
UNIVERSITY OF SOUTHERN CALIFORNIA,
Los Angeles, Calif., July 11, 1967.

DEAR SENATOR SMATHERS: I will welcome the opportunity to contribute at any time to further the goals of your Committee in improving the health of the elderly.

I have been impressed by the fact that the age specific death rates in this country for adults have not shown any improvement in recent years. This failure to gain, and in some cases an actual increase in mortality rate, suggests that

we have lost some ground in maintaining health. One should not conclude from this that our improved medical technology and medical research is irrelevant to the fundamental conditions, but rather, I suspect, infer that the environment has become increasingly adverse. As we broaden our inquiry to include some of the more remote antecedents of the level of health of middle-aged and older adults, we include many social and behavioral factors as well as the physical environment. The important variables in these relationships do not now fall within the purview of representative medical education. For this reason, medical services are best adapted to high quality care for hospitalizable conditions.

I would infer from the present health scene that bio-medical research and medical education will have to broaden its scope to include more training and research on the remote antecedents of health problems of adults. This will place both the health practitioner and the bio-medical researcher in new relationships with other fields, the physical sciences on one hand and the social behavioral sciences on the other.

More immediately, however, one might infer that we are delivering specialized services too near the terminal stages of diseases and we should make efforts to deploy services earlier in the processes of chronic diseases. To deploy services implies early detection and a more developed system of preventive health than is now commonly organized.

Best wishes to the success of the inquiries and actions of your Subcommittee.

Sincerely,

JAMES E. BIRREN, Ph. D.,
Director.

ROSSMOOR-CORTESE INSTITUTE FOR THE
STUDY OF RETIREMENT AND AGING,
UNIVERSITY OF SOUTHERN CALIFORNIA,
Los Angeles, Calif., June 16, 1967.

DEAR SENATOR SMATHERS: I am pleased to make a statement to the Subcommittee on Health of the Elderly. I regret, however, that because of my teaching schedule I will not be able to attend the hearings on June 19th. One of the limitations of the way health services are organized is that the needs for health services cannot be anticipated while individual health problems are in their early stages. This is particularly true in the elderly. Individuals over the age of sixty-five commonly suffer limitations of mobility and cannot travel easily to medical centers. Also, health services tend to be geographically ad psychologically remote from older persons. For this reason, they infrequently present themselves to health specialists unless a personal problem is advanced or acute in nature. At that time, the costs are high.

Insufficient effort has been devoted to ways of anticipating the need for specialized health services to the elderly. I have personally known aged persons who have had to receive dramatic and expensive care because the organization of health services did not lead to the early detection of incipient illness when intervention would have been less expensive and certainly more productive. The existence of Medicare and Medicaid does not solve the problem of making health services more easily available to older persons early in the development of serious illness. In this regard, I believe there is a notable shortage of trained personnel who have the background, conceptually and technically, to attack the problems. Public health personel can be trained in this area, although it must be said that until now they have been mostly concerned with matters other than health services to the aged. Schools of medicine may be encouraged to establish Departments of Community Health to train needed personnel. The issues appear to be less a matter of the quality of the technical health services than of how these health services are deployed and brought to the individual as early as possible in the course of an illness. This later matter is an area of study for medicine and for the behavioral and social sciences.

I personally have not been impressed that we have made any notable recent improvements in the health of middle-aged and retired persons. This is not intended to be a criticism of the quality of services but rather a comment about the need for broader study of health in relation to age and the delivery of services. It also occurs to me that The National Commission on Community Health Services may have examined the position of the elderly and their health needs in the total context of the quality of health in America.

Sincerely,

JAMES E. BIRREN,
Director.

ROSSMOOR-CORTESE INSTITUTE FOR THE
STUDY OF RETIREMENT AND AGING,
UNIVERSITY OF SOUTHERN CALIFORNIA,
LOS ANGELES, CALIF., *June 20, 1967.*

DEAR SENATOR SMATHERS: I am William R. Larson, Associate Professor of Public Administration and Sociology at the University of Southern California. I am also Research Associate in the Rossmoor-Cortese Institute for the Study of Retirement and Aging at the same University. Dr. James E. Birren, Director of the Institute suggested that I write to you about the questions you had posed. I am pleased to take this opportunity to present my views on some of the current problems in health care and services for the aged. As a medical sociologist, my particular research interests lie in the urbanization and aging process as it affects the type and quality of health care provided for the elderly. At our Institute, we have just begun a pilot study of some of these matters under a contract with the U.S. Public Health Service (PH 110-94).

A major characteristic of community medical care provisions that is often overlooked is the "two-way" nature of medical practice and care. Medical knowledge is primarily based on the cases and phenomenon which have been brought to medical attention. The early process of disease, the health medication habits, the behavior-altering attitudes, these are often unknowns to medical practitioners. What is needed is a *system* of medical data acquisition on a large scale, covering those special sub-populations such as the elderly.

Currently popular programs for the development of "age-segregated" housing for older persons have the effect of isolating them from general community health facilities. Transportation routes, waiting time, fare costs and mobile unit design contribute to the difficulties the elderly meet in using public transport facilities.

The recruitment of trainees into geriatric and gerontological fields has been dragging, since little "glamor" is attracted to care of the elderly. Although research on the aging process itself is in vogue, there seems to be few programs aimed at offering specialized and continuing education for physicians and paramedical personnel in the special needs of the aged.

It would appear that concerted effort is needed which can deal with problems of transportation, spatial segregations, specialized education, and legislative integration with programs.

I can envision a number of mobile clinics, operating on the newly developing multi-phasic screening principles, which could help to solve a number of the problems I've mentioned. By providing health data on a broad, community-wide scale, and using computer data storage techniques, such a system could allow physicians to get a far greater exposure to vital information on physiological, psychological, and social characteristics. By the use of educational system controlled by the data bank computers, physicians could participate in a learning experience. Community and public health organizations and personnel would have direct access to computer-based health information systems, allowing them to better plan for their involvement with those needing services.

The major element lacking thus far in dealing with the special health problems of the aging seems to be the failure to develop an overall systems approach to health information. As I have described it, the several social sub-systems involved need to (be) considered simultaneously. The present plans under way at our Institute are examining this approach, and I hope these hearings will cause others to move in a similar direction. Thank you.

WILLIAM R. LARSON, Ph. D.,
Medical Evaluation Data Systems,
Project Director.

THE CITY OF NEW YORK,
HEALTH SERVICES ADMINISTRATION,
OFFICE OF PROGRAM PLANNING AND EVALUATION,
June 23, 1967.

DEAR SENATOR SMATHERS: This is in response to your letter of June 7th, 1967. There is no doubt that Medicare and Medicaid together will, when fully implemented, provide substantial fiscal relief to urban communities which have in the past provided a substantial portion of the hospital and nursing home care which low income elderly persons have required, out of their limited fiscal resources.

It is also clear that Medicare, to the extent that its present benefits cover the medical expense of beneficiaries, provides for many elderly low and middle income persons the important element of human dignity and freedom from the worry of medical indigency by substituting entitlement to contributory insurance benefits for the previous welfare medical benefits available to them.

Younger families, with elderly dependents, have also benefited from this new security, and many of them have in fact been relieved of drains on family income involved in paying for medical care costs for these elderly dependents.

However, if the costs of medical care continue to rise as they have been in the last year or so, these increasing costs will create special difficulties for the elderly. Part of the fiscal relief provided by Medicare to both the community and to individual families will, in part, be cancelled out by these rising medical costs. As negotiated rates for hospital and physician reimbursement under tax-financed, open-ended programs rise, these negotiated rates tend to become the prevailing rates. This can only result in higher costs for middle income families not covered by the Social Security Medicare programs—i.e., higher voluntary health insurance programs and, of course, increased out-of-pocket costs for the uninsured portion of the medical care expenditures. For such items as drugs, sick room supplies, dental care and other non-covered items, the elderly with fixed incomes are adversely affected by rising costs.

Thus one enormously important area for public policy consideration is the impact of these developments on the entire area of non-subsidized medical care services, and especially on voluntary health insurance. It seems inevitable that there will be increased public concern with prepayment for health insurance coverage for the entire population. This suggests that profound and quick study of the problems here involved, and of possible alternative course of action, should receive immediate attention in the Congress and in the states.

It is too early to appraise what has been the impact of the new Social Security titles on the shortages of personnel, or on methods of utilizing the medical and medically related professions. It is not too soon to begin to make the observations and measures needed to assess these developments, and this New York City is now preparing to do.

Both Medicare and Medicaid have resulted in increased demand for health services. Voluntary hospitals are over-crowded, and elderly patients seeking elective surgery must often wait a number of months for admission. Extended care facilities are in great demand, and there has been considerable difficulty in finding bed space. Home health care needs to be dramatically expanded. There are not enough agencies nor personnel to fill the need. Aged patients seeking care in outpatient clinics are often subjected to fragmented, de-personalized services that characterize many of our clinics. The result of all of these factors is that in many instances the present health services are remote, geographically and sociologically, from many of the elderly. However, this problem is not confined to the elderly. It is more intense among the aged. The possibilities of developing neighborhood health programs and restructuring organization of health services and personnel in relation to these neighborhoods, needs to be examined.

It is quite clear that there is an intensified need for intermediate institutional arrangements of a satisfactory quality for aged persons—or, extended care facilities of the type encompassed by Medicare; improved quality and availability of nursing home type of accommodations; improved availability and quality of homes for the aged, on the one hand, and of organized services that will permit the aged to be maintained comfortably in the community, in preference to institutionalization in those cases where this is clearly the preferable arrangement.

A major problem in the present program is the very great need to simplify enrollment and payment procedures, particularly under the Medicaid program. Because the Medicaid program went into effect so quickly, the necessary tooling-up period for developing procedures was not available. Funds to permit adequate staffing of health and welfare agencies administering the law should be increased, and incentive should be provided to try new approaches to these problems. Moreover, some of the State programs for Medicaid split the responsibility for the program between the health and welfare agencies. No matter how good the degree of cooperation between these groups, it is impossible to run a program of this magnitude effectively and efficiently under this split responsibility.

There are shortages of trained personnel in the medical and medically related professions that serve the elderly. The elderly require more nursing care in hospitals and in extended care facilities. Nursing care in both of these is in short

supply. Rehabilitation services are particularly needed for the elderly in home care programs, as well as in extended care facilities. Moreover, the presently available personnel in the medical and medically related professions need re-training in the special problems of the elderly. This is particularly true as regards the problems of mental health which present themselves in the elderly. Dental services and the services of podiatrists are especially important in the elderly, but the supply of dentists and podiatrists is not nearly enough for the demand.

I hope that these comments are of some value to you and your Committee, and that they do not arrive too late to be of service. Dr. James G. Haughton, First Deputy Administrator in the Health Services Administration, will be glad to testify on these points at the hearings of your Committee, if you would like him to do so.

Sincerely yours,

PAUL M. DENSEN,
Deputy Administrator

SINAI HOSPITAL OF BALTIMORE, INC.,
Baltimore, Md., June 14, 1697.

DEAR SENATOR SMATHERS: I'm responding to your letter of May 31st and enclose a copy of the comments that I'm making at the American Geriatrics Society in Atlantic City in a panel on Medicare on the afternoon of June 16th. These comments include answers to some of the questions you raise in your letter.

With approximately half of the elderly in this Country living on incomes at the poverty level or lower, it is obvious that the continued inflation of medical care costs affects this group with fixed incomes more than almost any other sector of the population.

The poor elderly also meet tremendous obstacles in obtaining needed health services. They are not only faced with inadequate numbers of health personnel for their needs, but such personnel is not present in their own neighborhoods. In addition, the elderly are faced with real transportation problems to reach the health resources available in their community. When public transportation is not available, the elderly often cannot afford substitutes such as taxi fare to hospitals or clinics. Organized medical services do not exist and physicians' services are often not available on nights and weekends and so the aged find themselves forced to use emergency services of hospitals where they receive fragmented care and certainly not a plan of care adequate to their needs.

Some of the necessary services for sensitive care of the older person such as home health aides, visiting housekeepers, meals-on-wheels, social services are in short supply or are simply not available. The entire concept and development of comprehensive health teams brought to the neighborhoods where the elderly live is yet to be implemented.

Medicare may indeed have intensified some of the problems affecting the organization of health services in the interest of the elderly. Since the legislative mandate of Medicare and to a lesser degree, Medicaid is to purchase care from the providers of service in the traditional fragmented fashion—fee for service care, it leaves much to be desired at this time in promoting a program for organizing the services for the elderly with a plan of care. Up to now, there has been little encouragement of payment for comprehensive care programs and without such emphasis, the providers of traditional services in the health field will not be impelled to organize themselves in the interest of total care for the elderly.

Your committee, I hope will consider the uncovered cost of drugs, regular eye care and dental care as serious defects in the present Medicare legislation. Finally, we have found the coinsurance features, the deductibles to both confuse and work a hardship on the elderly. The coinsurance features are also difficult to administer and perhaps your committee will concern itself with the cost to society in personnel and money by the law's mandatory coinsurance features.

Sincerely yours,

FRANK F. FURSTENBERG, M.D.,
Medical Director.

[Enclosure]

IMPACT OF TITLE XVIII ON OUTPATIENT DEPARTMENTS

My formal assignment is to bring to you some of the changes Title XVIII has had on the outpatient departments. To do this I share my observations with you concerning the fate of Medicare patients in outpatient departments since the

program's inception almost a year ago. Our group at Sinai Hospital has often speculated on whether Title XVIII has been good, bad or indifferent for the aged person seeking care in the clinics and emergency services of the hospital. Have the rights and the payments intrinsic in XVIII produced more and better care for the elderly in the clinics of our hospitals in this Country? While I'm not privy to any survey of the changes and the problems that the aged have encountered in the Country's outpatient departments since last July, our experience at Sinai Hospital and my knowledge of other outpatient departments in Baltimore and elsewhere allow me to make a number of disquieting comments.

Older persons, the chronic sick and children in ever-increasing numbers continue to seek care in the outpatient departments in hospitals in urban areas. The elderly are by and large the poor and the medically indigent, formerly the Kerr-Mills recipients and now the Title XIX aged. *The care they receive in outpatient departments is fragmented, impersonal and given with little dignity. There have been few efforts by the hospitals to give these aged persons services which include a plan of care, comprehensive in scope, with continuous responsibility by designated health personnel. Services have not been designed to maintain the older person independently in his community medically and emotionally secure with maximal usefulness to himself, his family and society.*

An opportunity offered itself at Sinai Hospital six years ago to develop a professional group consisting of physicians, nurses, social workers and other health personnel to give continuous seven day-a-week, around the clock care to the elderly, delivering their primary medical services in the outpatient department setting. This team also gave indicated services in the home, the nursing home and the hospital. At present about 500 patients from our hospital district have selected our hospital outpatient department for this care. These patients are largely Social Security beneficiaries with limited income and classical of the geriatric patients who frequent the clinics of our Country. We are keenly aware how Medicare has affected these persons and are also conversant with its affect on other persons 65 and older who use our outpatient department for regular and emergency services.

There is no data as yet tabulated that I'm aware of which would give us facts of trends and usage patterns by the aged of the hospital clinics a year after Medicare, but in my conversations with outpatient department administrators in Baltimore and in a number of large urban hospital outpatient departments elsewhere there has been no sharp trend indicating increase or decrease in clinic use by the persons 65 and older. *More important is the evidence that Medicare has not made any real difference in the services given in the quality of care or in the organization of care.*

Some of us have speculated why the aged person has not left the outpatient department to return to a personal private physician now that this course can be taken if he has Part B Coverage. Is it because the poor and some of the ethnic groups feel that they obtain better or more interested care in the outpatient clinics or their favorite institutions than they do in the neighborhood physicians' offices? There are institutions who have been concerned with the chronic sick and the aged in Baltimore, both the Baltimore City Hospitals and Sinai Hospital have emphasized special programs for these needy persons. Do the elderly continue to come to the hospital because private medicine has deserted the poverty areas in the central cities where many of the aged reside and though the aged may now be able to pay for care, physician's services are in short supply, absent at night and week ends? Is it because many of these multi-problem, economically marginal individuals present such troublesome social problems that the solo practitioner is ill-equipped to handle these problems and for which his physician time is too valuable? Or is it because Medicare is so complex with its deductibles, co-insurance features, and lack of coverage for drugs, as well as lack of cash in the hands of many of the elderly that they prefer to cope with the impersonal outpatient departments rather than feel as second-class citizens in the solo practitioner's office because they have to ask the physician to accept assignment for payments of services?

There probably is no single answer for the use of the outpatient departments by the Medicare beneficiaries. There is little question, however, that since Title XVIII basically seeks to purchase services from providers of care for its beneficiaries, *it does almost nothing in social planning for the elderly and thus it has not affected the organization of services in the interests of the aged.* Indeed, in our own institution, we have had some unhappy experiences with some of the patients in our program since Medicare. Thus, a patient referred for surgical consultation or who develops an acute surgical entity may see a surgeon in our

outpatient department or emergency service, who now considers this patient with Part B insurance as a potential and actual private patient and proceeds with his therapeutic regime with little or no regard for the patient's previous care or in total planning for his after-care. Without casting any aspersions on my surgical colleagues, I know that they often do this with their own middle-class patients, but such an individual or his family is able at times to break through the jungle of fragmented care, plan for himself and often then pay for such private services. *It is the marginal aged person who, though he has benefitted by the rights of Medicare, is still unable to cope with its deterrents, uncovered needs for service and cannot find services that may not exist for the poor.*

Frustrating examples that we have experienced in our Aging Center are exemplified by the patient with prostate disease who was admitted without consultation with his personal physician in our group to the genito-urinary service and received necessary surgery without consultation with our staff. There was the orthopedic emergency admitted, operated and discharged to an extended care facility and then the patient was told by the orthopedist that he did not make visits to the nursing home and only then was the physician in our Comprehensive Care Program called. On another occasion, a patient with a cataract, told that she needed surgery, exercised her right to ask for the best in eye care and was admitted to the hospital for operation by one of our best eye physicians who ran into difficulty while the patient was under anesthesia and then called an internist who did not know the patient to give immediate consultation rather than using her personal physician, an equally competent internist, a member of our program. Now we are a hospital that prides itself on the high quality of inpatient care and if incidents such as these can happen as often as they have in our institution, what happens elsewhere where there is no organized program to help this minority group that is unable to compete in the private sector for quality care?

And what happens when the Medicare patient presents himself acutely ill in the emergency services of the hospitals of the Country? He is admitted either to the service area or to the private side with a designated physician. Inpatient services are perhaps regularly given with high quality, but on discharge what happens? Does the hospital physician follow his cardiac patient into the home or the extended care facility? Is the patient recovering from a cerebral accident followed by the interested hospital staff physician after hospital discharge? I'm afraid that the urban hospitals have understandably not felt the responsibility for continuity of care and often have staff physicians who limit themselves to hospital and office practice. The teaching of house officers does not usually include concern about the patient who cannot return to the institution for follow-up care. *I wonder what studies in the continuity of care for discharged Medicare patients with continuing illness requiring home and institutional care would show in specific reference to the implementation of care by any primary health team.*

Sinai has had an organized hospital-based Home Care program, part of our Aging Center since 1961. With the advent of Medicare, the program has gradually double in size and involved the private practitioner in some depth for the first time. It has expedited patient discharge from the hospital and brought an awareness of home health services to the physician. Often the physician has had to think in terms of home health services for the first time because the patients and families have become aware and ask about the specific benefits of this program. There is no question that we were having limited success with an excellent hospital-based Home Care Program until Medicare financed its benefits and the stress for better utilization of beds on the private side influenced the participation of physicians in the home health services and so expanded the scope of our outpatient benefits of a hospital-based home care program.

Now, in all fairness to Mr. Hess, Medicare was not conceived as a comprehensive health program for the elderly. Indeed, having watched the legislation go through Congress and accommodate to the diverse political forces and then later having participated in a number of the working groups of the Social Security Administration in developing guidelines for the present program, I marvel that we have come so far in so short a time. The outpatient department problems are really not central to the main thrust of Title XVIII. In a better-conceived total program for the aged, there could have been more emphasis on prevention

and effective planning for total care rather than emphasis on inpatient care, but in our American scene we take what we get and we try to move from there.

FRANK F. FURSTENBERG, M.D.

UNIVERSITY OF CALIFORNIA, LOS ANGELES,
June 19, 1967.

DEAR SENATOR SMATHERS: Thank you very much for your letter of May 31. My responsibilities as Professor of Medicine (Geriatrics) are concerned more with training in the medical care of older patients than with the socio-economic problems involved. For this reason I can answer your questions only in the context of my own experience.

Questions 1 and 2, "Are rising medical costs causing special difficulties for the elderly?", and "Do many of the elderly face insuperable obstacles in obtaining needed health services?" are related. It is my impression that, although the answers to both of these questions are affirmative, the general trend over the past several decades has actually been more favorable to the older patient. This has been due to the combination of better techniques and facilities, an improved general economy, and special programs especially at the state and federal levels. Your third question, "Are present health services remote geographically and sociologically from many of our older persons?", is also difficult to answer. It is again my impression that the increasing urbanization of our society and the tendency for older individuals to live within particular areas in the community reduces their geographic distance from community facilities and reciprocally tends to make them more accessible for community services.

The present Medicare and Medicaid policies seem to be intensifying old problems in the organization of health services and causing entirely new problems. The most important of the old problems is the shortage of trained personnel, especially in related health service professions. New problems include the inevitable adjustment to a new program, the increased number and the uncertainty of the details of the administrative procedures, the increased and not always appropriate hospital utilization, the problems of appropriate patient placement, and so forth. Many of these problems will undoubtedly resolve when health services personnel become more acquainted with and adapted to the program. However, others are inherent in the program itself.

The most serious problem and one with which I am most directly familiar is the intensification of the shortage of trained personnel. Most health services personnel require prolonged periods of training to meet standards which have been established not only by the professions but by the legal requirements of the program. There are shortages both of qualified applicants and of training facilities. This is true for all health services, not just those related to the aged. Despite competitive salary levels, there are an inadequate number of nurses in California to staff current programs. In some instances hospital beds are unavailable because of personnel shortages. Yet, a high school graduate can receive training as a registered nurse in two years in the junior college program, and after licensure be qualified for positions starting at $600 per month: this is a level comparable to that paid to 4-year college graduates in such fields as teaching and engineering which are more competitive in their requirements. It is true that this wage scale is relatively new, however, even if it were to attract more nurses to California its effect on training programs, if any, will not be felt for several years. At the same time other areas would suffer.

Less well-trained medical personnel, such as vocational nurses, aides, and attendants, have always shown a high degree of job mobility. Aside from economic remuneration, the attractiveness of working in a geriatric setting often suffers in comparison with such fields as surgery, pediatrics, or psychiatry. In my opinion, one of the major problems in the development of idealized medical care programs, and particularly those related to aging, will be the shortage of qualified personnel who can be attracted into the field as long as more apparently desirable occupations are available. In particular, the unattractiveness of the hours must be recognized. It will take much imagination and many new approaches in order to solve this problem. Financing is only one aspect, and perhaps not the controlling one.

I hope that these opinions will be of some use to you.

Sincerely,

RALPH GOLDMAN, M.D.

ALBANY, N.Y., *June 14, 1967.*

DEAR SENATOR SMATHERS: Thank you for your invitation to share with you some ideas on the health of the elderly.

As a specialist in cardiovascular diseases and geriatrics, I find shortages of trained personnel in the medical and paramedical professions that serve the elderly. More training and education must be made available for people working with the elderly. Basically, we are attempting to care for a large portion of our elderly population with personnel oriented and trained to care for younger people. Their habits cannot be easily changed to enable them to work efficiently and effectively in the field of aging. One solution is the establishment of more Institutes of Gerontology in State Universities and elsewhere. A second solution is the development and support of more senior citizen centers which provide qualified sociologic, psychologic and social work services by competent trained professionals. These centers can be set up as multi-disciplinary health centers for the general care of elderly people to keep them healthy and happy physically and mentally. Studies indicate such centers and programs keep elderly people from deteriorating and reduce their use of more costly medical facilities.

At the same time, doctors and institutions should be encouraged to set up new patterns of office care and to improve and renovate their offices and facilities so as to permit easier access for the elderly infirm and disabled, and to increase efficiency and effectiveness of such care. Tax credits and other benefits may be allowed to such doctors or institutions to build ramps and better office facilities for treating older people, who definitely require more time and need more space.

Another major problem is transportation. Elderly people are not mobile and are poorly served by present public transportation. Improved transportation facilities for older people should be developed to permit them to be more active, to end their social isolation, to visit their doctor's offices and other health facilities. Such transportation programs could include the use of omnibuses, and other vehicles, credits to public bus facilities and private facilities to extend their transportation services to older people etc.

Attention must also be directed to improving health faciilties for the care and maintenance of elderly people in each community. At present, many elderly people get expensive medical care in hospitals and then stay longer than necessary because of insufficient facilities in the community to care for these people after hospitalization. Utilization committees and other committees will not reduce hospital census in this age group unless communities build more facilities in the community to care for elderly people in a spectrum of facilities ranging from hospital care through convalescent homes, apartment care, homes for the aged and finally chronic illness homes. Furthermore, regional listing of nursing home beds and other beds available for eldery people coud be kept. At present, it is difficult to find out where beds are available in a region. Why not have Social Security or Medicare offices keep a computerized list of beds available in Medicare approved institutions so that families interested in placing their mother or father in such institutions can easily get this information?

Finally, I also urge you to ensure the use of effective forms and administration in these programs. Medicare is good, but Medicaid in practice, poses many unnecessary and foolish administrative problems to physicians and patients alike, leading to greater costs, aggravation and inefficient operation and relations among physician, patient and the welfare administration. For example, elderly people on Medicare may also be eligible for Medicaid, and are classed in the welfare department category, contrary to Medicare philosophy. Is there any reason why such patients could not be entirely under the administration of Medicare and reduce the unnecessary duplication of forms and other problems which hamper Medicaid?

I shall be happy to elaborate on these points. I take the liberty of enclosing some reprints for your review. I expect that Dr. Robert Morris, President of the Gerontological Society will also send you the position of the Society on these matters.

As you know, the Gerontological Society meets in St. Petersburg in November, 1967. I hope we have the opportunity of seeing you there. If I can be of any further help, please let me know.

Sincerely yours,

RAYMOND HARRIS, M.D.
President, Center For The Study of Aging.

MORGAN GUARANTY TRUST CO. OF NEW YORK,
New York, N.Y., July 14, 1967.

Mr. WILLIAM E. ORIOL,
Staff Director, Special Committee on Aging,
U.S. Senate,
Washington, D.C.

DEAR MR. ORIOL: We greatly appreciate your interest in our discussion of the economics of medical care. I am enclosing a copy of the May issue of The Morgan Guaranty Survey. The article begins on page 3.

Cordially,

MILTON W. HUDSON,
Editor, Morgan Guaranty Survey.

[Enclosure]

THE ECONOMICS OF HEALTH

In the annuals of American medicine, 1966 will be recorded as the year the United States took the long-debated plunge into governmental health insurance for the elderly. It also made history as a time when the prices of medical care—as compiled by the Bureau of Labor Statistics—took one of the largest jumps ever recorded, a 6.6% increase that exceeded the rise in any twelve-month period since 1946–47. Largely because of these two happenings—which in some degree appear to be interrelated—the nation's $45-billion health industry* presently occupies a position of even more than usual prominence in the national spotlight.

Particularly sharp attention is focusing on the swift rise in the cost of medical care—an occurrence that will be explored next month at a conference in Washington to which the Secretary of Health, Education, and Welfare is inviting some 250 persons representing both the medical profession and the public at large. It is expected that the participants in this National Conference on Medical Costs will devote much of their time to discussing and debating various recommendations for using medical resources more efficiently that were advanced earlier this year in the *Report to the President on Medical Care Prices.* This document, known as the Gorham Report after the man who supervised its preparation, Mr. William Gorham, Assistant Secretary of Health, Education, and Welfare, is significant mainly because it argues for a variety of efforts to induce rather far-reaching changes in the way that medical care in this country is produced and distributed.

Whatever the outcome of this particular meeting, there can be no question at all as to the desirability of greater discussion and study of the basic economics of medical care. Despite the large dimensions of the health industry, which employs more workers than do the steel, automobile, and aircraft industries combined, it has suffered serious analytical neglect by economists. Unfortunately, misconception and half-truth about the economics of the industry are commonplace, and they constitute a serious threat to the formulation of correct public policy. And in no area of national life is the need for prudent policy-making any more obvious. Worrisome as the health industry's problems may be to many people, no one wants to initiate correctives that will risk curbing its bounty of wonders and marvels.

Statistical headaches

The rising trend of medical prices is not easy either to measure precisely or to evaluate. The BLS Consumer Price Index, to be sure, includes not only a medical-care component but also 29 medical-care subcomponents that purport to measure a variety of things that range from the cost of aspirin tablets through hospital operating-room charges to the fees of psychiatrists. Additionally, it is possible to construct estimates of the cost, say, of maternity care or an appendectomy now compared with times in the past. All such data portray a pattern of more or less persistently rising medical-care costs and prices throughout the

*The $45-billion figure is a rough approximation of the nation's total anticipated expenditures in 1967 for hospital and nursing home care; the services of physicians, dentists, and other professionals; drugs, eyeglasses, and appliances; medical research; and the construction of medical facilities.

period since World War II and indicate that recently the trend in this direction has accelerated. For the ten-year period that ended with 1966, for instance, the BLS index of the prices of medical services (which in concept covers all consumer medical-care items except drugs) indicates that such prices rose more than twice as fast as did the over-all cost of living—an average of 3.9% year compared with 1.8% a year. The combined index for medical care, including drugs, rose less rapidly on the average in the ten-year-period (by 3.4% a year), reflecting the influence of a moderately declining trend in the BLS index of prescription-drug prices.

Despite the conscientiousness with which such data are assembled, however, they inevitably are marred by some deficiencies that every user should bear in mind. It is clear, for one thing, that they overstate the longer-term rise in the prices of medical services, and probably appreciably, because of the inability of compilers to take account of the considerable but immeasurable quality improvements that have occured over time in medical care. The indices do not measure a fixed and unchanging kit of medical care but instead measure units of medical services that increasingly embody greater and greater know-how and skill. The higher fee a patient pays his doctor for an office visit today, compared with a decade ago, reflects not just a "pure price" increase but also the greater probability that his health will benefit from the call. And the hospital expenses of the maternity patient or the person undergoing heart surgery reflect, among other things, a portion of the cost of having in existence in the modern hospital a variety of services and equipment that guard against complications and fatalities. The quality change reflected in declining rates of maternal and infant deaths pere 100,000 births cannot be measured in a way that permits adjustment of obstetricians' fees and hospital charges, but it clearly should not be disregarded in an analysis of the trends in such prices. While price increases also are undoubtedly overstated for many other components of the Consumer Price Index because of the impossibility of accurately measuring and allowing for quality improvement, the likelihood of such bias is especially great in the case of medical care.

The sharp postwar climb in the prices of medical services, moreover, needs to be viewed in the broad perspective of what has been happening to the prices of services in general. The pattern of increase in the medical area is not an isolated phenomenon, reflective merely of conditions peculiar to the health industry. Rather, virtually all service prices (for personal care, transportation, housekeeping, and so on) have risen much more rapidly since the end of World War II than have commodity prices or the over-all cost of living. The average price of a haircut, for instance, has far more than doubled in the postward period. And for the twenty years that ended with 1966, the general service component of the CPI rose by 91%, compared with an advance of 57% in the commodities component. The underlying reasons for the more rapid rise in service prices are complex and varied, but basically they trace to the fact that the American economy has grown increasingly service-oriented. As levels of affluence have risen, consumers have spent an increasing proportion of their current incomes on intangibles and amenities.

This aggressive bidding by consumers for services has produced upward price pressures in the service area of the economy, particularly because of the limited opportunities that exist in many service industries for expanding output by means of productivity increases. In some areas of medical care—most notably in hospital operations—it has been especially difficult to realize cost savings per ailment or per patient. The American Hospital Association reports that in the past twenty years the number of hospital employees per 100 patients has nearly doubled. In part because the obstacles to "productivity" improvement are especially formidable in health care, the prices of medical services have risen even more sharply in the postwar years than have the prices of services in general. Compared with the 91% rise for all services since 1946, prices of medical-care services are up 129%. The difference, however, is one of degree rather than kind, and it is proper and necessary to view trends in the medical-care field within the context of what is happening to services at large.

Special prods to demand

Rising prices for medical care must also be judged in the light of several special influences that have powerfully stimulated the demand for medical services in the postwar period. One of these has been an expansion in the availability of "free" or minimal-cost medical care under both philanthropic and public-

assistance programs. Also of great importance has been the remarkable growth in the last several decades of the population's health-insurance coverage—something that clearly is positively correlated with the demand for medical services.

Whereas in the prewar period less than a tenth of the populace was enrolled in voluntary health-insurance programs, today the situation is radically altered. At the end of 1965, 156 million Americans—or four-fifths of the civilian population—had some kind of private hospital insurance, while 146 million carried surgical protection. Some 113 million people, moreover, had regular medical-expense coverage, providing benefits toward physicians' fees for nonsurgical care given in the hospital, home, or at the doctor's office. And 52 million Americans were covered by so-called major-medical expense policies. In 1965, health insurance payments to beneficiaries totaled $8.6 billion. Although this was only about a third of total personal consumption expenditures on medical care, it presumably covered a substantial part of "big-ticket" outlays.

The evidence is overwhelming that people who have health insurance make appreciably more use of medical services than people who have no coverage. With the financial barrier removed or lowered, individuals tend to seek treatment they otherwise might view as postponable or optional. This no doubt is part of the explanation of the fact that the annual rate of hospital admissions per 1,000 members of the civilian population is now running some 40% higher than in the early postwar period. Somewhat surprisingly, even the incidence of surgery tends to be considerably higher for insured groups than for the uninsured. It seems clear that not only do previously neglected real ailments tend to be treated after a person acquires coverage but also that some people seek and get care where the actual need is marginal.

Of course, where increased demand occurs in the context of underutilized capacity, it will not necessarily prod prices upward. In fact, the tendency will be precisely the reverse, since unit costs will be reduced by spreading overhead expenses over a larger volume of the service rendered. And there have been communities and regions where hospital beds, for instance, have not been fully used, and indeed there still are. But there also are areas where medical facilities have been taxed or where bottlenecks have been significant. And more important than any strain on physical plant has been the chronic shortage of medical workers needed to man facilities—a shortage characteristic of both professional and nonprofessional personnel.

Enter Medicare

Significantly, the enlarged demand for medical services that has been brought about by expansion of private health insurance and of subsidized medical care is now being reinforced by the operation of the so-called Medicare and Medicaid programs. Under Medicare, which originated with the Social Security Amendments of 1965 and became operative on July 1 of last year, almost everyone 65 years of age and over is automatically covered for a large part of hospital bills, skilled nursing-home expenses, outpatient diagnostic services, and post-hospital home services. Roughly 19 million people come under the program, which is being financed largely by an increase in Social Security taxes. Additionally, these elderly persons can subscribe to voluntary insurance toward physicians' fees and a variety of other medical services and supplies, which is financed by payments of $3 a month from each insured person and matching payments by the federal government. About 18 million have signed up for this feature of the Medicare program.

Under Medicaid, whose significance wasn't fully appreciated by many people at the time of its enactment, a much larger number of Americans, irrespective of age, are potentially eligible for a variety of appreciable medical benefits. The Medicaid program, also a part of the 1965 Social Security Amendments, consolidated and extended the coverage of numerous federal programs of medical assistance. It provides for the federal government to share with state governments the costs entailed in public payments for the medical care of patients who can qualify as "medically indigent," with the federal share of cost varying from 50% to 83% depending on average per capita income within state boundaries. Once the legislation was enacted, various states moved relatively quickly to establish programs, with New York setting an exceptionally liberal standard of medical indigence. For a while it appeared that the number of those eligible for Medicaid benefits might rapidly balloon beyond expectations, involving far larger costs than had been originally anticipated. Congress is now engaged in reconsidering portions of the 1965 legislation, and some tightening is probable. Even

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so, Medicaid seems certain to assume sizable dimensions, amplifying Medicare's tendency to enlarge the demand for services.

Swifter price increases

It was widely predicted that enactment of the Medicare and Medicaid programs would exert additional upward pressure on the broad structure of medical prices. Actual price experience during the past year has been consistent with that expectation. In the span from June 1966 through March 1967 (the period during which Medicare became operative), the prices of all medical services, according to BLS data, rose at an annual rate of 10%. By contrast, in the year that preceded the beginning of the Medicare program, such prices advanced less than half as rapidly—by 4.7%. The difference is particularly striking, since the annual pace of general price advance, as measured by the overall cost of living, was almost exactly the same in both periods, amounting to 2.5%.

By far the sharpest acceleration in medical prices has occurred in hospital rates. The average daily service charge in hospitals climbed at an annual rate of more than 25% in the nine months that ended with March 1967, triple the rate of advance in the year preceding Medicare's beginning. And the rate of increase in hospital operating-room charges and X-ray fees also has accelerated markedly. Although patient loads have been enlarged somewhat by Medicare, this does not appear to explain all that has happened. Rather, the mechanics of Medicare, requiring hospitals to itemize charges in detail, apparently have prompted numerous hospital administrations to initiate basic re-examinations of their rate schedules. In many instances, the conclusion seems to have been reached that previous rates did not fully reflect real costs.

Physicians' fees also have been rising more rapidly in the period since Medicare began than before, although here the before-and-after contrast is not nearly as marked. Doctors' fees climbed at an annualized rate of 7.9% in the nine months that ended with March 1967, compared with an increase of 5.7% in the year before Medicare started. Whether this difference in the rate of increase can properly be ascribed to the impact of Medicare is uncertain, particularly since fees charged by doctors who specialize in treatment of younger age groups have tended to show the same sort of acceleration recently as have fees charged by doctors with more general practices.

In time, however, one would expect the increase in the demand for medical care implied by the 1965 legislation to push upward on all medical prices, reinforcing the thrust in this direction that has been produced by the spread of private health insurance. Thus, the outlook in the years immediately ahead is for continuing price pressures in the medical area unless the supply of medical and paramedical personnel can be rapidly expanded or unless a major breakthrough can be achieved in the health industry's productivity.

The problem of supply

Unfortunately, on the basis of recent trends, it is not possible to be especially optimistic about the supply side of the medical equation. The nation's medical schools, to be sure, have been increasing their enrollments, and the country also has received an inflow of about 1,600 foreign-trained doctors each year recently. These two factors in combination have been sufficient to keep the ratio of physicians to the total population fairly constant during the past decade and a half. Nevertheless, with an increasing proportion of physicians going into nonpracticing pursuits—such as teaching, preventive medicine, and research in the basic sciences—the number of doctors in private practice has not kept abreast of population growth. Because of the growing trend toward specialization, moreover, the number of physicians in general private practice has actually declined in the last fifteen years. This has resulted in increasing patient loads per doctor, made possible by such things as a drastic reduction in the relative frequency of house calls and a pronounced trend toward treating patients in hospitals where sophisticated equipment and auxiliary medical personnel can be employed.

Even with such economizing of time, however, shortages of physicians' services clearly have existed in various parts of the country especially in poorer regions and communities. The precise dimensions of the shortage are impossible to gauge since the criteria of "need" are inevitably arbitrary. Suggestive of the nature of the problem, however, is the fact that in the nation's 88 medical schools about 6% of the budgeted teaching posts have been vacant the past few years. And it is estimated that in hospitals the number of unfilled internships and residencies currently numbers approximately 10,000—equivalent to about a fifth of

such positions offered. The war in Viet Nam has contributed to the shortage, since there are now approximately 2,700 more physicians in the Armed Services than there were before that conflict escalated. This is an increase of approximately 20%. Various surveys indicate that nurses and auxiliary medical personnel also are in short supply. A study last year of supply and demand for nurses, technologists, therapists, etc., in hospitals and nursing homes, conducted by the Public Health Service and the American Hospital Association, revealed an "urgent" need for 62,000 registered nurses, or an increase of 15%; for 22,000 licensed practical nurses, or 12% more; and so on down a list of more than twenty occupational classifications.

Widespread recognition that a serious personnel problem was emerging in the medical field developed relatively slowly. When concern finally did set in, however, it moved Congress to provide substantial remedial help. In each year since 1963 Congress has passed some significant piece of legislation intended to speed the training of doctors, nurses, and allied health workers. Loan and scholarship programs have been established, and funds have been voted to help finance construction and expansion of educational facilities in the medical field.

Aided by this Congressional action, the training of medical professionals and auxiliaries is expected to quicken in tempo in the years ahead. Not only are many existing medical schools enlarging their enrollments, for instance, but universities also are planning to open twelve new medical schools by 1971—equaling in five years the number of openings in the preceding sixteen. Thus, the number of graduates from medical schools is almost certain to rise faster in the future than it has in the past. Whereas only about 7,400 students received medical degrees in 1965, the American Medical Association estimates that a graduation class of 10,000 might reasonably expected in 1975. And it is not unreasonable to anticipate an even sharper acccleration in the training of nurses and allied health workers, since in these areas the problems encountered in expanding educational programs are less formidable.

The outlook

Even with intensified training efforts, however, there still can be relatively little confidence that the complement of medical and related personnel will be numerous enough any time soon to relieve the pressure of demand. The Public Health Service, which puts the shortage of physicians at 50,000 currently, estimates that the doctor shortage will still number about 40,000 in 1975. While this figure rests on criteria that many analysts quarrel with, the belief is widespread that significant manpower shortages will plague the nation's health industry for years to come.

This expectation of continuing personnel shortages is why students of the problem place so much emphasis on the desirability of finding ways to increase productivity in the medical field. Physician productivity has increased in recent years in the sense that doctors have found ways to treat more patients per hour or per working day. This has reflected such things as the efficacy of powerful new drugs, increased use of auxiliary personnel, a shift from treatment in patients' homes to treatment in offices, hospitals, and clinics, and a tendency for groups of physicians to work together under one office roof, sharing equipment and personnel.

These in general are the same avenues by which productivity gains can be expected to come in the future, with the reservation, however, that so-called inpatient treatment in hospitals is an increasingly doubtful source of improvement in the efficiency of over-all medical care. In fact, the evidence indicates that the point of diminishing returns—for general health-industry productivity—has already been passed in funneling patients through hospitals. Many persons who could be treated just as effectively in other facilities become hospital inpatients because their health-insurance policies pay only for treatment that takes place in a hospital. It is coming to be recognized that such use of hospitals (advantageous as it may be from the standpoint of the individual) has added sizably to the cost to society of medical care. In some measure, the Medicare program avoids this kind of stimulus to hospitalization by providing benefits for diagnostic services in outpatient clinics, for stays in extended care facilities, for health care in the home, and for visits to the offices of physicians.

General agreement now exists that anything which can be done to discourage inpatient treatment in hospitals in instances where alternatives are feasible will be of importance in holding down total medical costs. The Gorham Report, for

example, urges private insurance carriers to put special stress on promoting comprehensive coverage that will induce more treatment in doctors' offices and outpatient clinics and less in hospitals. Doctors also are being urged to deemphasize solo practice and instead to group themselves together in partnership arrangements so as to achieve economies of scale. Such group practice, already growing in popularity, affords much the same kinds of opportunity for division of labor and the use of special personnel and special equipment as are associated with hospital treatment. Another recommendation frequently advanced is that the health industry develop new types of personnel—physicians' assistants, for example, who in training would stand somewhere between nurses and doctors and who would take over much of the routine and follow-up treatment physicians now give. In view of the physician shortage that exists and that seems virtually certain to continue, this suggestion warrants serious study, even though some problems of patient acceptance are certain to be encountered.

Opportunities and pitfalls

Numerous additional suggestions for improving the efficiency of the health industry are beginning to emerge in the growing body of literature concerned with the economics of medical care. This itself is encouraging, as is the general sharpening of public focus on existing cost and supply problems in the medical field. And conferences such as the one which is to be held in the nation's capital next month could—if properly structured—serve as important forums for the exploration of ideas and the furthering of public understanding of problems and issues. There is an especially important need for general comprehension of the fact that the advance in medical fees and charges is a complex phenomenon that stems basically from an enormous swelling of demand (in part the product of public policy) occurring in an area where there are many stubborn obstacles to the rapid expansion of supply. This demand-supply relationship points to the virtual certainty of further increases in the prices of medical services. Unless the underlying causes of such a development are understood, however, there predictably will be impatient urgings that the government "do something" about it.

But this is an area in which to move cautiously. Neither admonition nor coercion will change the basic fact of upward pressure on prices. Either, if attempted, would tend rather to discourage the efforts—sorely needed—which providers of health services are making to close the gap between what they are now capable of producing and what a properly health-conscious society demands.

JULY 14, 1967.

DEAR SENATOR SMATHERS: The testimony of Mr. Alvin M. David, Assistant Commissioner of Social Security, on June 22, before your subcommittee, shows we have good reason to be pleased with Medicare's performance during the past year. According to Dr. Carroll L. Whitten, President of the American Academy of General Practice, "it has worked better than most physicians had expected." But Mr. David made no mention of still unsolved problems in the area of the stated subject of your Hearings, "Costs and Delivery of Health Services to Older Americans." Among the witnesses appearing at the same time was Dr. Jeffrey H. Weiss, Operations Research Analyst in the Office of the Assistant Secretary for Program Coordination, also on the panel representing Sec. Gardner and the Dep't of H.E.W., who was actively engaged in preparing the report to the President on Medical Care Prices.

This report to the President shows that the Social Security Administration has been too slow in coming to grips with the economic problems of Medicare. It deplores the absence of moves toward "cost reducing methods" in the Medicare reimbursement guidelines. "The present Medicare reimbursement scheme, based on 'reasonable cost' does not provide hospitals and other health facilities with adequate incentive to be efficient. The Medicare and Title XIX reimbursement formulas, as well as the reimbursement formulas of some private insurance plans, tend to maintain institutions that are inefficient in size, plant, layout and equipment." According to the H.E.W. Report to the President on Medical Care Prices, whose ideas are only slowly beginning to penetrate the Social Security Administration; "At present, hospitals have inadequate incentive to be efficient. They are not under strong pressure from patients because a substantial part of patients' bills are paid by third parties. Third parties have usually reimbursed hospitals for costs incurred without pressing for greater efficiency, Hospital

administrators often lack the training required for effective management. The medical staff of the hospital often presses the hospital administrator and board of trustees for acquisition of the latest medical equipment without regard to cost implications involved. Trustees are often subject to pressures imposed on them by the community and the medical staff. Even where the incentive does exist, initiation and application of cost reducing innovation is often beyond the resources of an individual institution."

The H.E.W. Report to the President makes the following recommendation, among others: "The Dep't of H.E.W. should review the reimbursement formulas used in Medicare and Medicaid in an effort to find practical ways of increasing the incentives for hospitals and other health facilities to operate efficiently." H.E.W. Secretary Gardner, at the final session of the National Conference on Medical Costs on June 28 called for "a radical shift in emphasis." Hitherto, he said, we were preoccupied with the "financing mechanism," but now "we are forced to examine the efficiency, the productivity and the logic of the system by which (health) care will be delivered." I called for this "radical shift in emphasis" while employed in the Social Security Administration but got, and am still getting, the cold shoulder there. However, my letter to the Chairman of the Senate Finance Committee (Hearings on H.R. 6675, *Social Security*, 89th Congress, First Session, 1965, pages 1123–5), contrasting the dominant "actuarial" approach and the newly-required "economic" approach, gave some inspiration to Senator Russell B. Long, now Finance Committee Chairman, to say on the Senate Floor just before they passed the Social Security Amendments of 1965; "The worth of the Social Security bill of 1965 cannot be measured solely in terms of dollars. It can better be judged by an economist than an actuary, better by a social worker than an accountant, and even better by . . . the needs that are met, the fears that are dissolved, the wants that are satisfied by what we have wrought." He was calling for cost-benefit analysis, just as Sec. Gardner is doing now.

The House Ways and Means Committee Hearings on H.R. 5710 ("President's Proposals for Revision in the Social Security System") has in its record (Page 2445–9) my letter to the Chairman, Honorable Wilbur D. Mills, which provides evidence that the Social Security Administration has been dragging its feet when it comes to moving in the direction to which H.E.W. Secretary John Gardner is pointing. An elaborate statistical program is provided for but no economic study in the sense called for by the Gorham group which prepared the H.E.W. report to the President on Medical Care Prices. (See *Social Security Bulletin*, January 1967, "Health Insurance for the Aged: The Statistical Program" by Howard West. "Analytical Studies," including "Studies of Utilization and Costs of Health Services," "Studies of Effectiveness of Administration," and "Studies Relating to Specific Provisions," are here envisaged as awaiting future findings of the "statistical system." Defense Secretary Robert S. McNamara's warning that we must do our basic thinking "before we start to bend metal" has not yet reached the Social Security Administration. Here they are in the habit of awaiting the results of "actuarial experience," (another name for muddling through.) According to an article in the March 23, 1967 *Washington Post* ("Budgeting System Spreading Slowly" by William Chapman) the Programming Planning Budgeting System, or PPBS, announced with fanfare almost two years ago by President Johnson as a "very revolutionary system' still meets with bureaucratic resistance. "Even in H.E.W., where the most significant progress has been recorded, Gorham encountered considerable inertia when he pushed custom-ridden officials into the cost-benefit field." I can supply evidence of such "inertia" in the Social Security Administration. Some of this may be found in my letter to the Honorable Wilbur D. Mills, mentioned above. In this, I refer (page 2448) to testimony before the Subcommittee on the Health of the Elderly on April 27, 1964, which I tried to bring to the attention of my supervisors in the Social Security Administration in connection with an official assignment.

Your subcommittee already has in its record one letter from me addressed to the Honorable Maurine Neuberger (See Hearings, "Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques," 89th Congress, Second Session, pages 577–8). This spells out a criticism of sloppy thinking on "costs" and "expenditures" in the health field, touched upon in a letter from me in the *Washington Star* of July 10.

I would appreciate your inclusion in the record of your Hearings on "Costs and Delivery of Health Services to Older Americans" this letter, my short letter in

the *Star* and a letter I wrote while employed in the Social Security Administration which is relevant to showing there has been "inertia" in the Social Security Administration. This is in the interest of stimulating as much discussion as possible in how to do a better job in providing better health services to Older and Other Americans.

Yours sincerely,

SIDNEY KORETZ.

[Enclosures]

[From the Washington Star, July 10, 1967]

MEDICAL COSTS

SIR: In your editorial, "The Doctor Shortage," you should also have mentioned the American Medical Association's report of the Commission on the Cost of Medical Care, 1964, especially Volume I. Too many fail to heed the warning in this study that "cost, price, and expenditure may be, but generally are not, equal." Official government reports on medical economics fail to distinguish between "costs" and "expenditures." They talk as if the rich have higher costs than the poor because they spend more. When the President boasted that health expenditures of the government had more than doubled since he became President, was he boasting of higher costs?

One of the tasks of the recent National Conference on Medical Costs was to proceed with hitherto neglected public education in health economics. A beginning was made in the American Medical Association study, but the Social Security Administration administering Medicare has not yet caught on. What good does it do to have mention of "reasonable costs" in Title 18 of the Social Security law when there are no reasonably clear cost concepts?

SIDNEY KORETZ.

MARCH 18, 1965.

MR. BERNARD POPICK,
Deputy Director,
Division of Disability Operations,
Social Security Administration,
Baltimore, Md.

DEAR MR. POPICK: In the *Report of the Advisory Council on Social Security,* 1965, the subject of costs other than costs to a fund-entity gets less than a page's treatment. This is Section 6 of Part II (pages 42–3): "Payments on the Basis of Reasonable Cost." This ends on the following note: "Payment on a reasonable cost basis would be in line with the recommendations of many expert groups, including the American Hospital Association. The established practices of most Blue Cross plans are generally in line with this recommendation." But some, including Dr. Robert S. Morison, Director for Medical and Natural Sciences of the Rockefeller Foundation, are critical of prevailing cost studies which are nothing but extrapolations of existing trends. If they are right, we cannot assume current practice represents "reasonable cost."

The printed record of the House Ways & Means Committee Hearings on H.R. 3920 ("Medical Care for the Aged," part 5, page 2497), contains my letter to the Continental Casualty Company, asking for "light on the economic principles whereby hospitals price the services they provide." This committee did not consider this question, but a representative of this company testified to a Senate subcommittee that they were not qualified to discuss "the cost of health care itself" (including hospital services).; they only considered "the cost of the insurance process; administrative and marketing costs, costs of paying benefits, and a risk charge or profit." In no other economic field would anyone get away with concern only for the marketing of goods to the neglect of their improved production.

The same printed record (pages 2501–2) has an exchange of letters between me and Governor George Romney, relating to my inquiry about the McNerney-University-of-Michigan Study of Hospital Economics. An official assignment had introduced me to this Study. I was to prepare "a summary analysis . . . which might pertain to a Medicare statistical program," which was to "devote itself" to certain problems, including "ways in which an evaluation of reasonability of costs were arrived at."

The Advisory Council on Social Security might well have considered points and questions I raised in my report. Some of these appear in the Ways & Means Committee printed record (pages 2496–2502).

I would like guidance as to what use I am permitted to make of a carbon copy of my report, not being sure whether it is mine or belongs to the Social Security Administration.

Yours sincerely,

SIDNEY KORETZ.

FLORIDA NURSING HOME ASSOCIATION,
June 21, 1967.

DEAR SENATOR SMATHERS: I am responding to a letter forwarded to me by Mr. Cary Williams in regard to your hearings with the Special Senate Committee both currently and in the future on the subject of "Costs and Delivery of House Services to Older Americans".

I am writing from the point of view of the nursing home field on how it affects or is being affected by the current federal legislation.

Your first question regarding rising medical costs, the rising costs are, of course, causing difficulties for the elderly and everyone else, I might add, not merely the elderly.

Comment: I think especially the rising hospital costs are a burden to everybody, the elderly included. It appears to me that one of *the major causes for this rise in hospital costs is the complete lack of any concern on the part of the federal government for efficiency of operation.* This is in sharp contrast to other federal programs of competitive bidding, negotiated contract, incentive plans under the Defense Department and other similar ideas. In *the health field, it is currently written on a cost-plus basis. It is actually encouraging inefficiency and rising costs.* This, of course, reflects very strongly on the pocketbooks of all of your citizens.

2. Do many of the elderly face insurperable obstacles in obtaining needed health services?

Comment: It has been my experience here in dealing with numerous welfare clients over the years that while there are numerous obstacles in the way of obtaining service in time delays in getting service through socialized practices, that these are not insuperable and are part of the system of socialized services.

I might add that private people experience similar delays when they go to their doctors. I can't remember getting into a doctor's office on time with an appointment any time in the recent past.

Here in St. Petersburg various services both at the Welfare Clinic level and in other Welfare programs have been speeded up and the Welfare Department, I feel, today is doing a substantially better job in serving the elderly and the indigent than they were doing a couple of years ago.

3. Are present health services remote geographically and sociologically from many of our older persons?

Comment: I can't answer this for the general area, but in the St. Petersburg area, it is quite the opposite. The health services are located right in the heart of the greatest concentration of elderly people as well as close to the greatest concentration of indigent people, so I would say that they are quite close both geographically and sociologically.

4. Are present Medicare and Medicaid policies intensifying old problems in the organization of health services or causing entirely new problems?

Comment: On this subject, I can speak with considerable authority both as Vice President of Region III of the American Nursing Home Association and as past president of the Florida Nursing Home Association. I think that many old problems in these fields have been solved by Medicare in Florida in that many of the older people are getting care that they did not get before. However, on the other hand, Medicare has created untold additional problems and entirely new problems and problems which are yet only on the horizon. I have never in my life been associated with anything that took so much time and effort, procedure, change, rechange, and new issues and ideas than the Medicare program has presented. While I recognize that this is somewhat inherent on all governmental programs, it seems to be unduly complicated in the Medicare Administration. I suspect that it will be equally complicated in the Medicaid Administration *unless the Congress somehow changes these programs to the right incentives for efficiency of operations.*

5. Are shortages of trained personnel in the medical and medical-related professions especially severe in the fields that serve the elderly?

Comment: There is no question that there are great shortages in the field, especially in the areas of nursing and nurse-related types of services. We are in great need in this area of expanded LPN training programs and Aide training programs. I think Pinellas County has done very well in that it has had an LPN school for many years which is accredited and will have two more schools this coming year under the State Vocational Education Program.

It has also done well in the Aide training program. We, at my three nursing homes, have graduated over 300 Aides under the State Vocational Program, but there are many more needed. It is needless to say that the *minimum wage laws which will increase the cost of nursing each year for the next four years are, of course, increasing the general cost of all nursing care for all patients, and this, of course,* is something that should be taken into account in the planning of new medical programs which are going to be much more costly than originally anticipated and much more costly than the current situation *unless the federal government sincerely and seriously considers some sort of reward for efficient operation instead of penalizing the efficient operator and rewarding the inefficient one.* My experience, broadened in the last year or so, shows that there is no necessary relationship at all between a non-profit medical-care institution and a proprietary medical-care institution or a governmental medical-care institution. We have right in St. Petersburg some non-profit homes providing care at very reasonable rates; we have others providing care at rates substantially higher than the tax-paying institutions of first class quality. Likewise, we have proprietary institutions that are both efficient and inefficient and in each case, the patient in the inefficient institution really is suffering and the federal pocketbook is paying the bill directly or indirectly.

Final comment: May I commend to your consideration the fact that under the proposed Medicaid Programs in Florida and in some 20 other states, the proposal of HEW to cut off the supplementation in these states will grossly increase the cost of the Medicaid Program in the states and suggest that you look into this problem, especially in Florida which will be the worst hurt in the nation in terms of its own finances and suggest some sort of alternative legislative approach to phase out supplementation from January 1, 1969 over a 2, 3, or 4-year period rather than cutting it off. If it is cut off, the cost of medical care in Florida will rise astronomically and indirectly the cost of the private patient also as has been the case under Medicare.

Sincerely yours,

DAVID R. MOSHER,
President.

PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY,
June 15, 1967.

Senator GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate, Washington, D.C.

DEAR SENATOR: In connection with the hearings scheduled for June 19, I am enclosing a policy statement of our organization on Title XVIII of P.L. 89-97 It calls for extension of coverage to preventive services and out-of-hospital prescriptions. It also calls for elimination of deductibles, co-insurance, and limits on certain services. Change in methods of paying hospital-based specialists, and encouragement of group practice are also advocated.

The Public Health Association of New York City, an affiliate of the American Public Health Association, has a membership of individuals working in health professions and of agencies concerned with the public health.

With all best wishes for your subcommittee's activity,

Yours sincerely,

CHARLOTTE MULLER, Ph. D.,
President.

[Enclosure]

NEW YORK CITY PUBLIC HEALTH ASSOCIATION RESOLUTION ON PART B, TITLE XVIII, PUBLIC LAW 89-97, AS AMENDED

The New York City Public Health Association's legislative objective is to assure the availability and provision of adequate total health care at reasonable cost for all people.

Public Law 89–97 as amended expands the social security system to provide for part payment for specified health care expenses for persons age 65 and over. This law affects indirectly the private and public cost and the availability of services to persons of all ages.

The Association urges amendment of Part B which provides for payment for physicians and related health services:

(1) to meet fully the total health care needs of beneficiaries;

(2) to develop reasonable cost criteria and encourage coordination and optimal utilization of skilled specialized personnel and facilities.

(1) Full coverage of health needs requires extension to needs not now covered. This includes preventive services and out-of-hospital prescribed drugs and biologicals.

Full coverage also requires control of out-of-pocket costs in services now under Medicare. This includes:

a. Elimination of deductible and co-insurance features now required.

b. Elimination of limits on home health services, out-patient hospital care, and psychiatric care.

c. Provision under Part A for payment to hospital-based specialists as part of the hospital charge. This would replace collection of fees from patients. Anesthesiology, pathology, radiology and psychiatry are the specialty fields involved. Also affected would be services of residents and interns.

(2) Encouraging of coordination helps assure that adequate specialized services of varied types will be rendered in relation to the continuity of patient care. Group practice mechanisms providing prepaid care on a per capita basis rather than fees for service should be recognized as a useful device for such coordination. Principles of organization and registration procedures should be defined and incentives provided for use of such programs in Medicare. (For example, costs of forming new prepaid groups could be absorbed.)

Elimination of deductibles and limits on service will reduce administrative costs to the trust fund and will assure that needed care will be sought and received. Elimination of deductibles for medical service and inclusion of specialist services in hospital charges will help hold down medical charges for the entire population.

These improvements will also help establish a more adequate type of coverage as the minimum to be extended to other social security beneficiaries in coming legislative sessions.

THE GEORGE WASHINGTON UNIVERSITY,
June 12, 1967.

Hon. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, New Senate Office Building, Washington, D.C.

DEAR SENATOR SMATHERS: In your letter of May 31 you asked for my thoughts on organization of health services for the elderly and methods of delivery of such services.

My response confines itself to selected aspects of the general topic of your inquiry.

(1) Build-up of home health services.

Changes in family living arrangements, urbanization of the population and medical advances make it necessary to foster a build up of organizations that can provide health services to individuals in their homes or in nursing homes. While progress has been made over the past seven years or so to establish under health department or general hospital auspices a complex of health services that would give support to private physicians in the care of patients outside of hospitals, we appear to be far from meeting needs.

The range of home health services should include nursing services (both professional and practical), therapy services (speech, physical, occupational, etc.) and homemaker services. Dental services also should be coordinated with the other health care, as well as supervisory services and such ambulance or other transportation services as would permit movement of patients to hospitals when required for effective care.

Adequate home health services, provided in accord with a doctrine of "pay-ability," not only would be of aid to those aged whose illness permits

of care in the home, but also to other groups in the population. For example, ready access to supervised nursing services would be of considerable support to working mothers whose children become ill and to relatives of disabled persons.

(2) Preventive health services.

To the extent that disabling conditions can be prevented or controlled it would appear to serve the national medical interest, as well as the welfare of the elderly, to provide an ancillary preventive health care program. For example, such a program might call upon health departments hospitals and other health agencies to provide diagnostic health examinations for the aged, with appropriate referrals to treatment and rehabilitative services as required.

Appropriate provision should be made for defining the state of medical knowledge about health examination and diagnostic procedures that offer some promise of reducing chronic illness or its impact. Authorization should be provided for implementing a program of health examinations and for referrals to facilities that can provide the care indicated for the patients.

(3) Ancillary health worker training.

Special manpower (and womanpower) training programs should be enlarged to develop the ancillary health program staffing required to achieve adequate health care for the aged. Such a program, if well designed, not only would contribute importantly to attaining the objectives of the medicaid and medicare programs but also would contribute to the Nation's attack against poverty.

The training provided should not only build the health manpower skills needed, but also be concerned with health manpower attitudes toward the aged sick and dying.

It should emphasize that we have not been directly concerned in the administration of medicare and have little knowledge about the many specific problems that have evolved.

As we work with selected states, counties and cities toward the implementation of planning, programming, budgeting systems in the 5–5–5-project demonstration we shall observe more immediately the impact of the medicare program on hospital and health agency operations. Accordingly, we shall be in a better position a year from now than we are at present to respond to your inquiry about geographic and financial impacts.

Sincerely.

Dr. SELMA J. MUSHKIN,
Project Director.

THE PROVIDENCE DISTRICT NURSING ASSOCIATION,
July 12, 1967.

Hon. GEORGE A. SMATHERS,
Chairman of the Subcommittee on Health of the Elderly,
Senate Special Committee on Aging,
Washington, D.C.

DEAR SENATOR SMATHERS: The staff in the office of Dr. C. J. Wagner, Director of the Bureau of Health Services, United States Public Health Service, has contacted our agency, as they felt we would be in a better position to give you and your Committee follow-up on the Dexter Manor Story as told by the pamphlet "Portraits in Community Health".

First of all could I tell you how pleased we are that you were able to use some of the material in the very well prepared pamphlet. We feel this venture demonstrates federal, state, local, public and private agencies working together.

We were more than appreciative of the financial assistance and the fine guidance contributed throughout the project by the Public Health Service.

Since the completion of the demonstration we have not only continued the program at Dexter Manor but have extended it to two additional projects for the elderly. The second program was established at Hartford Park Housing where presently approximately more than 700 elderly people are living. Unlike Dexter Manor this project is made up of scattered units, but we have essentially the same plan operating; namely, an office in a central area where the nurse has daily consultation hours. People can bring their problems to her and she can give them correct advice and referral to the proper agency. If the people are in need

of direct nursing care in the home arrangements are made for this. We have continued to use as our entrance to people's home the completion of the Tenant Emergency Card which in so many instances we have found helpful.

In June 1966 the Providence Housing Authority opened another single story building called Bradford House. Once again, as at Dexter Manor, the architectural plans included space for the nurse on the first floor. Most tenants frequent this floor daily as the housing office, the laundry and the craft and meeting rooms are all on this floor. About 300 elderly people live at Bradford House which is no more than five minutes by car from Dexter Manor. This proximity enables one nurse to provide similar service to the residents of both buildings.

At Hartford Park from January 1 to December 31, 1966 as well as daily office hours a total of 1,212 visits were made for direct nursing care and 183 visits for health instruction. A screening program for chest conditions was also carried out through cooperative effort.

At Bradford House from June 1 to December 31, 1966 a total of 174 visits were made to give direct nursing care and 204 health instruction visits were provided.

We did learn that clerical services are not necessary at each project so all clerical details for the nurses assigned to the projects are handled by the office staff at our headquarters. The social worker from the Department of Social Welfare continues to visit and have consultation hours in each of the three units.

The social worker originally employed in the Dexter Manor project is now on the staff of our Association and is also available for service.

Here in Providence we are still enthusiastic about this approach for our Association has continued to have the support of the Providence Housing Authority, the Rhode Island Department of Health and Social Welfare and the residents themselves.

For many years the value of home nursing visits made by public health nurses for the prevention and early detection of disease have been found to be efficacious in helping to secure early diagnosis and treatment for the young age groups in the population.

As a result of our experience we are convinced that the public health nurse is well equipped to carry out this same type of approach with the elderly.

If we can be of assistance do not hesitate to contact us.

Sincerely,

RHODA W. PLAZA,
Director.

STATEMENT OF RUSSELL KOCH, O.D., FOR THE AMERICAN OPTOMETRIC ASSOCIATION

Mr. Chairman and Members of the Committee, thank you for the opportunity to again present the views of the American Optometric Association on the subject of vision care for older Americans. I am Dr. Russell M. Koch, Chairman of AOA's Committee on Vision Care of the Aging. I engage in the private practice of optometry in Elk City, Oklahoma. As a Committee Chairman, I speak on behalf of more than 17,000 full-time practicing optometrists located in over 5,000 communities throughout the Nation.

Members of the optometric profession have always directed their attention to the vision problems of those people in their communities who are approaching the golden years of life because almost without exception these people need the services of a doctor of optometry. We have learned about the specialized problems these people encounter in obtaining health services at reasonable cost.

In 1957, our Colorado Optometric Association affiliate retained Donald A. Seastone, Professor of Economics at the University of Denver, as a consultant to investigate the cost of vision care for Aged Pensioners of Colorado. The results of that investigation were conveyed to Mr. Guy Justus, then Director of Colorado's Public Welfare Department. A copy of that report is appended to this statement for your records.

The proposal conveyed to Mr. Justus projected several alternate methods for controlling costs as well as controlling any possible abuses in providing vision services to Aged Pensioners. This proposal was one of the earliest attempts optometry made to arrange for delivering vision care services for these special optometric patients as a group.

Shortly after making this proposal, our profession participated in making arrangements for and attending the White House Conference on Aging. Our

report to that Conference, titled "The Senior Citizen and Optometry," is also appended to this statement.

The report's Forward contains a statement by Dr. Ralph E. Wick of Rapid City, South Dakota, then Chairman of AOA's Committee on Vision Care of the Aging. He said:

"Today, we realize that reduced visual efficiency is nothing to be ashamed of. It occurs in both old and young alike. In the aging person, it is a natural physiological change that takes place. When properly corrected, vision offers the senior citizen the facilities to indulge in all his regular activities with interest, vigor, and visual efficiency.

"A greatly increased life span (from 20 to 30 years of age during the Roman Empire, to 40 years of age by 1850, to 50 years of age at the turn of the century, to almost 70 years of age today, and even more tomorrow) has created many problems for the human being. Much the same, it has created new areas of research for the ophthalmic professions. Increased longevity has changed our pattern of life, and our modern environment makes more and more demands on vision that optometry must cope with and conquer.

"From a clinical viewpoint in optometry, a demarkation had to be made to indicate where youth ends and aging begins. Through studies, the age of 40 was found to be the place in life where presbyopia (a clinical classification for 'old age' vision deficiencies) begins. The actual age depends on the individual, but by the age of 50 to 55, the process has taken place in nearly all persons, and some type of visual correction is necessary.

"Since presbyopia appears around the age of 40....(long before most companies even consider retiring their employees.... at least 30 years prior to the end of today's life expectancy), it become apparent that vision is no longer a problem of the aged, but rather the aging.

"Optometry gives special attention to the vision problems of our senior generation. Recognizing the physiological and psychological changes that accompany normal aging, optometry is concerned with visual acuity, refraction, accommodation, and the visual neuromuscular system. Optical aids and clinical techniques used offer every American a more productive, comfortable, self-sufficient life, even in the late years, through good vision care."

On page 12 of this White House Conference Report you will find three general headings relating to delivery systems for opometric care which were in effect then and which continue. Dr. Wick stated concerning these systems:

"Because opometry's interest is so keen and its function so important in alleviating problems of the senior citizen, it is only natural that many community projects are spear-headed by local and state optometric societies."

The three systems that have proven successful are:

1. COMMUNITY CLINICS FOR THE PARTIALLY SIGHTED

Community vision screenings are conducted at cost to the patients. This is a valuable community project because it enables aged individuals who have reduced or limited incomes, because of their physical limitations, to obtain good vision care. Should S. 513, the Adult Health Protection Act, introduced this year by Senator Harrison A. Williams pass this Congress, our Association envisions that more of these individuals will receive care at a cost they can afford.

Many of the clinics just described have been conducted in cooperation with the public health departments, service clubs, and other organizations within local communities. Vision clinic programs can be arranged in most communities upon request.

2. SENIOR CITIZEN PLAN FOR THE INDIGENT AGED

This is another type of community project in which citizen's groups and local optometrists cooperate for the welfare of the community's indigent aged. The citizen's groups contribute ophthalmic material, while the optometrists contribute their time. This is a very valuable combination that can benefit a large number of otherwise neglected senior citizens.

As you are well aware, the provision of vision care and ophthalmic materials is optional with the various states under Title XIX of the Social Security Act. Only sixteen states provide reimbursement or payment to vendors for optometric care and then, most states do not pay the total cost.

Title XVIII of the Social Security Act excludes "eye examinations for the purpose of fitting, prescribing or supplying eyeglasses." Consequently, most older

Americans find it necessary to pay out-of-pocket for vision care when they must have it.

For those people unable to pay for needed optometric services, optometry is developing philanthropic centers where individuals receive care without obligating themselves for a current claim or later payment. At present, optometric centers are located in: New York City; Denver; Atlanta; Miami Beach; Oakland, California, Harrisburg, Penna.; and East Lansing, Michigan. More are being organized. Two of these optometric centers, Denver and Oakland, have received partial funding from the Office of Economic Opportunity.

Additionally, in New Jersey and Pennsylvania, visiting mobil vision care units, partially financed by state trucking associations and Lions Clubs, travel to convenient locations where the elderly have their homes and provide care.

3. EYE CARE PROGRAMS FOR HOMES FOR THE AGED

As the title suggests, this program is designed specifically to benefit aged individuals in nursing homes and shut-ins. This care is particularly valuable in smaller communities and smaller nursing homes which do not retain regular staff optometrists.

Where this program operates, local optometric societies provide panels of local optometrists, who provide visual screening services for the homes. They also offer consultation on methods for improving lighting conditions, general environment, types of printed reading material to be provided, and other services helpful to comfort and aid of the partially sighted or blind aged patient.

In presenting figures on prevalence of defective vision ("Eye Care," a term generally used to indicate surgical or medical care of eye disease and/or injury, is not included), the effect of age must be recognized as one of the most variable factors, yet one which can be weighed with a reasonable degree of accuracy.

The Life Extension Institute has compiled figures on a study of 10,924 male and 11,694 female subscribers. In making these tests, the criterion upon which the person was declared "defective" was his inability to read normal Snellen or Jaeger test letters with either eye. We believe this study is particularly significant because it provides a year by year percentage showing the attrition of age, as well as a comparative value for the factor of sex. There were two approaches:

Age group	Male percent defective	Number tested	Female number tested	Female percent defective
30 to 34	42.04	19,204	2,347	48.87
35 to 39	43.78	19,037	2,197	50.80
40 to 44	48.60	14,723	1,727	60.74
45 to 49	65.57	10,512	1,228	72.88
50 to 54	77.24	6,937	741	75.71
55 to 59	81.73	4,034	362	77.90
60 to 64	82.89	2,204	----------	----------
65 to 69	83.56	1,827	----------	----------
70 and over	82.67	864	----------	----------

[In percent]

Age	Male defective	Female defective	Age	Male defective	Female defective
30	42.13	48.18	41	47.11	58.06
31	42.18	48.27	42	48.87	60.82
32	42.25	48.41	43	51.07	63.74
33	42.36	48.41	44	53.74	66.56
34	42.51	48.72	45	56.83	69.09
35	42.72	49.33	46	60.24	71.22
36	43.01	49.94	47	63.77	72.90
37	43.41	50.80	48	67.23	74.14
38	43.97	51.99	49	70.42	75.10
39	44.73	53.58	50	73.22	75.76
40	45.75	55.60			

Studies by the U.S. Department of Health, Education and Welfare indicate that per capita costs of personal health services for those age 65 and over total approximately 2½ times more than costs for the rest of the population. As would be expected because most of the aged do not have earnings from employ-

ment, income levels in the aged population are relatively low, and as has been indicated, this age group is the one requiring vision services most. Developing sound, effective means for providing optometric care to our aging citizens is one of the most important and urgent matters of unfinished business before our nation. More attention to the problem is urgently needed due to the critical shortage of optometric manpower and the lack of philanthropic funds which limit our optometric societies' capacity to provide all the vision care needed to protect the independence and dignity of our elderly people.

Our Association is delighted that Congress has given the Public Health Service Surgeon General the funds needed to provide grants for developing and researching new systems of health services, and renovating old systems. It is our hope that full advantage will be taken of the opportunity to assist in providing more and higher quality vision care for our senior citizens.

Optometry is primarily concerned with adding "life to years." We look forward to learing that the result of these hearings by your Committee may assist us to fulfill this mission.

Your kind attention to this statement is greatly appreciated. I respectfully request that it be entered into the transcript of your hearings together with the two attachments I have discussed.

If you have any questions, I will be happy to attempt answers to them.

[Enclosures]

THE COLORADO OPTOMETRIC ASSOCIATION,
OFFICE OF THE EXECUTIVE SECRETARY,
Denver, Colo., October 28, 1957.

Mr. GUY JUSTUS,
Director, Colorado Department of the Public Welfare, State Capital Annex, Denver, Colo.

DEAR MR. JUSTUS: Your request for data and suggestions on the inclusion of vision care in the projected health care program for Colorado old age pension recipients has been carefully considered by the Board of Directors of Colorado Vision Services, Inc., and its parent organization, The Colorado Optometric Association, Inc.

For your consideration we are submitting a study completed by our Group Health Consultant, Donald A. Seastone, Professor of Economics, University of Denver. His observations, suggestions, and series of recommendations give full consideration to the best experience available in the field of prepaid vision care.

You will note that no single, definite proposal is recommended in this study. This is in line, I believe, with discussions among you and members of your staff and representatives of Colorado Vision Services and the Colorado Optometric Association, including Dr. H. J. Kendrick, Association president, William B. O'Rourke, field representative for Colorado Vision Services and myself.

In addition, the possible alternatives outlined should make it possible for you to develop a vision care program for inclusion in your overall program for old-age pension recipients which can be expanded as your health program fund builds. Representatives of our profession are ready to discuss the specific details of this program whenever you are ready. In addition, if there are any phases of the study which are not clear to members of your staff or need additional explanation, we will be pleased to furnish whatever additional information you need.

In the case of each suggested program outlined in the attached study, you will note that a provision is made for the cost of developing a small reserve and for the payment of administrative expense. This figure is based on a 7 percent surcharge of the dollar volume of each of the suggested programs.

This amount is intended to cover the program's proportionate share of office overhead, the processing of claims and services, the enforcement of professional standards and the handling of grievances, the preparation of reports which your Department may require and the conduct of an education program for the profession and the beneficiaries, in addition to the above-mentioned reserve or contingency.

Colorado Vision Services, Inc., the non-profit corporation which would execute any contract with the State Department of Public Welfare in the field which this study encompasses, is most anxious to work directly with you and your

state board on any program which is developed to provide vision care. We believe C.V.S. is the most logical vehicle available for the execution of such a program since it is operated by members of the profession and can provide an effective means of insuring high standards of care for the recipients of any program that is adopted. In addition, by working through Colorado Vision Services, Inc. it should be possible for the State Department of Public Welfare to simplify the problems involved in operating such a program and to hold administrative costs to a minimum.

Please do not hesitate to call on us for any help we may be able to provide.

Sincerely yours,

RICHARD L. HANEY, O.D.,
President, Colorado Vision Services Inc.

UNIVERSITY OF DENVER (COLORADO SEMINARY) DENVER 10, COLORADO, ESTIMATES OF COST OF VISION CARE FOR AGED PENSIONERS UNDER VARIOUS ASSUMPTIONS

There are some 54,000 pensioners in Colorado who might be entitled to vision care under a master contract. Depending on the type of contract and its utilization experience, the cost of vision care protection will vary significantly.

Any estimate made in advance of an actual experiment with some form of contract will be subject to wide margins of error. No adequate statistical series offering a sound basis for prediction appears to be available. For the purposes of this memorandum, certain assumptions are used as the basis for calculating costs. Almost every person over 60 uses glasses whether part time or full time. Moreover, in later years, vision is subject to more deterioration than in middle years. Ostensibly, therefore, every person over 60 ought to have a vision examination at least once a year, and some will be tempted to seek service more often.

Let us assume, first, that a screening examination, and referral if needed, will cost $5.00; that a refraction and related service will cost $15.00, instead of the $5.00 charge for the screening examination alone; that lenses for single vision will average $5.50 per pair; that lenses for bi-focals will average $12.00 per pair; and that frames will be provided up to $5.00, but at an average cost of $4.00, which will buy a good pair—choices of frames costing more would not be charged against the program. Finally, it is assumed that the program could be administered with a *7 per cent surcharge.

The highest cost estimate would arise from the premise that no charge would be made to the pensioner, except for frames costing more than $5.00, for the portion above $5.00. It can be assumed that if there were no limit upon the program, every pensioner would use the service every year, resulting in 100% utilization.

Of the 54,000 pensioners, it can be further assumed that not more than two-thirds would require refractions and new lenses annually, and that not more than one-third would require new frames in any given year. The following costs would result:

18,000 screening only, at $5.00	$90,000
36,000 refractions and service, at $15.00	540,000
13,000 single lenses, at $5.50	71,500
23,000 bifocals, at $12.00	276,000
18,000 frames, at $4.00	72,000

Under these assumptions, the high cost of this program, if utilization lived up to these estimates, would come to $1,049,500 for service and materials, plus $73,500 surcharge, or $1,123,000 in all. If by any chance, utilization showed any tendency to go above this cost and this seemed to be the upper limit to be supported, the program could place a limit covering one full service a year per client.

Assuming that the program would be initiated under a provision that the client would pay the first $5 of the cost of service, this would provide both a co-insurance feature, and place some inhibition upon utilization. The effect might well be to restrict the utilization significantly below the levels set forth under the estimate above, so that only 50% of the aged had refractions, lenses, and fittings, and only 25% had new frames each year. Then there would be no charge to the fund for those taking the screening examination. The $5.00 charged for the visit

*See explanatory note in letter of transmittal.

would reduce the charge against the fund for refractions and service to $10.00. The cost estimates that would result are:

27,000 refractions and service, at $10.00	$270,000
9,500 single lenses, at $5.50	52,250
17,500 bifocals, at $12.00	210,000
13,500 frames, at $4.00	54,000
Total	586,250

Given these assumptions, the service cost would total $586,250 plus 7% surcharge of $41,000 to make the total cost $627,250. The cost through insurance funds could be reduced further by raising the co-insurance cost to the pensioner so that he pays the first $10.00 per year for service rendered. It may be expected that this charge to the pensioner would further reduce the demand for service so that costs might be as follows:

23,000 refractions and service, at $5.00 (Net charge to the fund $15 less $10)	$115,000
8,000 single lenses, at $5.50	44,000
15,000 bifocals, at $12.00	180,000
11,500 frames, at $4.00	46,000

Given these assumptions, the service cost would total $385,000, which together with $27,000 surcharge would total $412,000.

Another way of limiting cost would be to have the client pay one half of the first $30.00 of the cost, with the fund to pay all of the balance of the service needed. Assuming that this would restrict demand for service to a figure somewhat below that shown for the first estimate, utilization might result in these costs:

15,000 screening only, at $2.50	$37,500
30,000 refractions and service, at $7.50	225,000
10,500 single lenses, at $2.75	29,000
19,500 bifocals, at $6.00	118,000
10,000 frames, at $2.00	20,000

The apparent cost of service under these assumptions would total $429,500 but there would be several thousand cases among this group which would have a combination of costs that would total more than $30.00, and the cost based upon this assumed utilization might be nearer $440,000, plus $31,000 surcharge, making a total of $471,000. This approach is more costly than that arising out of charging the client the first $10.00 as shown above, because it involves having the fund pay a portion of every service rendered.

One final approach to cost estimation would combine both an initial charge of $5 to the client, and then require him to pay half of the next $20 of the service cost, bringing his participation to a maximum of $15 for a full service, except as he might wish frames more costly than $5. The exact impact of such a system cannot be judged any more accurately than in the other estimates shown here. The cost might be something like this:

Screening service—no charge to the fund

25,000 refractions and service, at $7.50	$187,500
9,000 single lenses (the fund paying half of the first $5.00, and all the balance) estimated average $3.25	29,250
16,000 bifocals, estimated average cost to the fund: $9.50	152,000
12,500 frames, at $4.00	50,000
Given these assumptions, the service cost would total	418,750

which, together with surcharge of $30,000 would total $438,750.

These differences in utilization are predicated upon the economic concept of price elasticity of demand, even for vision care. Until more experience has been gained, it is difficult to know whether the differences in impact assumed under alternative payment relationships are reasonable. One can only make an educated guess, and make preliminary judgments thereon. Experience will be the definitive test. Even then, unless experiments are run with different types of arrangements, the impact of co-insurance features, or of deterrent first charges, can only be guessed at. These estimates offer some preliminary estimates that may prove helpful in analyzing alternatives.

Any contract for this age group, involving as it does wide uncertainties with respect to the predictability of utilization, might well contemplate that if cost varies by more than 10% from the estimate used in the contract, at the end of any 3 month period, when computed cumulatively over the life of the contract to date, shall be the occasion for such modification in either premiums or benefits or both, as may be mutually agreed between the parties. Such a renegotiation clause may be needed for a period of time long enough to also establish predictability in cost estimates.

WHITE HOUSE CONFERENCE REPORT ON THE SENIOR CITIZEN AND OPTOMETRY

Prepared by The American Optometric Association Committee on Vision Care of the Aging

FOREWORD

Not many years ago, a pair of spectacles was symbolic of old age, and old age was a vague period of life that most individuals sought to escape. In doing so, they often refused to admit their vision was becoming defective, that what they read easily before, now became a blurred challenge, that, where in most cases, they now had more time for leisure activities, they could no longer fully enjoy them. But pride said, "Don't submit to old age . . . . don't give in to father time . . . . don't show everyone you're getting old . . . . by wearing glasses."

Today, we realize that reduced visual efficiency is nothing to be ashamed of. It occurs in both old and young alike. In the aging person, it is a natural physiological change that takes place. When properly corrected, vision offers the senior citizen the facilities to indulge in all his regular activities with interest, vigor, and visual efficiency.

A greatly increased life span (from 20 to 30 years of age during the Roman Empire, to 40 years of age by 1850, to 50 years of age at the turn of the century, to almost 70 years of age today, and even more tomorrow) has created many problems for the human being. Much the same, it has created new areas of research for the ophthalmic professions. Increased longevity has changed our pattern of life, and our modern environment makes more and more demands on vision that optometry must cope with and conquer.

From a clinical viewpoint in optometry, a demarkation had to be made to indicate where youth ends and aging begins. Through studies, the age of 40 was found to be the place in life where presbyopia (a clinical classification for "old age" vision deficiencies) begins. The actual age depends on the individual, but by the age of 50 to 55, the process has taken place in nearly all persons, and some type of visual correction is necessary.

Since presbyopia appears around the age of 40 . . . . (long before most companies even consider retiring their employees . . . . at least 30 years prior to the end of today's life expectancy), it becomes apparent that vision is no longer a problem of the aged, but rather the aging.

Optomery gives special attention to the vision problems of our senior generation. Recognizing the physiological and psychological changes that accompany normal aging, optometry is concerned with visual acuity, refraction, accommodation, and the visual neuromuscular system. Optical aids and clinical techniques used offer every American a more productive, comfortable, self-sufficient life, even in the late years, through good vision care.

Old age can well be the golden years of human life. The optometric profession can help to make it that, by the proper care of the most vital of senses—vision!

CHANGES ASSOCIATED WITH AGING

Aging, in its broadest sense, is a biological phenomenon that occurs in every living organism. Although it is difficult to narrow down to an exact definition, it might be best described as "the period when growth or proliferation has ended but the powers of regeneration still remain (Mazow, 1958)". It does not occur in all human beings at the same age, because it is controlled by such factors as heredity and environment, both variables.

When "senescene" or aging takes place, changes in tissue occur to cause visual as well as other disorders. Not all tissues and organs are effected at the same time, because not all of them reach their optimum performance at the same time.

In addition, general systemic changes occur universally in almost everyone over the age of 40, taking into consideration the considerable variations and differences of physiological and chronological ages in individuals. Few people, if any, reach old age without some complications caused by disease, particularly of a degenerative nature. The most common are heart and vessel trouble, cancer, arthritis, rheumatism, and nervous disorders.

To offer maximum benefit to the aging person, the optometrist must take these systemic disorders into consideration, and coordinate his efforts with those of the other practitioners in the health field.

Like the other organs, the eye participates in the aging changes which take place in the human body. It is subject directly to all the degenerative conditions that prevail, and likewise is often affected by disorders occurring in other organs.

From a psychological aspect, optometrists are deeply concerned with understanding the older years, for they are not only involved in correcting certain anomalies and complaints; but also in the practice of training people in the development of certain practical visual skills.

Many studies show some loss of visual acuity (the ability to see clearly) with age. There are many other questions that can be asked when considering the physiological and pathological changes of age on vision. To corect these, accurate measurement is of extreme importance. This has been the basis for the development of numerous physical and statistical methods for accurately measuring acuity, visual capacity and perception.

Although there are definite refractive changes that come with age, a complete understanding is made difficult by the lack of accurate measurability of some of the structures of the eye. The greatest obstacle is the crystalline lens, which unlike most other body structures continues to grow in size throughout life.

Stenstrom, in 1948, established that the refractive state among young adults is more closely correlated with axial length than any other variable or combination of variables. Studies also show that refractive changes are more marked during major growth spurts. Most experts agree that changes in refraction are rare between the ages of 25 and 40. The concern felt by a patient over forty relative to his "failing eyes" might well be the result of his having gone through 20 years or more of vision in which his refractive state has changed very little. A regular periodic examination is still necessary at any age to properly assess individual refractive changes.

The most dramatic change which occurs in aging is in "accommodation", the ability to change focus from far to near and back. The rate of decrease in ability is fairly gradual and remarkably uniform. There have been, however, some variations leading to proposals that the rate of decrease be used as an aid in predicting the life span of any given individual (Bernstein & Bernstein, 1945).

However, this as yet, has not been proven by longitudinal studies. As the inability to "accommodate" progresses, it eventually becomes necessary to supplement natural accommodation with a convex lens known as an "add". When this occurs, the condition is termed, "presbyopia" or "old age sight". When most people become aware of their loss of focusing ability for near work, their reaction is that they feel their "arms are too short" for ordinary reading. The supplementary lenses prescribed for older persons to do near work depend on the amount of accommodation still available, plus the distance of the usual work from the eyes and the size of detail involved.

In addition to the inability to change focus, among aging individuals there is often a change toward lack of binocular control of the eyes. Normal binocular vision requires the intraocular and extraocular neuromuscular mechanisms to operate in a coordinated manner, so that a sharp image can be maintained on both foveas at the same time, without undue effort. As one grows older, the possibility of a pathological involvement of the neuromuscular system greatly increases. Examination of the neuromuscular mechanism involves the investigation of fixation (ability to move an eye in order to place and maintain the image upon the fovea), the versions (ability to move the eyes in the same direction), and vergences (ability to move the eyes in opposite directions).

Some of the changes occurring in the ability to control the eyes that accompany aging are generally agreed to be the result of lack of proper care during the formative years. It is in the area of the visual neuromuscular system more than any other that the value of periodic vision examinations is evident. Many of the physical changes affecting the visual neuromuscular system are indications of serious general pathological problems. It is here that the optometrist as a member of the health team often has an opportunity to aid and correct an aging

person's condition. The most important consideration in correcting improper motor coordination of the eyes is the patient himself, his symptoms, his requirements, and his ability to adjust.

EXAMINATION OF THE AGING PATIENT

As the average life span of the American increases, the number of senior citizens also increases. This means that the percentage of patients past the age of 40 will continue to rise. These people require a different approach in many phases of eye care and the diagnostic significance of tests varies considerably. Final prescriptions and recommendations to the senior citizen are based on the physical and mental changes that come with age, as well as the need.

The importance of the physical and visual history of a patient becomes greater with age, for the deficiency of the current visual mechanism often is a result of earlier injury, disease and general physical being. In dealing with aging individuals it has been learned that members of the patient's family can throw a great deal of light on the patient's history, especially in supplying needed details that are lost in the haze of the older individual's memory.

A patient's occupation, hobbies and activities, although perhaps more restricted, take on increased importance after 40. In examining the aging person, details such as location and position of his work, distances and eye levels while engaged in the task are considered. In some cases, actual measurements of working distances are taken. In addition, lighting and general conditions are noted. The amount of fixed attention and prolonged eye use under various conditions are also considered, and often different types of lenses are prescribed for different kinds of visual tasks. It is not unusual for the aging person to require several different types of lenses in order to see more efficiently and comfortably in his varied occupations.

There are a variety of tests used to determine all aspects of the individual's visual acuity and general eye health. Included are external examinations, opthalmoscopic examinations for detailed inspection of the interior of the eye including particularly the lens, retina, nerve head, macular area and vessels; retinoscopy and subjective tests, in order to determine exactly what lenses are needed; phorias and ductions, which are prismatic calculations for correction of neuromuscular disabilities; and, specific near-point tests, which assume increased importance for the patient past 40.

Many optometrists, in taking histories of patients, are surprised to learn that some patients have never had a physical examination, or perhaps haven't had one in several years. It is important to understand that the body is under constant duress and change. A person reaching 40 is at a turning point physically. By working with physicians and geriatric specialists, the optometrist has the opportunity to assist in preventive care. The optometrist is often consulted professionally before other symptoms of aging have appeared. Diseases of the heart and arteries, cancer, nephritis, diabetes and others are best controlled if discovered early.

Decreased vision is found more commonly in the older age groups, and according to Wick, (1960), "Optometry's forte for the older age group lies in helping to make this period of life more worth living. With the reduction of physical stamina, so common to this period, increased use of the eyes is the general rule. Much careless advice has been given to patients with regard to saving their eyesight. There are no statistical data to substantiate any theory to the effect that use of the eyes wears them out. This advice only serves to make visual hypochondriacs of otherwise normal patients".

TIPS TO THE AGING PATIENT

Because of a deficiency in both near-point and far-point vision, often the result of natural changes in aging, the senior citizen may require bi-focal or tri-focal glasses. In order to make the adjustment as quickly and conveniently as possible, optometrists will often make a series of simple suggestions:

1. Try not to look at your feet when walking.
2. When reading a newspaper, fold it into half or quarter size, move it, rather than tilt your head upward, until you can read comfortably.
3. Be certain that the lenses are in the right position by making sure the frames are properly adjusted.
4. Wear your bifocals continuously for the first week or two, even though you may not require them for all tasks.

CATARACT AND GLAUCOMA

In considering the problem of aging as related to vision, two pathologies of clinical importance should be noted. They are senile cataract and glaucoma.

The cataract is defined as "any opacity of the crystalline lens". Although there are other manifestations which occur in individuals of all ages, the "cataract" as we generally know it is primarily associated with senility.

The complaint found most frequently among patients suffering cataracts is "my vision blurs" . . . . "I can't see as well". The degree of loss depends on the nature, extent, and position of the cataract. In addition, there are other symptoms which include distortion of images, and a change in color values and hues.

Another symptom quite common is the development of "second-sight". This is a characteristic that the uninformed individual becomes quite proud of, because of a newly acquired ability to read or see at certain distances without his glasses. With the senile cataract, this is often the result of a change in the crystalline lens, which causes the eye to become more myopic or less hyperopic. In such cases, the loss of vision at other distances is often overlooked because of the "improvement" in reading.

Fundamentally the exact causes of the senile cataract are unknown. There are a number of suggested causes, including changes in permeability of the lens capsule, changes in the lens proteins, excessive efforts to accommodate, effect of radiant energy on the lens, inadequate nutrition, and systemic disorders such as Diabetes. Surgery at present is the only effective treatment for cataract.

Glaucoma is defined by Duke-Elder (1941) as "that pressure which the tissues of the particular eye in question are unable to withstand without damage to their structure or impairment of their function." Of all ocular pathologies, glaucoma is most important to both the optometrist and ophthalmologist, because it is hardest to detect in early stages, and may eventually result in total blindness.

It is estimated that 1 percent to 2 percent of patients over the age of 40 have glaucoma, that there is three times as much simple glaucoma as acute, that the greatest incidence of adult primary glaucoma occurs in the 60–70 group (although it should be investigated in persons over 40), that males are somewhat more prone to simple glaucoma than females, but females show a definitely higher incidence of acute glaucoma.

Acute glaucoma is seldom found in myopic patients, but chronic simple glaucoma has an incidence which is unrelated to refractive error.

It is generally agreed that heredity may play a role in glaucoma. In a report by Posner and Schossman (1949) of 373 patients with primary glaucoma, 51 had one or more relatives afflicted with the same disease.

Unfortunately, symptoms are not easily detected clinically, except in acute glaucoma where the patient may complain of such symptoms as pain or headache over the eye, visual disturbances or haziness, the seeing of halos around lights, and the seeing of flashes of light.

Other than from diseases, many studies show that loss of visual acuity occurs naturally with age. In the healthy normal adult this loss is very slight, but nevertheless a very real one that often interferes with the aging person's regular activities.

Along with age usually comes a steady decline in the ability of the eyes to resist glare. This creates a problem especially in night driving for a person over the age of 60.

CONTACT LENSES FOR THE OLDER PATIENT

The development of the micro-corneal (small) lens has inspired a great popularity in the wearing of contact lenses. Today, approximately 4 million persons are wearing them, as compared to less than 200,000 just six years ago. The majority of today's wearers are females, estimated to be about 60 percent of the total. The great majority are also younger persons, and most are first attracted to contact lenses for cosmetic reasons. In males, it has been found that because of the wide field of vision and the safety and convenience values with contact lenses, they are used a great deal to advantage for sports. Aside from sports and cosmetic uses, there are also benefits in wearing contact lenses for certain vision conditions. Those suffering from keratoconus, irregular astigmatism, corneal scarring, aniridia and monocular aphakia are offered an opportunity through contact lenses to find dramatic improvement not possible with ordinary glasses.

Of the patients coming to contact lens specialists, 47 percent are under 25 years old, 45 percent are between 25 and 40 years old and only 8 percent are over 40 years old. The lack of cosmetic incentive to improve one's appearance, a failure to appreciate the optical and physical advantages, and an unwillingness to be inconvenienced during the adaptation period, are no doubt prime reasons for the lack of popularity of contact lenses with older people. Another strong deterrent is the fact that many of these people are presbyopic, which requires glasses in addition to their contact lenses for near-point or reading vision. There are a number of types of bi-focal contact lenses now on the market, and others are in the process of being developed. It is hoped that eventually the advantages of bi-focal correction will be available in a generally acceptable contact lens.

The most spectacular use of contact lenses in later maturity occurs after cataract operations. They are generally superior to spectacle corrections for aphakic patients. Their greatest advantage lies in the fact that they practically eliminate all aberrations found with regular glasses, mainly because they move with the eye, rather than the eye moving behind the lens. From a cosmetic viewpoint, the contact lenses do not give the highly magnified eye appearance that the heavy-plus spectacles do, because of the latter's thick convex lenses. The thickness and weight of aphakic spectacle corrections often cause discomfort to older patients, especially during warm weather. Contact lenses for these same people are light in weight, and found to be comfortable once the patient has become adapted to them. Generally, the older aphakic patient becomes adapted to contact lenses faster than the young person, probably because of reduced corneal sensitivity from the incidental severing of some of the corneal nerve fibers during the cataract operation.

The future of vision correction through the use of contact lenses opens vast new areas of progress for the aging as well as for the young.

PARTIAL VISION AND OPTICAL AIDS

The degree of visual acuity in the past was the basis of the three classifications of sight. In the normal range was anyone whose vision checked out at 20/70 or better (the first figure represents the distance in feet at which a line of letters on an eye chart is read, while the second figure represents the distance at which it should be read by a person with "normal" vision). In the second group, called "sub-normal", were those with vision 20/200 or better and less than 20/70. The third was composed of those with vision less than 20/200, and this was called "blindness".

Although this arbitrary classification served a useful purpose in problems relative to vision, a more reasonable approach is one based on the positive aspects of vision. This indicates how much a patient can see in contrast to his loss, rather than vice versa. It is acknowledged and agreed that from "above normal vision" to "blindness", there is an entire range of vision possibilities. Any vision, no matter how much below normal, is an advantage, especially if it can be corrected to provide more useful sight. The preferred term of classification of deficient visual acuity might be "partial vision", rather than "sub-normal vision" or "blindness".

Practically everyone with vision desires to use the eyes in perception. And with modern techniques, it is the rule, rather than the exception, that partial vision can be improved with optical aids. This is a great boon to the senior citizen, for as he gets older, more and more of his self sufficiency is dependent on vision. Most of the ability to use the knowledge and adeptness gained from a lifetime of experience is controlled by the eyes . . . . even though in their uncorrected state they might offer only partial vision.

From a legal standpoint, the difference between "blindness" and "vision" is strictly an arbitrary one based on the presence or absence of useful vision. The fallacy of identifying limited vision as "blindness" becomes more evident when the following fact is considered. Only 25 per cent of the "total blind" people have no perception to light, while the remaining 75 per cent have varying degrees of useful vision, from the bare minimum capable only of giving guidance, to sufficient amounts to allow reading. Many of the senior individuals heretofore classified as "blind" have found that what vision they do have can often be mobilized and made more efficient through the use of various optical aids developed by research in optometry. It is for this reason that the diseases and anomalies that cause impaired vision are of deep concern to the modern optometrist.

One of the problems to be coped with by the ophthalmic professions is the "shock" that occurs when an aging person learns that his vision has become impaired. Much of this is due to a lack of understanding or lack of information as to the tremendous strides that have been made in correction and aid.

In perception, those with impaired vision (especially those requiring optical aids) find a problem in habituation and automazation . . . . getting used to the new visual demands, so to speak. It is a matter of changing one's habits in order to use new "vision". This is especially difficult in reading and writing where so much is based on making use of "visual cues" (scanning and tip-off words). Until the individual learns to use his optical aid and automatically "see" without requiring conscious analyzation and interpretation, vision is restricted.

Another major problem for the partially-seeing individual is an inadequate rate of perception for meaningful comprehension in reading. It is not at all uncommon to have the rate of perception reduced to individual letters. And since effective reading requires recognition of a group of letters as a word, a group of words as a phrase, a group of phrases as a sentence, and a group of sentences as a paragraph, those with partial vision find reduced ability a difficult handicap, until proper and effective optical correction is made.

Mobility, the capacity of facility for movement is another essential function that creates a problem for the visually handicapped. Mobility has two components: mental orientation and physical locomotion. Lowenfeld (1950) defined mental locomotion as the "ability of an individual to recognize his surroundings and their temporal or spatial relation to himself", and locomotion as "the movement of an organism from place to place by means of its organic mechanism". Both are essential.

One of the greatest handicaps to the aging person is the loss of mobility. It is considered by many as the most severe single effect of the loss of sight, and creates conflict and frustration. But although good vision is desirable for mobility, it is not always necessary. Even limited sight, skillfully used, maintains orientation and mobility. As a general rule, if visual acuity is better than 20/400, there is little restriction of mobility.

Magnification makes it possible to correct or increase the resolving power of the eye by increasing the size of the retinal image. This is the basis of most compensating lenses. For example, if the best visual acuity of an individual is 20/80, the relationship makes necessary a magnification of 4-times if the individual is to see normally. Correction can be made in only three ways: by decreasing the distance of the object from the eye, by increasing the size of the object (as enlarging the print in a book), and by angular magnification through the use of one or more lenses in front of the eye.

A COMMUNITY RESPONSIBILITY

With the trend moving toward a population of older people in our society, it is only natural that aging has become a community responsibility, as well as an opportunity.

There has been a growing interest in the older citizens, in hundreds of communities throughout the United States. This in turn has been transformed into activity designed to cope with the challenge of aging.

All of our fifty states have now established commissions or committees on aging. Scores of conferences have been held, and geriatric organizations and meetings are becoming more prominent.

The American Optometric Association and many individual optometrists are deeply active, for good vision is a deterrent to many of the worst handicaps of age.

Because optometry's interest is so keen and its function so important in alleviating problems of the senior citizen, it is only natural that many community projects are spear-headed by local and state optometric societies. Among those that have proved successful are:

Community clinics for the partially sighted

Community vision screenings are conducted at cost to patients. This is a valuable community project because it enables aged individuals who have reduced or limited incomes, because of their physical limitations, to get good vision care.

Many of these clinics are conducted in cooperation with the public health department, service clubs, and other organizations. Vision clinic programs can be arranged in most communities upon request.

Senior citizen plan for the indigent aged

This is a community project in which citizen's groups and local optometrists cooperate for the welfare of the community's indigent aged. The citizen's groups contribute ophthalmic material, while the optometrists contribute their time. This is a very valuable combination that can benefit a large number of otherwise neglected senior citizens.

Eye care programs for homes for the aged

As the title suggests, this program is designed specifically to benefit aged individuals in nursing homes, and shut-ins. This is particularly valuable in smaller communities and smaller homes where regular staff optometrists are not retained.

Where this program operates, local optometric societies provide a panel of local optometrists, who are made available to provide visual screening services for the homes. They also offer consultation as to methods of improvement of lighting conditions, general environment, types of printed material to be provided for reading, and other services helpful to comforting and aiding the partially sighted or blind aged patient.

Public information

One of the major problems facing any profession is education of the general public to facilities that are available. The more specialized the profession, the greater the problem. It has been found that the general public is usually several years behind in receiving correct information concerning vision care. Often the information is misconstrued or misinterpreted. There are times, too, where the public believes baseless information from an unreliable source, often nothing more than opinion or superstition.

To counteract the lack of reliable information, the American Optometric Association, through its Committee on Vision Care of the Aging, has established a special panel program available for meetings, radio, and television. Available to service clubs and citizen groups, as well as through the broadcasting media, the program presents information in an interesting and easy to understand manner.

Many optometric societies are also active in providing exhibits for meetings and programs sponsored by various senior citizens' organizations, hobby clubs, county and state fair boards, and other groups interested in the care of the aged.

Material and equipment, such as telescopic spectacles, glaucoma screening devices, books and articles on vision care, vision aids for the partially seeing adult, and specialized and unusual types of lens corrections, are shown. This affords the community an opportunity to see a wide variety of the latest ophthalmic devices.

The programs listed above are currently being used in various communities throughout the United States. Unfortunately, a lack of manpower and funds has prevented their adoption in all communities. In many instances, optometric societies have spearheaded such projects, and have volunteered the services of their members. Most optometric societies will assist in any good vision program that provides general benefit to the aged.

RESEARCH

Basic research into new methods and techniques in vision care for the aging is at an all-time high. Many public and private organizations are conducting projects or clinical studies to improve and retain the vision of our most valuable generation—our senior citizens.

For the past several years, the American Optometric Foundation has sponsored research fellowships in major colleges of optometry. It has been estimated that at least 30 percent of the Foundation's research has been directly related to the study of vision of the aging patient. Among the projects of major importance now under way is an investigation of motorists' vision, part of which is devoted to the problem of night vision of the aged driver.

The American Academy of Optometry has also been quite active. Each year it conducts a program devoted to encouraging the presentation of research papers by practicing optometrists and faculty members of optometric colleges.

In a recent program, over 20 percent of the papers presented related to vision care of the aging patient. Subjects of research were varied, ranging from a longitudinal study of refractive changes with age, to a discussion of special refractive techniques for decreased vision problems in the aged.

The National Health Institute has issued grants to some optometry schools in order to further research. As in most other professional fields, the big problem still remains—attracting sufficient numbers of well-trained persons to conduct studies in the field of aging. This is not an easy task, and is greatly dependent on our newly awakened public interest. The stimulation of additional funds for use by qualified teams of researchers in optometric colleges is a big step.

Each new year brings great strides of accomplishment and new hope to the aging, thanks to research in vision. Past research has given optometry a fruitful beginning into understanding the problems of vision; current research will serve as the road to complete understanding. Gratefully, the aging person may look forward to several more decades of productive, "seeing", alert years—all because of the vision progress being made through research.

SUMMARY

America has entered into a new phase of social development. Greater life expectancy and a rapidly increasing older population has created new problems, more challenges, far greater potential for national growth and development.

Since 1900 the number of men and women over 65 has increased 4½ times, while our total population has little better than doubled. Approximately 1 out of every 12 people are over 65, a total of about 15 million. By 1975, it is estimated the total will reach 21 million people. Another 40 million men and women are between the ages of 45 and 65. This means that almost 50 percent of our population is over 40.

Our country's great strength lies in our aging and aged. Here lies a vast and growing reservoir of energy and experience. Harness this power through unhandicapped vision . . . . give it expression, dignity and independence, and it becomes an asset. Allow it to degenerate, vegetate and become dependent, and it becomes a liability.

Our age of mechanization and automation has afforded a rise in our standard of living, but it has also increased the amount of leisure. Work has become more specialized requiring greater visual efficiency, leisure time has become broader, requiring better visual acuity for true enjoyment. The frequency of retirement has increased while age of retirement has decreased, requiring adequate visual acuity to keep the older person occupied. With these new-found "leisures", many older people are making use of their freedom from family and work responsibility. But many find themselves having the desire, but being hampered by visual defects. The unfortunate part of it all, is that this is a period of life when the person has the experience, knowledge and desire to enjoy life to the utmost, and offer more to humanity.

Perhaps one of the most tragic aspects of old age is feeling dependent, lacking a sense of self-sufficiency, feeling as though not wanted. Much of this lack of confidence is the psychological results of physical handicaps, often those in the vision category.

Through research and development, optometry has surged forward to find new ways and means to keep the visual facilities comfortably active longer. Optometrists discovered long ago that they must prescribe not only for the task but also for the mode of life. This is being done more and more in order to aid the senior citizen. Bifocals, multifocals, coated lenses, light and environment studies, hardened lenses, microscopic lenses and contact lenses, among other optical aids, are serving to prolong the "seeing" life of the aging person.

There is much more to be learned . . . . much more that the senior citizen of tomorrow can look forward to and see than those of today. But the effort is a worthy and compensating one, because in the senior citizen, you have humanity at its highest level of mature judgment.

In "Federal Responsibilities in the Field of Aging", President Dwight D. Eisenhower said:

"In considering the changed circumstances presented by lengthening the life span, we must recognize older persons as individuals—not a class—and their wide differences in needs, desires, and capacities. The great majority of older persons are capable of continuing their self-sufficiency and usefulness to the community if given the opportunity. Our task is to help in assuring that these opportunities are provided."

Vision is the precious sense that stimulates opportunities, and fulfills them after they have been established. We are looking forward to even a better life for the senior citizen through improved vision.

THE JEWISH HOSPITAL OF SAINT LOUIS,
St. Louis, Mo., June 15, 1967.

Hon. GEORGE A. SMATHERS,
New Senate Office Building,
Special Committee on Aging,
Washington, D.C.

DEAR SIR: In your letter of May 31, 1967, you kindly invited me to comment on a number of questions concerning the health-care of the elderly. In my reply, I shall take up each question separately.

1. Are rising medical costs causing special difficulties for the elderly?

Medicare benefits have, of course, greatly lightened the economic burden of illness upon the aged. Hospital costs have risen more sharply than any other medical expense over the last decade and, this aspect at least, is now covered by Plan A of Medicare. There are other areas of health care, however, which continue to present serious financial problems to the sick aged.

a. Drugs: The cost of drugs prescribed to the patient, not in a hospital, is not covered by medicare insurance. Drugs are often expensive, and many elderly patients find it difficult or impossible to purchase the medications needed to retain or restore their health.

b. Nursing home care is covered only as extended care for brief periods following hospitalization. Unfortunately, many aged patients must remain in nursing homes for long periods of time at a cost which they canot afford.

c. Preventive Care: Plan B of Medicare specifically excludes routine examinations and diagnostic procedures which might uncover illness at a latent stage. As a result, many elderly will not seek medical aid until they are actually ill, and the opportunity to prevent illness and incidentally reduce the overall cost of care for the individual is lost.

2. Do many of the elderly face insuperable obstacles in obtaining needed health services?

This problem appears to be most severe in rural areas which suffer from shortages of physicians and other health-care personnel. Here, the aged patient often competes unsuccessfully with younger patients for medical attention. Physicians, nurses, etc., usually prefer to treat younger patients whose diseases are confined and more quickly responsive to therapy.

The greater the shortage of physicians in a community, the more apparent is this attitude and the more disastrous to the welfare of the aged.

I believe that this problem is less acute in large cities which have more physicians per capita and which provide out-patient services in hospital clinics.

3. Are present health services remote geographically and sociologically from many of our older patients?

The sociological problems of health care for the elderly are complex and their needs are frequently not well met. The aged patient often suffers from several diseases at the same time, each of which may require the services of a specialist. As a result, the patient may find himself referred from one physician's office to another, or from one specialty clinic to the next. Yet nobody takes charge of the overall management and nobody pays attention to the social and emotional problems which are entwined with the illness. This may, of course, be true for patients of all age groups but this deficiency in the overall management becomes more serious and more frequent in the aged who are ill more often and to whom diseases are more frightening and more costly. In order to meet this problem, some health centers have established comprehensive geriatric clinics which deal with all of the medical and social aspects of the care of the aged. Unfortunately, such geriatric clinics are rare. In most centers the elderly patient may receive excellent care during the acute phase of an illness. However, once the critical stage has passed and the patient has been dismissed from the hospital, care again becomes fragmented and little attention is given to those measures which might prevent another acute breakdown.

I hope that federal legislation may eventually encourage the establishment of comprehensive geriatric centers which will give preventive care and out-patient care, as well as hospital care and home health services.

4. Are present Medicrae and Medicaid policies intensifying old problems in the organization of health services or causing entirely new problems?

Medicare, by providing hospital insurance is bringing too many patients to hospitals and keeping them there too long. This has seriously aggravated the shortage of hosptial beds. A patient should be at the proper place at the proper

time, but it has been the experience of the past year that too many Medicare recipients remain in the hospital when they could just as well be treated in a nursing home or at home.

Medicare legislation provides for home health services. It has been our experience, however, gained by operating a Training Center for Home Care, (under contract from the U.S. Public Health Service) that the establishment of such services is badly lagging. Home health services require the cooperation of several community agencies. Very often, hospitals, visiting nurses associations and local health departments find it difficult to get together for the establishment of home health services so vital to the care of the aged.

Obviously, not all aged patients can be managed at home. Those who show severe senile mental changes or who have no suitable home will require care in a custodial institution. But too many elderly sick who could have remained with their families wind up in nursing homes just because well organized home health services were not available to them. It was clearly the intent of Medicare Legislation to keep as many aged in the community as possible. However, concerted efforts will have to be made by State Health Departments, local agencies and the existing eight Home-Care Training Centers to combat the serious lag in the development of home health services.

Similar problems exist with regard to nursing home care. Nursing homes are important health care facilities. In many cases they could provide more than custodial care; they could be used as geriatric rehabilitation facilities and some of their residents, restored to an acceptable level of independence, could return to their homes. Some nursing homes have made the effort to increase the scope of care along these lines but many others have failed. Medicare legislation provides for affiliation agreements between hospitals and nursing homes. In most cases these agreements exist on paper only. Hospitals often fail to give necessary professional support to those nursing homes with which they are affiliated, and often the homes fail to seek the advice and guidance which could improve the level of care.

These problems have, of course, existed for a long time. They have not been aggravated by Medicare. Rather, health care facilities have failed to utilize the opportunities which Medicare legislation is offering them.

5. Are shortages of trained personnel in the medical and medical-related professions especially severe in fields that serve the elderly?

Shortages are critical in all health care professions. As pointed out before, the care of the aged is not attractive and for this reason facilities which serve the aged find it even harder than others to recruit personnel. Often they are forced to combat negative attitudes by offering higher salaries. This in turn tends to increase the cost of caring for the elderly.

I greatly appreciate your giving me the opportunity to express my opinions on this vital subject. Kindly let me know if you wish me to elaborate further on any of the points discussed. I shall be happy to be of service.

Yours very truly,

FRANZ U. STEINBERG, M.D.,
Director, Department of Long-Term Care.

HARVARD UNIVERSITY,
SCHOOL OF PUBLIC HEALTH,
Boston, Mass., June 19, 1967.

HON. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly
U.S. Senate, Special Committee on Aging
Washington, D.C.

DEAR SENATOR SMATHERS: Your letter of May 31st arrived while I was absent from the office due to a recent illness. I regret that it was not possible for me to respond to your invitation to submit a statement for the hearings of the Subcommittee on the Health of the Elderly.

I believe that it is particularly appropriate to review the present status of health care for our aged citizens. Medicare has been of significant help in reducing but not eliminating the financial barrier to health care for persons over 65. Medicaid has not been implemented in a number of states and has had but token implementation in many states.

While the health manpower shortage is indeed acute, I am convinced that the haphazard way in which our health services are organized is wasteful of manpower and is a significant factor in the less than optimal state of health care for the elderly.

Sincerely yours,

ALONZO S. YERBY, M.D., M.P.H.,
Professor and Head.

AMERICAN HOSPITAL ASSOCIATION,
June 9, 1967.

Hon. GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly,
Special Committee on Aging, U.S. Senate,
Washington, D.C.

DEAR SENATOR SMATHERS: This statement is sent to you in reply to your letter of May 24, 1967. We hope the contents will be helpful in your committee's consideration of the subject of "Cost and Delivery of Health Services to Older Americans." The hospitals of the country, of course, have been continually concerned with the organization and provision of services to the elderly as they have been involved in the over-all efforts of hospitals to care for the total population. It is not an over-statement, I think, to say that the Medicare program would not have "gotten off the ground" except with the complete cooperation of the hospitals of the nation.

Title 19 of the Social Security Act dealing with indigent and medically indigent persons will come into effect July 1 as the federal standards are to be implemented starting on that date. This program will gradually develop so as to involve a very large segment of the population and will without doubt be concerned with health services to large numbers of aged persons. Here, again, a successful implementation of Title 19 will be dependent upon full participation on the part of hospitals. This essential participation on the part of hospitals can only be assured if the financial needs of hospitals to provide community health services is fully recognized by the federal government.

The following discussion is directed toward the questions raised in your letter to me:

1. Are rising medical costs causing special difficulties for the elderly?

In the main, rising hospital costs for the aged are a problem to be faced by the federal government and particularly the Hospital Insurance Trust Fund. Therefore, for the aged beneficiaries themselves, escalation of hospital costs is quite limited in its impact and would become a major factor only for those aged individuals who have exhausted the benefits provided under Title 18. Even here, however, if states implement Title 19 in an appropriate manner, the escalation in costs of those who have exhausted their benefits under Title 18 will become a matter for state and federal governments under Title 19.

The Medicare law provides, of course, that the $40 deductible for hospital admissions can be increased at stated intervals. However, it is not likely that this would become in any way a major factor for elderly persons.

Services and supplies required by elderly persons who are not hospital patients may well suffer increased charges and thus affect the costs of health services to the elderly. However, we are not in a position to provide essential information on charges or costs outside of hospitals.

It is conceivable increased costs in health services might occur insofar as the services of extended care facilities and organized home health programs are not available. An enderly person under such conditions has two choices: either do without the care or personally finance whatever may be available in the way of substitute care. This may involve seeking care in an institution which fails to qualify either as a hospital or extended care facility. This might be an unskilled nursing home or the care might be provided via periodical visits by a physician to the private home. Or, perhaps home nursing services may be obtained on some basis. In either instance, the cost of such care would have to be borne by the individual, completely or in part, and thus would subject such individual to the impact of escalating health care costs.

2. Do any of the elderly face insuperable obstacles in obtaining needed health services?

There are three major aspects to obtaining health services: the availability of facilities, the availability of adequate personnel and the financing. By and

large, the elderly are no different than the rest of the population in terms of the relationship which the existence of these three factors bears to their ability to obtain health services. There are acute shortages of certain categories of health personnel. The development of extended care services and home health services has an absolute relationship to the availability of adequate numbers of well trained nursing personnel. Thus, the existing major shortages of such personnel will directly affect the availability of these services, which are of particular importance to the elderly. The financial problem of the individual aged person is ameliorated through the passage of the Medicare law and if Title 19 is adequately developed by the states it should rather completely remove any financial obstacle to the obtaining of health services by the aged. It is obvious from the hospital occupancy figures being reported that substantially increased numbers of the aged are now receiving health services and this was a basic purpose of the Medicare law.

3. Are present health services remote geographically and sociologically from many of our older persons?

There is already a widespread distribution of hospitals throughout the nation. For this reason and because of the availability of good highways and modern transportation, geographic location in terms of physical distance from a hospital facility is of quite minor importance today. The more important factor is time, and it is fact that there are a great many persons in metropolitan centers that are further away time-wise from hospital facilities than are individuals in rural areas. The problems involved here, however, are not unique to the aged but are related to the whole population. We strongly believe that what we need in the country is better hospitals rather than more hospitals. It would be a great mistake to plan for a hospital at every crossroad. This would be most likely to result in a deterioration in the quality of health services. Medical advances increasingly dictate the need for concentrations of available equipment, facilities and personnel in centrally located facilities. Widely dispersed and fragmented units can be wasteful in the use of personnel. They would be extremely costly and would not elevate the quality of health care. Such an approach would not result in increased availability of "modern medicine" to the aged. In those instances where elderly persons fail to seek health services because of a fear of the costs or because of a strong sense of pride, the development of Medicare has probably done much to eliminate these barriers. There are undoubtedly elderly persons who refuse to seek medical care or refuse to be admitted to hospitals for other reasons; and, of course, this problem would have to be approached in other ways.

4. Are present Medicare and Medicaid policies intensifying old problems in the organization of health services or causing entirely new problems?

Without doubt the existing provisions in respect to the services of radiologists and pathologists are intensifying old problems and developing new problems in hospitals. Also, without doubt the present provisions of the law in respect to outpatient services are nearly impossible of administration, are extremely costly to administer and quite likely are frustrating large numbers of older persons from utilizing the outpatient benefits of the Medicare law. The present provisions for outpatient services create such obstacles that certainly there is no incentive for institutions to develop such services.

Hospitals throughout the nation are expressing their deep concern in respect to the reimbursement received for Medicare and, of course, this concern is magnified now that a decision has been reached to utilize the same basis of reimbursement under Title 19. The belief is increasing that any continuation of the present inadequate reimbursement and continuation of the basis of apportionment of costs now insisted upon by Social Security will inevitably lead to deterioration of hospital care. This situation poses very real problems for hospital boards of trustees in light of their responsibilities to the over-all community they serve.

It is quite clear that a major role of hospitals in the future is going to be care for patients who are not confined to beds. The outpatient services and the diagnostic and treatment services are increasing dramatically. It is also obvious that the public more and more is turning to the hospital for the provision of medical services of all kinds. Undoubtedly, this trend is of importance to the elderly.

The American Hospital Association is strongly in favor of group medical practice. The growing numbers of such groups reflect their increasing public acceptance. As the hospital develops increasingly as the center of health affairs in the community, it is obvious that increasing attention will be paid to such develop-

ments. Undoubtedly, therefore, the rendering of hospital services to the elderly as to the rest of the population will be affected by changes in organization which may result.

Medicaid has thus far only really been implemented in some of the states. It is not yet clear how the program will develop in many states. There is a vast difference between programs of health services envisioned under Medicare as compared to Medicaid. Medicaid will in the main be directed towards individuals who are under 65 years of age. Most of those persons over 65 years of age are covered under Part B of Title 18 for physician services. The scope of benefits provided under Medicare are the same nationwide for all elderly who are eligible. Except for broad federal criteria, the benefits which the fifty states may decide to provide under Medicaid may vary greatly. Thus, at the present time it is not possible to evaluate the Medicaid program in terms of its effect on the organization of health services.

This Association fully supports voluntary planning for health services, facilities and personnel. We are making every effort to assist hospitals in their participation in planning activities. Undoubtedly, as planning becomes fully implemented throughout the nation, there will be changes in the organization of health services affecting the elderly as well as all others of the population.

5. Are shortages of trained personnel in the medical and medical related professions especially severe in fields that serve the elderly?

As stated previously, there are acute shortages in many areas of health personnel. These shortages affect the elderly as they do all other individuals requiring health care.

It is believed that physical therapy services are of particular importance to the rehabilitation of the elderly. Such services are included in the benefits of Medicare, and it may well be that the shortages of trained physical therapists restricts the availability of these rehabilitative services.

We have already referred to the shortages and need for greatly increased numbers of qualified nursing personnel and the fact that the lack of availability of such personnel will curtail certain of the services needed by the elderly. Also, current studies indicate that aged persons require a greater amount of nursing care than young persons, thus aggravating the impact of the shortage of nursing personnel upon care of the aged.

6. Can you give us recommendations for reducing paper work relating to Medicare? Do you feel that many Medicare recipients are confused by present procedures?

There are wide-spread reports from hospitals of the necessity of adding substantial numbers of personnel to carry the administrative burden of Medicare. Since we understand that similar procedures are to be followed under Title 19, we expect that such administrative costs will be further increased.

The various procedures which are required for Medicare are being studied carefully by the Social Security Administration, by the intermediaries and by hospitals. It is expected that improvements can be made in certain of the procedures. If deductibles now required are eliminated and a co-insurance factor substituted as we recommended in our testimony of March 8 before the Ways and Means Committee on the pending Medicare amendments, a great deal of administrative cost and confusion both for hospitals and for older recipients will be eliminated.

The requirement of physician written certification of medical need at the time of admission is an unnecessary duplication of effort and results in substantial delay in the processing of the forms and in hospitals receiving payment.

The present statute and regulations require hospitals to separate the costs of radiologists' and pathologists' services on the part of the hospital from the remuneration of the hospital-based radiologists and pathologists. This is time consuming especially when the hospital has been designated as collection agent for the physician and must claim payment on his behalf from another trust fund. Payments for physicians' services is subject to the $50 annual deductible while the hospital portion of payment for radiologists' and pathologists' services are not subject to a deductible. Similarly and even more expensive to administer and confusing to all who are involved, is the procedure for obtaining payment for outpatient diagnostic services. Here, again, the hospital must obtain payment from one source, after first considering a $20 deductible, while the physicians' compensation must be obtained from another source and subject to the $50 annual deductible under Part B. Not only is this extremely difficult to understand but it

results in very little payment to hospitals, physicians, and patients for outpatient care and in frequent waiving of potential benefits because of the complications inherent in trying to obtain payment. As presently written, the statute and regulations appear to provide no alternative to this overly complicated, expensive and less than satisfying arrangement. This Association has presented to the House Ways and Means Committee a specific proposal which we feel will alleviate in large measure these problems. It is felt to be of utmost importance that every effort be made to reduce the problems, to eliminate unnecessary complexities and to avoid hospitals having to "channel their talents away from making positive contributions to the improvement of patient care."

It is our belief that continued efforts must be made by everyone concerned to inform the aged recipients of the intent and extent of the Medicare program. For example, the term "extended care facility" is widely misunderstood and many aged persons and their families have assumed this means all nursing homes. It is apparent also that the beneficiaries do not understand the application of the deductibles. Hospitals often find themselves in a difficult public relations problem as it falls upon them to try to justify an action taken by the Congress. As stated we do not intend to dwell on various problems related to physician services; but hospitals are, of course, continually made aware of the problems of Medicare beneficiaries in respect to the payment for physicians' services.

In the over-all as we view the problems associated with Medicare they fall into two categories: first, those which it is expected can be alleviated through experience and administrative change; and secondly, those problems which seem to be inherent in the law and which will require legislative action for their correction.

While we have been pointing out various problems involved in the operation of Medicare, we must not overlook the fact that this law has made a most important contribution to high quality standards in the provision of health services. It is to the credit of the Congress that it required high standards for institutional participation, thus, assuring reasonably high quality of care to old people in this country. Medicare is at best a complicated law and because of its sheer size and implications it is unlikely that it will ever be simple to administer or completely understood by the beneficiaries.

Some years ago the American Hospital Association strongly supported legislation promoting housing for the elderly. At that time we urged that as a matter of national policy the federal government not move solely in the direction of institutionalizing elderly persons. We pointed out that large numbers of the elderly would best be provided for through housing particularly adapted to their living needs and that to the fullest extent possible we should follow a national policy of providing incentives for the elderly to remain in a normal housing environment. The key to such a program would be to relate health services to the housing of the elderly in such a way that they would have available physician services, nursing care, frequent checkups, consultation and the reassurance which the elderly need. Thus, we urged that provision be made in housing programs for the elderly for minimal health facilities so that hospitals and physicians could develop programs to serve the elderly in their home environment.

We appreciate this opportunity of expressing our views to you and your distinguished committee, and we hope that this will contribute to the very commendable objectives of your hearings.

We would appreciate your including this statement in the record of the hearings.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director.

ANCHOR BAY BEACON,
New Baltimore, Mich., June 16, 1967.

Senator GEORGE A. SMATHERS,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate, Washington, D.C.

DEAR SIR: If you have heard testimony from Molly Guiney, you now have a deep insight into the Well-Being Project and the viewpoint of one of the most informed persons on the problems of aging in this country.

Where I live, in southeastern Michigan, the good Lord is provident and during a certain period of the year my old country place has what might almost be called a plethora of lilacs. On Memorial Day, my wife suggested we take some

to the convalescent home nearby. We did. We encountered the faces of about twenty-five persons there. The experience has haunted me ever since. It was ghastly. From not one—neither the female nor the male persons present—could I draw a smile. They reacted like expired persons—figures in a mortuary—who somehow were still not dead but waiting to die. An attendant brusquely asked us who we wanted to see. When we told her, "No one in particular," she seemed disappointed; this was too inexact; it meant that we could not be routed to a specific place so that we would be removed from the premises as quickly as possible and in a stereotyped manner. Oh, what a travesty on time our presence meant!

This type of thing is a reflection on all of us. It is barbaric. It is uncivilized. One is young, one is middle-aged and one is old. At the third stage one is put into what is commonly called a nursing or convalescent home—to die.

Almost everyone at some point in his or her lifetime has entered a hospital. When you do this you say to yourself "I don't like the looks of this building, I don't like the smell of a hospital and I hope I can get out of here as quickly as possible." If you go in for a serious operation, you know it will be two or three weeks. If it is a relatively minor matter, you know it will be a matter of a few days. Whatever the time element, your mind is focused on getting well again and getting out.

Unfortunately, the deposit of your person at the doorstep of a convalescent home has a far different connotation.

Psychologically, when you enter a hospital you are a whole person going in and you hope to be a whole person coming out.

For older persons going into a convalescent or nursing home, psychologically, you go in knowing that this is the end of the line—you are to be there until you die.

This is horribly inhumane, and not in keeping with the humane thinking of society today.

Ninety per cent of the present nursing homes would have it so. It is economically more feasible to admit a patient, figure out the arrangement for payment and keep that person in bed or in a semi-invalid condition until the expirant breathes his last. Then, a bed opens up and another patient can be admitted.

It need not be so. The knowledge of medicine today has advanced to such a degree that two thirds of the persons entering nursing homes could be returned to their own homes if application of this knowledge could practically be put to use and these patients had a home to which they could return. I have seen demonstration projects that prove this out. For instance, a public health nurse in Detroit, if my memory serves me correctly, picked out five stroke cases in as many nursing homes and set out to teach the staff how to treat stroke cases. Three out of the five were returned to their own homes, one expired and one remained in the nursing home.

The profit motive in nursing homes has made a mockery out of the intent of such places.

I strongly advocate that all nursing homes be publicly owned and administered. This is, of course, a general statement that should in no way take away the rights of existence for non-profit homes. Many of these are engaged in highly meritorious service.

But the present arrangement in which most persons are treated in non-profit hospitals where the professional impetus is to make people well regardless of cost while at the next stage most people are taken to for-profit nursing homes where the incentive is to take care of people at the lowest possible cost to the nursing home operator is senseless.

It is hardly in keeping with our times.

The Well-Being Project was not created to keep persons out of nursing homes. But it has substantially served this purpose.

It was created to do a direct service job for older persons. The federal grant came under the heading of health but it is a well-known fact that health is only many problems that face older persons. I have already pointed out the one of the psychological factor. Finances, lack of communication and loneliness —particularly loneliness—are probably more important components of the total picture.

The Metropolitan Detroit Committee on Aging sponsored a number of in depth studies on the question of what are the needs of older persons. These go back to the late 1950's and early 60's. In Detroit's largest public housing project,

Herman Gardens, we studied the wants of close to 1,000 older persons, possibly more. Was it health? Was it something else that caused them worry? We found out. It was a multiplicity of problems. With a social worker, Lois Pettit, I participated in in dept studies of older persons living in hotels, in rooming houses, in private homes. Stories on all of these subjects, including a story on a public health clinic at Herman Gardens, are available.

We found out.

What to do next?

The Well-Being Project with a highly skilled social worker and a registered nurse with public health training, working as a team, without rigid controls at the neighborhood level was the answer. We did not want these teams to make intricate detailed reports. Either you give service or get reports.

The program is not one hundred per cent perfect. As these workers become better established in their communities the time spent on aggressive visitation in their neighbor hoods decreased. These are highly dedicated workers. In another type of service one might recommend bringing in a new team—always with the intent of putting on the muscle to visit more people in their homes. But when you deal with old people change is a factor you can do without.

If not too many social scientists get involved, the Well-Being Project, not easily defined because it deals with human beings in the best method to cope with human beings, offers a formula, or a principle, if you will, that should be duplicated on a broader scale throughout the Detroit area and applied in every community throughout the country.

While I am on the subject of aging I would like to take this opportunity to make a couple of other points.

On the question of insurance I have had a devilish time trying to figure out how to get the protection through Medicare and two private insurance policies for my own eighty-five-year-old mother-in-law. My wife nags me because she says as an expert I should have all the answers. I have developed a fair understanding of what I am doing. I have appealed to other experts, such as Bill Fitch in Washington, and they in turn indicate that the problem is so involved they don't have all the answers. God pity the old person who does not have someone helping him.

Recently, at a hospital in Detroit I overheard an older person tell the snippy clerk dressed in a nurse's uniform at the desk, "The hell with all this stuff. So, I'll pay my bill and let it go at that."

Most doctors and most hospitals don't give a damn how the patient makes out with respect to his own pocketbook. All they are concerned with is the responsibility incumbent upon them. The doctor treats. The hospital wants payment for its services. How the patient is reimbursed is the patient's business. And I'm afraid that nine out of ten older persons do not have the knowledge to pierce through all of the red tape to get what he or she is entitled to.

All laws such as Medicare should be simplified. And doctors, hospitals and nursing homes that do not subscribe to the system in full, including the task of processing the claims of their patients, should be stricken from the approved list.

All of this in addition to the requirements concerned with high standards of care.

The government should take into consideration the need for keeping older persons—except those chonically ill—in their own homes. My mother-in-law and I fight like cats and dogs. But she is a part of our family life. She takes part in taking care of her great grandchildren. She has duties and chores. And as much as she gripes at age 85 she also laughs and gets great satisfaction out of being part of life. Furthermore, she is never told that she may be taken to a nursing home. She has a home.

I regret that I could not participate in your hearing in person. I was informed that your meager expense allowance permits coverage for only one person per project. I have had close to forty years in newspaper work, first in Chicago and then Detroit. I was with the Detroit Free Press for 26 years—for about the last 15 as a reporter in the social sciences covering mental health, the aging and the handicapped—and I left there about Feb. 1.

One of the reasons is that I came to the conclusion the "big," monopolistic press is not interested in doing a real job of serving people. The communications field is dominated by the motives of big business. I felt I could build up a weekly newspaper to the point of economic and professional status so that the real pur-

pose of a newspaper could be preserved: to give top quality news to its readers and serve its community. When that goal is reached I can then, again, become a spokesman for those who cannot speak for themselves on a wider basis. For the time being it was not economically possible for me to be there—although my heart is entirely with what you are doing.

Maybe, sometime, the rules can be changed to the extent that you can have the privilege of hearing from persons who may have something to offer, whether they are on a payroll or not and whether they can afford to pay their expenses to appear or not.

I am completely dedicated to the spirit of the Well-Being Project. It has a purpose. To me, keeping people from the despicable prospect of being victims of a nursing home is enough.

Sincerely yours,

WARREN STROMBERG.

APPENDIX 3

A REPORT TO THE PRESIDENT ON MEDICAL CARE PRICES BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE FEBRUARY 1967

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON

February 28, 1967

MEMORANDUM FOR THE PRESIDENT

Last August, you asked me to study the reasons behind the rapid rise in the price of medical care and to offer recommendations for moderating the rise. In response to your request, I am transmitting herewith a Report on Medical Care Prices. The Report was prepared by Assistant Secretary William Gorham of this Department with the assistance and advice of the Department of Labor and the Council of Economic Advisers.

Medical prices have been rising for many years at a rate substantially in excess of the rise in the general price level. Like other prices, medical care prices accelerated in 1966. The Bureau of Labor Statistics Index of Medical Care Prices rose 6.6 per cent in 1966. Hospital room rates rose even more precipitously.

The Report attributes these price rises to the pressure of the rising demand for medical services, the relatively slow growth in the supply of physicians, rising wage costs in hospitals without commensurate increases in productivity, and the increasing complexity of medical care provided to the patient.

The Report holds out little hope for an early end to medical price increases. Growing population and rising incomes, as well as the public commitment to assure adequate medical care for all citizens, will continue to put upward pressure on medical prices.

Nevertheless, steps can be taken to moderate the rise in medical prices by using medical resources more efficiently. To this end, the Report recommends:

1. The establishment of a National Center for Health Services Research and Development to discover and disseminate new ways of delivering health care efficiently.

2. The encouragement of the group practice of medicine.

3. Strong Federal support for State and area-wide planning for the efficient use of health resources.

4. Re-examination of the reimbursement formulas under Medicare and Medicaid in an effort to design formulas which increase the incentives to health institutions to operate efficiently.

5. The appointment of a Presidential commission to review Federal programs of support for health institutions with an eye to the efficient distribution of such institutions.

6. Training and use of physician assistants and other innovations in medical education and the efficient use of medical manpower.

7. A study of frequently prescribed drugs to determine the relative therapeutic value of brand name products and other drugs with the same generic name.

Implementing these recommendations will demand the concerted efforts of the medical community, the insurance industry, State, local, and Federal officials, and concerned public groups.

Secretary

FOREWORD

This Study represents the collective efforts of many people. It was prepared in my Office, under the supervision of Alice M. Rivlin, by Jeffrey Weiss and Douglas Wilson, with the assistance of Robert Turtle.

Substantial contributions to the data and analysis were received from the Bureau of Labor Statistics, especially Arnold E. Chase and his staff; the Public Health Service, especially Agnes Brewster and her staff; and the Social Security Administration, especially Ida Merriam and her staff. Ideas and advice from the Council of Economic Advisers, the Department of Labor, the Department of Justice, and many parts of the Department of Health, Education, and Welfare are reflected in the Report.

Rashi Fein of the Brookings Institution and several other experts outside the Government were extremely helpful.

William Gorham
Assistant Secretary
for Program Coordination

Part I. Summary and Recommendations

Cause for Concern

The price of medical care rose rapidly in 1966:

The Bureau of Labor Statistics index of medical care prices rose 6.6 percent.

The index of hospital daily room rates went up 16.5 percent.

Increases of this magnitude cause severe hardship to individuals in need of medical care, whether they pay the prices directly or indirectly through higher insurance premiums. Medical price increases make Government-financed medical care programs more expensive for the taxpayer.

There is nothing new about rising medical prices.

Since World War II, medical prices have been rising considerably faster than consumer prices generally. But the 1966 increases were the largest in many years.

The purposes of this report are to—

- identify the causes of the longrun upward trend and the recent acceleration in medical prices;
- estimate what is likely to happen to medical prices in the future; and
- recommend Government actions to moderate the price rise and to encourage greater efficiency in the delivery of medical care.

Why Doctors' Fees Are Rising

More people are seeking doctors' services more often.

Increases in population, rising personal income, wider private and public insurance coverage, and other factors contribute to rapid increases in demand for physicians' services.

The number of active physicians is rising relatively slowly.

Between 1950 and 1965, the number of family physicians (pediatricians, internists, and general practitioners) actually declined.

In the face of rising demand for their services, physicians have been—

- seeing more patients per week; and
- raising their fees.

Physicians' fees—like many other prices—accelerated in 1966.

The Bureau of Labor Statistics index of physicians' fees, which had been increasing less than 3 percent per year in the period 1960–65, rose almost 8 percent in 1966.

Much of this increase was to be expected in view of the general inflationary pressures in the economy this year. In the past, doctors' fees have risen about twice as fast as the consumer price index. In 1966, the consumer price index rose 3.3 percent.

There is no evidence that medicare was a major factor in the rise in doctors' fees.

Why Hospital Charges Are Rising

The cost of providing hospital care is rising rapidly.

Wages, which account for two-thirds of total hospital costs, are the most important factor.

The wages of hospital employees, still low relative to other sectors of the economy, are rising more rapidly than other wages.

This increase in wages has not been offset by any measurable increase in the "productivity" of hospital employees. The number of employees per patient is rising, not falling.

Nonwages costs of hospitals are also rising, reflecting the growing complexity of hospital plant and rapid increases in the specialized care facilities available in hospitals.

The 1966 acceleration was primarily related to—

- rising wages in a tight labor market; and
- increases in the prices of things hospitals buy.

Although medicare raised hospital occupancy rates in many places, increased occupancy does not generally lead to higher costs per patient. However, participation in medicare required hospitals to reexamine their costs and charges. In the course of this reexamination, many hospitals probably decided to increase their charges.

Drug Prices

Drugs contribute to the high cost of medical care, although they have not contributed significantly to recent price increases.

The use of drugs is increasing, and many consumers are conscious of an increased burden of drug expenditures not generally covered by insurance.

Drug prices are higher than they would be if there were more vigorous price competition at either the manufacturing or drug store level. Advertising costs are high and doctors often prescribe costly brand name drugs when cheaper equivalents are available.

Future Price Movements

Continued increases in the price of medical care are inevitable. The question is not whether medical prices will rise in the future, but how fast they will rise.

Forces which have been pushing up demand in the past—population increase, rising income, increasing insurance coverage—will continue to exert pressure.

Moreover, a new element has been introduced: rising public conviction that excellent medical care should be available to all Americans.

> The passage of medicare and medicaid are evidence of this new conviction.
>
> Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens.

These new demands add to the upward pressure on medical prices.

There are two means of moderating increases in medical prices:

- adding to the supply of medical resources by increasing medical facilities and training more medical manpower; or
- increasing the efficiency with which medical resources are used.

Federal resources are devoted to a wide variety of programs designed to increase the supply of medical resources. The President's Commission on Medical Manpower is reviewing the adequacy of all Federal programs affecting manpower supply.

This report concentrates on steps that can be taken to use medical resources more efficiently.

The recommendations which follow are designed to increase the effectiveness of medical care delivery in order to moderate future price increases and make it possible to meet the rising demand for medical care.

ENCOURAGING ALTERNATIVES TO HOSPITAL CARE

Hospital services are the most costly form of medical care. The average cost of a day in the hospital is about $45. To protect themselves against these high costs, most people presently have hospitalization insurance.

Far fewer people have insurance which covers less expensive medical care services, such as care in nursing homes and convalescent hospitals, outpatient care, or organized home health services. Hence, doctors often put patients in hospitals for diagnosis or treatment rather than utilizing less expensive alternative services because a third party will pay the hospital bill.

Many people are hospitalized unnecessarily: some for unnecessary surgery, some for conditions which better or more timely medical care would have prevented, some because they have no other place to go. Much of the care given in hospitals could be given less expensively outside, but lower cost alternatives are unavailable in many communities.

Recommendation

Comprehensive community health care systems should be developed, demonstrated, and evaluated.

The Federal Government should take the lead by creating a National Center for Health Services Research and Development in the Department of Health, Education, and Welfare.

1. The center would offer technical assistance and financial support for the development of model comprehensive systems.

   These model systems would make available intensive care, hospital care, extended or convalescent care, nursing home care, outpatient care, and organized home health services. Doctors would be encouraged to choose the least costly appropriate service for their patients.

   The costs and effectiveness of such model systems would be evaluated and the results widely publicized.
2. The center would undertake research dealing with the medical care system and support such research in industry, universities, health services, institutions, and areawide planning groups.
3. The center would serve as a clearinghouse for information and would disseminate the results of research on medical care delivery.
4. The center would support the training of health planners, systems analysts, health economists, and other specialists in methods of improving the efficiency of health care delivery.
5. The center would make the services of such specialists available for consultation with communities and health institutions seeking to improve medical care delivery systems.

Recommendation

Group practive, especially prepaid group practice, should be encouraged.

Groups of doctors practicing together can make more efficient use of equipment, auxiliary personnel, and consultation than doctors practicing alone. Where the patient has paid in advance for comprehensive medical care under a group practice plan, less incentive exists to use high-cost hospital services where lower cost alternatives would meet the patient's needs just as well.

1. The Federal Government should encourage group practice prepayment plans by amending title XIX of the Social Security Act to require States to allow medical beneficiaries to use such plans.
2. The Department of Health, Education, and Welfare should encourage the States to use title XIX funds to foster and extend the group practice of medicine.
3. The National Center for Health Services Research should provide "seed money" to encourage incipient group practice prepayment plans and to evaluate their ability to provide quality care efficiently.
4. The Department of Housing and Urban Development and the Department of Health, Education, and Welfare should make maximum use of the Group Practice Facilities Mortgage Guarantee Program.

Recommendation

Private and public health insurance plans should be broadened to include more alternative types of medical care.

The Federal Government has already taken major steps in the direction of comprehensive health insurance coverage. Medicare beneficiaries are covered not only for hospital care, but for diagnostic services in outpatient clinics, stays in extended care facilities, and home health care services, as well as physicians' office visits. Title XIX beneficiaries are similarly intended to be the recipients of comprehensive health care.

Other groups in the population can be expected to seek more comprehensive health coverage. This development should be encouraged by the carriers, by the States, and by the Federal Government.

- The Department of Health, Education, and Welfare should—confer with representatives of the health insurance industry, State officials, labor, management, and public representatives on ways of moving toward more comprehensive coverage;
- develop, with the assistance of insurance experts and others, model State laws to encourage or require comprehensive health insurance coverage.

PLANNING FOR HEALTH FACILITIES AND SERVICES

Uncoordinated development of health services and facilities often leads to costly duplication and underutilization of facilities, as well as to serious gaps in the availability of health services. Most communities have no mechanism for health planning. There is nothing to prevent two nearby hospitals from installing the same rarely used

special facility, the construction of a hospital or nursing home in an area already well served, or the perpetuation of several inefficient facilities where replacement with a modern health center would be preferable.

The Comprehensive Health Planning and Public Services Amendments of 1966 (Public Law 89–749) authorized grants for state- and area-wide planning for comprehensive health services, health manpower, and health facilities. In addition to promoting and assuring the highest level of health attainable for every person, this planning activity is intended to coordinate existing and planned health services, to reduce overhead costs by increasing utilization rates, to prevent unnecessary expansion of hospital beds, and to encourage expansion of less costly services and facilities. It will also encourage the development of needed facilities which are not now available and improve the quality of medical care.

Recommendation

The States should move quickly to establish and support strong health planning agencies at the State and local levels.

1. Where they have not yet done so, State Governors should designate a comprehensive health planning agency to carry out the purposes of Public Law 89–749 and assure that agency adequate powers and staff to carry out its mission.
2. States should enact legislation providing for a State system of area planning bodies with the power to affect the rate of expansion of health facilities in the community and to set standards of service.

   These bodies, operating under the aegis of the statewide planning agency, would have the power to prohibit construction or expansion of health facilities where such construction or expansion conflicted with the development of an efficient system of health care delivery for the community. They should have the power to close substandard facilities.

Recommendation

The Federal Government should actively assist and support health planning at the State and local levels.

1. The Federal Government should implement Public Law 89–749 by providing funds to help staff state- and area-wide planning agencies.
2. The Surgeon General should review the State plans submitted under Public Law 89–749 to make sure maximum attention has been given to efficiency in the development and provision of health services.

3. The Federal Government should require that grants to State and local governments for health purposes be spent in accordance with these plans and should deny funds for construction or expansion to health institutions which refuse to comply with the directions of the State or area planning agency.
4. The Federal Government should require that money paid to the providers of medicare services as reimbursement for depreciation costs must be held in a separate account to be used only for capital expenditures consistent with the overall plan of the State or area planning agency.
5. The National Center for Health Services Research and Development should evaluate the effectiveness of area planning as a means of reducing medical costs.
6. The President should appoint a commission to review all Federal programs for the construction, expansion, and modernization of health and medical facilities and to advise him on the future direction and scope of such programs and their potential role in moderating the rising trend in the cost of medical care.

   The expiration of the Hill-Burton Act in 1969 makes imperative a thorough reexamination of Federal policy toward health facility construction, expansion, and modernization.

   The commission should have all types of medical facilities within its purview, including: hospitals, extended care facilities, nursing homes, mental hospitals, community mental health centers, and neighborhood health centers. It should reexamine needs for these facilities and recommend a Federal strategy for assuring efficient distribution and utilization of facilities and coordination of Federal programs with State and local planning.

IMPROVING THE INTERNAL EFFICIENCY OF HOSPITALS AND OTHER PROVIDERS OF HEALTH SERVICES

At present, hospitals have inadequate incentive to be efficient. They are not under strong pressure from patients, because a substantial part of patients' bills are paid by third parties. Third parties have usually reimbursed hospitals for costs incurred without pressing for greater efficiency. Hospital administrators often lack the training required for effective management. The medical staff of the hospital often presses the hospital administrator and board of trustees for acquisition of the latest medical equipment without regard to the cost implications involved. Trustees are often subject to the pressures imposed on them by the community and the medical staff.

Even where the incentive does exist, initiation and application of cost-reducing innovation is often beyond the resources of an individual institution.

Recommendation

Cost-reducing methods of reorganizing the delivery of services in hospitals and other providers of health services should be developed, demonstrated, and implemented.

1. The National Center for Health Services Research and Development should support research directed at improving the internal operation of health services facilities and disseminate the results of its research projects. Special emphasis should be placed upon the development of new methods of organization and more efficient patterns of staffing in health facilities.
2. The center, in conjunction with area planning agencies, should undertake an active program of technical assistance to health facilities and institutions to promote effective application and implementation of cost-reducing innovations.
3. Government hospitals and other Government health facilities should be used to demonstrate new methods of construction and delivery of services.
4. Loans and grants should be made available to finance cost-reducing innovations in non-Federal health institutions and facilities.

Recommendation

The Department of Health, Education, and Welfare should review the reimbursement formulas used in medicare and medicaid in an effort to find practical ways of increasing the incentives for hospitals and other health facilities to operate efficiently.

The present medicare reimbursement scheme, based on "reasonable cost," does not provide hospitals and other health facilities with adequate incentive to be efficient. The medicare and title XIX reimbursement formulas, as well as the reimbursement formulas of some private insurance plans, tend to maintain institutions that are inefficient in size, plant layout, and equipment.

Two examples of reimbursement plans that might be considered are: cost-plus-incentive-fee approaches in which the institutions' demonstrated efficiency would determine the amount of an allowable growth factor; or a fixed-price approach in which the institution prices its services in advance and then gains or loses depending on its ability to control costs. In either case, detailed standards of service would have to be specified.

INCREASING THE SUPPLY AND IMPROVING THE UTILIZATION OF HEALTH MANPOWER

This study has not examined the demand for or supply of particular types of health manpower. Detailed recommendations will be made by the President's Commission on Health Manpower.

It is clear, however, that the demand for physicians will far outrun supply unless ways are found to use physicians more efficiently. The need is particularly acute in child health. About 15 million children in low-income areas are receiving little care. With current methods of delivery, providing comprehensive care for these children would require the services of about 15,000 doctors. However, many functions now performed by physicians could be performed just as effectively by less-highly trained personnel supervised by a physician. The use of physician assistants would reduce both the number of additional doctors needed and the costs of providing care.

Recommendation

Federally supported health care programs should be used to train physician assistants, evaluate their performance, and dissemiante the results.

Large-scale use of assistants in actual care programs will be necessary. Training programs alone will not suffice, because jobs will not be available to such medical personnel until their usefulness and acceptance by patients and doctors have been demonstrated on the job.

Legal obstacles to the employment of physician assistants should be examined and model State laws developed.

Recommendation

Federal funds available under the Health Professions Educational Assistance Amendments of 1965 should be used to support and encourage innovations in health professions' education and training which promote the efficient practice of medicine.

At present, medical educators are considering a variety of innovative changes in both undergraduate and graduate medical education programs. Although improvements in the quality of medical schools and teaching hospitals are of paramount interest, the rising prices of physicians' services can be moderated through innovations in medical education designed to: (1) shorten the length of training programs without a reduction in their quality; and (2) train physicians to utilize ancillary personnel effectively and to organize their own medical practices efficiently.

IMPROVING THE KNOWLEDGE AND THE FLOW OF INFORMATION ON THE EFFECTIVENESS OF DRUGS

Although drugs are not contributing significantly to the rising price of medical care, there is evidence that they are higher than they would be if there were more vigorous price competition in the industry either at the manufacturing or at the retail level, and more knowledge on the part of doctors about the costs and effectiveness of drugs.

Recommendation

The Department of Health, Education, and Welfare should undertake an intensive examination of frequently prescribed drugs to assess the therapeutic effectiveness of brand name products and their supposed generic equivalents.

Doctors often prescribe costly brand name products when equivalent drugs could be made available to the patient at lower cost under the generic name. Requiring generic prescribing under Government programs, however, will not be possible until doubts are resolved about whether certain drugs with the same generic name are actually equivalent in therapeutic value.

Recommendation

The Food and Drug Administration should provide doctors with authoritative information on the efficacy and side effects of all new drugs.

Doctors get much of their information about the efficacy of drugs from the manufacturer. There exists no official compendium which a doctor can consult for information about the efficacy of a drug. Preparation and distribution of such a compendium might reduce advertising outlays of drug manufacturers. It would make it easier for doctors to prescribe the least expensive appropriate drug for their patients.

A CONTINUING NATIONAL EFFORT TO IMPROVE THE EFFICIENCY OF MEDICAL CARE DELIVERY

The rise in medical prices is not a temporary phenomenon. Upward pressure on medical prices is likely to continue for many years. Measures to assure that all citizens receive good care will increase that pressure. Their success will depend in part on a serious and comprehensive national effort to use medical resources efficiently. The Federal Government can contribute leadership and offer incentives, but it cannot make a major impact on the efficiency of medical care de-

livery without the cooperation of the medical profession, the hospital industry, insurance carriers, State and local governments, and many other public and private groups.

Recommendation

The Department of Health, Education, and Welfare should call a national conference on medical costs.

Leaders of the medical community and concerned public representatives should be called together to discuss implementation of the recommendations of this report and cooperative efforts to improve medical care services and control medical costs.

Recommendation

The Department of Health, Education, and Welfare, in cooperation with the Department of Labor and others, should continue to monitor and attempt to explain medical price behavior.

The studies undertaken for this report revealed many gaps in our knowledge of what has happened to medical prices and what determines their movement.

Statistics on medical prices should be improved; indexes of medical productivity should be developed; and the search for an understanding of the determinants of medical price and cost behavior should be pursued.

II. Medical Care Price Trends

The Medical Care Component of the Consumer Price Index

This section examines the rise in medical care prices through the years and in the recent past. The main source of information is the Consumer Price Index (CPI) prepared by the Bureau of Labor Statistics. The BLS obtains prices on a wide variety of items customarily purchased by urban wage earners and clerical workers, weighting these items by their importance in a typical city worker's family budget. Among the items for which prices are obtained are several types of medical and surgical procedures and hospital services, as well as a variety of drugs. These medical care components of the CPI constitute the major source of data on medical care prices in the United States.

Some limitations of these data should be borne in mind in interpreting their movements. First, there is the quality problem, common to all price indexes. A visit to a doctor, or a day in the hospital is not a homogeneous product. The quality and effectiveness of care received by a patient in a day or a visit varies tremendously. Since the quality and effectiveness of care are undoubtedly rising over time, the medical care component of the CPI overstates the actual long-run increase in medical care prices. Moreover, the average consumer of medical care is not as interested in the price of a visit or a hospital day as he is in the total cost of an episode of illness. The cost of a particular illness may be rising faster or slower than the price index for medical care, depending on the amount, quality, and price of the medical care provided.

Medical Care Prices and Total Consumer Expenditures

Consumer expenditures for medical care reflect both the quantity of care purchased and its price. Price increases reduce the amount of care that can be purchased for a given dollar expenditure.

In 1950, consumer expenditures on medical care were 4.1 percent of disposable income. By 1964, the ratio had risen to 5.7 percent. Demographic factors and changes in consumer preferences (in part, the result of the improved quality of medical care) undoubtedly contributed to this increase. But a major factor in rising expenditures for medical care has been the rise in medical care prices.

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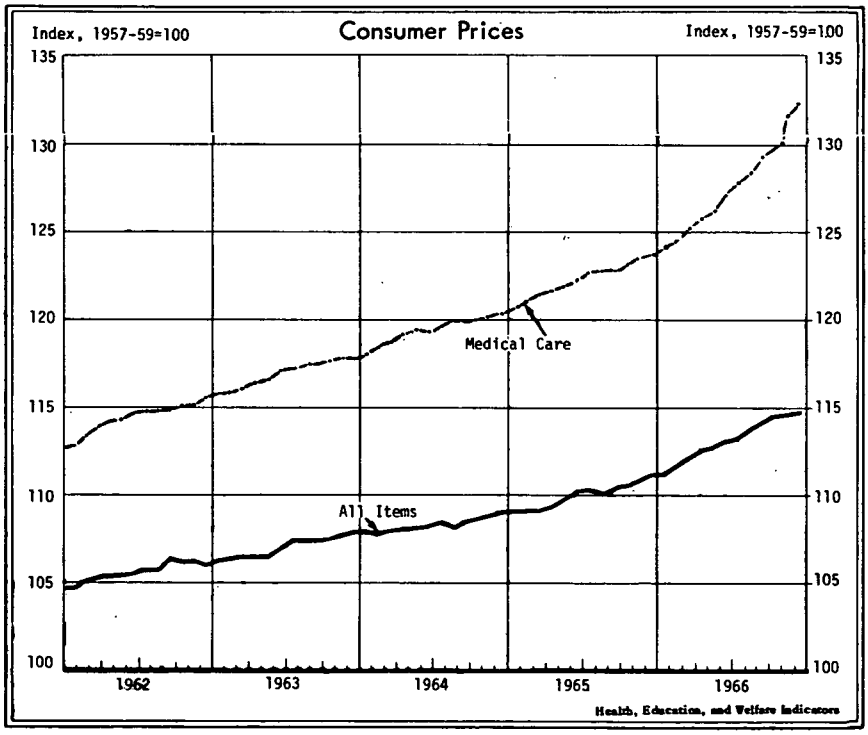
If, in the period 1950–64, the Medical Care Index had increased at the same rate as the Consumer Price Index, instead of over twice as fast, the quantity of medical care purchased in 1964 would have cost $19.7 billion rather than $24.8 billion. This would have represented about 4.5 percent of income after taxes.

The relatively rapid rise in medical care prices has resulted in an increase in the proportion of income devoted to medical care and a probable reduction (over what would otherwise have taken place) in the quantity of care consumed by the public.

Trends in the Medical Care Price Index

Both the Consumer Price Index and its medical care component have been rising continuously for 25 years. Their rates of increase, however, have differed. Since the end of World War II, medical prices have been increasing considerably faster than consumer prices generally, as the following decade figures show:



Percentage Increase in Components of the Consumer Price Index

Period	Medical care	All items
1936 to 1946	22	41
1946 to 1956	51	39
1956 to 1966	42	19

Except for drugs and prescriptions, the medical care index is made up entirely of services. Since World War II, the prices of services have generally advanced more rapidly than the prices of goods. But the prices of medical care services have risen even more rapidly than those of other services, especially in the last 10 years.

Percentage Increase in Service Components of the Consumer Price Index

Period	Medical care services	All services
1936 to 1946	26	19
1946 to 1956	57	48
1956 to 1966	50	33

Over the two decades since World War II service prices in general doubled, while medical service prices rose 129 percent.

Components of the Medical Care Price Index

Just as the total Consumer Price Index is made up of many goods and services, so the Medical Care Index is a composite of medical care items whose prices change at widely differing rates.

For example, there have been wide disparities in price movements among services provided by different kinds of physicians, especially in the recent period. In the year ending in June 1966, pediatric fees rose about 2½ times as fast as obstetric fees. Among hospital charges, the daily service charges for hospital rooms went up 7.7 percent; operating room charges, 6.5 percent; and the charges for a diagnostic X-ray (priced to represent in-hospital ancillary services), only 2.5 percent (table 1).

The Recent Acceleration in Medical Care Prices

Between 1960 and 1965, medical care prices rose fairly steadily at between 2 and 3 percent per year—a slower rate of increase than in the 15 years following World War II. In 1966, however, the Medical Care Index increased 6.6 percent—the largest annual increase in 18 years.

An acceleration in medical prices occurred in the first half of 1966 and was intensified in the second half, as quarterly figures clearly show (table 2).

The 1966 acceleration affected both major components of the Medical Care Index—hospital charges and physicians' fees (table 3). Physicians' fees, which had been rising about 3 percent per year in the period 1960–65, went up 7.8 percent in 1966. This was the biggest annual increase since 1927 (the earliest date for which the physicians'

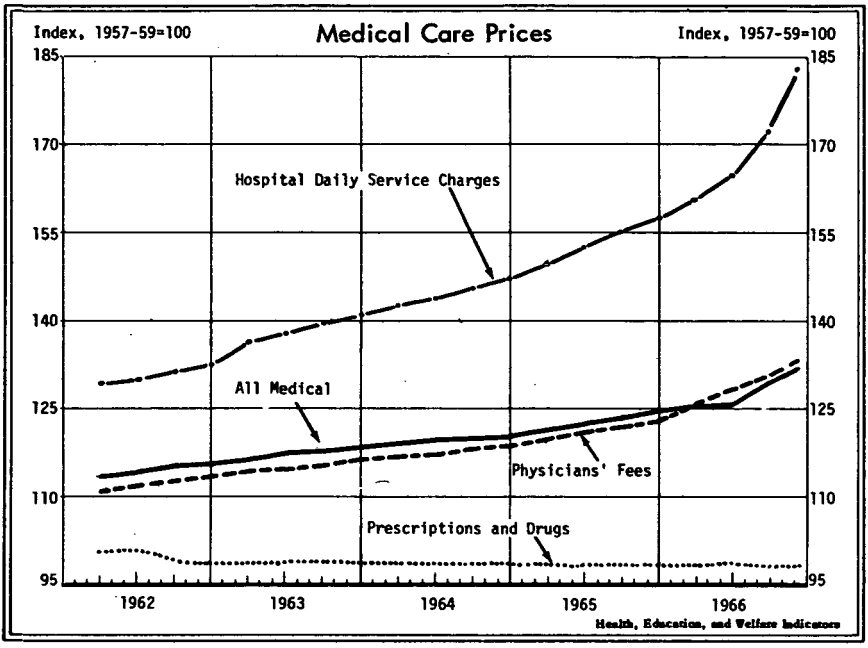


Table 1.—Medical Care Price Index: Annual Percent Changes by Type of Item

Item	Year ending June 30					
	1961	1962	1963	1964	1965	1966
All medical care	3.1	2.8	2.4	1.8	2.4	3.9
Medical care services	3.8	3.4	3.1	2.2	3.2	4.7
Physicians' fees	2.6	3.1	2.2	2.3	3.5	5.7
Family doctor—office visits	2.4	3.3	2.5	2.4	3.7	6.0
—house visits	2.8	3.6	2.1	2.8	3.8	7.4
Herniorrhaphy, adult	NA	NA	NA	NA	2.4	4.2
Tonsillectomy and adenoidectomy	1.9	2.1	2.3	2.9	3.1	4.4
Obstetrical cases	2.3	3.4	1.5	2.3	2.3	3.6
Pediatric care-office visits	NA	NA	NA	NA	5.5	8.5
Psychiatrist-office visits	NA	NA	NA	NA	2.1	4.3
Hospital services:						
Daily service charges	8.2	6.4	6.6	4.9	5.5	7.7
Operating room charges	NA	NA	NA	NA	3.8	6.5
X-ray, diagnostic, upper gastro-intestinal	NA	NA	NA	NA	1.3	2.5
Dentists' fees	.2	3.0	2.7	2.3	3.4	3.0
Examination, prescription, and dispensing of eyeglasses	3.5	1.7	.5	1.1	2.0	2.6
Routine lab tests	NA	NA	NA	NA	1.9	2.1
Drugs and prescriptions	−1.1	−1.5	−1.3	−.1	−.5	.5
Prescriptions	−3.5	−3.9	−2.8	−1.3	−1.2	−.3
Over-the-counter items	NA	NA	NA	NA	.6	1.5

Source: U.S. Department of Labor, Bureau of Labor Statistics, *The Consumer Price Index.*

fees index is available). Hospital daily charges, which had been rising about 6 percent per year between 1960 and 1965, went up 16.5 percent in 1966—the largest annual increase in 18 years.

The rise in hospital daily charges was especially sharp in the second half of 1966—11.5 percent as compared with 4.5 percent for the first 6 months. In contrast, physicians' fees increased 3.8 percent in each half of 1966.

Medical care prices have been rising faster than other prices throughout the postwar period. The rapid increase in medical care prices in 1966 is at least partly a reflection of the widespread inflationary pressures in the economy. The rate of increase in the Consumer Price Index for 1966 was 3.3 percent—the largest in 15 years.

Table 2.—Consumer Price Index: Quarterly Percent Increases

Quarter	Medical care index		Consumer Price Index
	All components	Services	
1964			
June-September	0.3	0.5	0.4
October-December	.5	.6	.4
1965			
January-March	.9	1.1	.2
April-June	.7	.9	1.0
July-September	.5	.6	.1
October-December	.7	.9	.7
1966			
January-March	1.3	1.5	.9
April-June	1.4	1.7	.8
July-September	1.9	2.4	1.1
October-December	1.9	2.2	.5

Table 3.—Consumer Price Index: Percent Increases by Type of Component

	Percent increase		
	Average annual 1960-65	Dec. 1964-Dec. 1965	Dec. 1965-Dec. 1966
Consumer Price Index	1.3	2.0	3.3
All medical care	2.5	2.8	6.6
Hospital charges	6.3	6.6	16.5
Physicians' fees	2.8	3.8	7.8
Drugs and prescriptions	−.8	0	.2

III. Physicians' Fees

About 27 percent of the consumer's health dollar, on the average, is spent for physicians' services. Physicians' fees have been rising for many years, but the increase has recently accelerated. According to the Bureau of Labor Statistics Index, physicians' fees rose 7.8 percent in 1966, as compared with 3.8 percent for 1965.

This section will attempt to answer three questions: (1) What explains the rise in physicians' fees in the last 15 years? (2) What accounts for the recent accelerations? (3) What is likely to happen in the future?

Supply, Demand, and Doctors' Fees

A doctor is not an ordinary businessman and one might question whether the price of his "product" is governed by the laws of supply and demand. Medical services are extremely personal in nature and their quality varies from physician to physician, from place to place, and from year to year. Any price index necessarily reflects price movements for only one of many possible sets of "physician visits" or surgical procedures.

Moreover, there are strong traditions in medicine which affect physicians' price policy. Denying a patient necessary care because he cannot pay the bill is considered unethical. Many physicians use a sliding scale of fees—charging patients according to their ability to pay. If an epidemic or disaster causes a temporary increase in the demand for their services, physicians do not ration their time by raising their fees—they simply work longer hours and postpone nonessential services.

Nevertheless, it is clear that a substantial and sustained increase in demand without a corresponding increasing in supply sooner or later exerts pressure on physicians which leads them to raise their prices. Moreover, doctors are likely to be able to raise fees by fairly large amounts without losing many patients. The amount of medical care which patients seek is relatively insensitive to changes in price for several reasons: (1) A patient with an emergency medical problem has no choice about whether to get treatment; (2) even in nonemergency situations the patient often regards medical care as essential, not optional; (3) the patient seeking medical care usually lacks information about the price of physicians' services or assumes that

more expensive care is better care; (4) the patient is often referred from one physician to another without being given a choice.

The Rapid Growth of Demand

In the period 1950 to 1965, population grew by 28 percent. Had there been no changes in medical technology, in education, in the incomes of patients, in the age distribution of the population, in urbanization or in residential patterns, the sheer impact of population growth would have added a substantial demand for physician care. But other things did not remain the same. In the period 1950 to 1965, disposable personal income per capita (in 1958 prices) increased by almost 34 percent. Based on the spending habits of Americans, an estimated 10-percent increase in consumer income results in at least a 3.3-percent increase in the demand for physicians' services. Therefore, this income increase would have added a minimum of 11.2 percent to the per capita demand for physicians' services.

The increase in the number of persons in the United States and the increase in income per person would, in the period 1950 to 1965, have added about 41 percent to the demand for physicians' services. Moreover, at least three additional factors increased even further the demand for physicians' services in this period:

1. *The public's faith in doctors and desire for physicians' care has increased as medical practice has become more effective.*—It has been said that at the turn of the century a random patient with a random illness meeting a random physician stood perhaps a 50–50 chance of benefiting from the encounter. Today, the chance is much greater. Medical science has advanced. Medical education has improved. As the public's faith in the power of the physician and of the equipment and drugs that he uses has increased more people have turned to physicians for care. The public's desire for medical care has grown.
2. *Changes in the characteristics of the population—as well as in its size—have tended to increase the demand for physicians' services.*—Women go to doctors more than men; urban people more than rural people; educated people more than uneducated people; young children and old people more than the rest of the population. In general, although the effect is not major relative to the effect of the increase in income and the overall size of the population, groups who use more physicians' services are increasing relative to other groups.
3. *Insurance coverage has expanded greatly.*—The total number of persons covered by surgical expense insurance increased from 54 million in 1950 to 140 million in 1964; those covered by regular medical expense plans with benefits for nonsurgical physicians' fees increased from 22 to 109 million. Once a

patient has insurance, he tends to use more medical services. In emergency situations, of course, the patient has little choice about the amount of care he receives. But most situations are not emergencies; many medical procedures are optional or postponable. There is evidence that insured persons use more medical services than noninsured persons. One study, for example, showed that persons with health insurance were hospitalized for surgery 25 percent more often than persons without insurance. The growth of insurance covering physicians' fees seems likely to have added appreciably to the demand for physicians' services.

The Slower Growth of the Supply of Physicians

During the period 1950–65, the total number of active physicians increased by 33 percent. During this same period, however, there was a marked downward shift—from 72 percent in 1950 to 62 percent in 1965—in the proportion of all active physicians who were engaged in private practice. Increases occurred in the proportion of physicians employed as full-time staff in hospitals, full-time medical school faculty, and physicians whose primary activity is administration, laboratory medicine, public health, or research. The proportion of physicians in postgraduate training also increased.

Between 1950 and 1965, the number of physicians in private practice increased only 14.3 percent, and there was an actual decline in the total number of family physicians (pediatricians, internists, and general practioners) as more physicians went into other specialties.

The effective supply of physicians' services, however, rose faster than their numbers because physicians' productivity also rose.

Estimates of Physician Productivity

Some rough indicators of physicians' productivity can be found. Between 1947 and 1964, the median gross income of physicians in private practice rose at an annual rate of over 6.7 percent compared with an average annual increase in physicians' fees of 3.0 percent, as reported by the Bureau of Labor Statistics.[1] Since the median gross income of physicians rose faster than the average fee per visit or procedure, physicians must either have been putting in more hours or their "productivity" (number of patients seen and quantity of care given) must have increased, or both.

Since there is no evidence that the average physician worked longer hours over this period, the difference between the rate of increase in

[1] Source: "Medical Economics." Median gross income is income before subtraction of professional expenses. Adjustments were made for increases in collection rates over time.

physicians' fees and their median gross incomes may be attributed to the increase in the output of physicians' services per physician hour. The rise in physician productivity can thus be estimated at about 3.4 percent per annum between 1947 and 1964. There are indications that most of the increase in physicians' "productivity" took the form of seeing more patients in the same amount of time. One study shows a 24-percent increase (between 1959 and 1964) in patients seen per week by the average physician.

The doctor who sees more patients per hour may be giving a lower level of care. Ideally, one would like a productivity measure which reflected the quality of care given, such as the number of patients cured or health improvements effected.

No quality measure exists, but there are at least four reasons to believe that physicians are using their time more efficiently without lowering the quality of care:

1. *The advance of medical science.*—Powerful new drugs and advanced surgical procedures have clearly made it possible for the present-day physician to treat more patients—and effect more cures—in the same amount of time than could yesterday's physician.
2. *The shift from house to office and clinic visits.*—A recent survey showed that the average general practitioner spends 10 minutes per patient in his office and 30 minutes, on a house call. He has shifted away from house calls, which accounted for 9 percent of all out-of-hospital visits in 1959 and only 5 percent in 1964. In the interim, the number of physician visits in offices expanded by 9 percent, physician visits in hospitals and clinics, by 40 percent. There has also been considerable expansion in the proportion of telephone consultations.
3. *Increases in capital equipment and auxiliary personnel.*—Staff assistants and the elaborate equipment of a modern hospital greatly increase the productivity of the hospital-based physician. And modern medical practice is increasingly hospital oriented. Moreover, doctors' offices are far better equipped than they used to be. There is evidence that the number of employees per physician is increasing and that physicians with more assistants are more productive.
4. *New forms of organization.*—Physicians have grouped themselves in partnerships of one form or another. The Internal Revenue Service reports that between 1958 and 1964, the number of partnerships, groups, and prepaid groups increased by 61 percent (at an annual rate of about 8 percent).

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By 1964, the IRS reported that there were 44,500 physicians in 15,300 partnerships or groups. Grouping of physicians makes possible more efficient use of personnel and equipment.

Explanation of Rising Physicians' Fees

The demand for physicians' services increased by at least 41 percent—and probably considerably more. The total supply of active physicians increased only about 33 percent, while the supply of physicians in private practice increased considerably less.

In response to this considerable pressure of demand on supply, physicians increased their productivity and raised their fees. If the increase in physician productivity had not occurred, the rise in fees would have been even more rapid.

Changes in the Level of Physicans' Fees During 1966

In the past, physicians' fees have tended to increase faster when the increase in other prices in the economy was accelerating—as it was in 1966. From 1959 to 1965, the average annual rate of increase in the price of physicians' services was twice the average annual rate of increase in the price of all items in the Consumer Price Index. If this average relationship had been maintained during 1966, the 3.3-percent increase in the price of all items in the Consumer Price Index would have been matched by a 6.6-percent increase in the price of physicians' services. In fact, the price of physicians' services increased 7.8 percent during the 12-month period ending December 1966. Thus, less than one-sixth of the recent increase in physicians' fees is "unexpected" on the basis of past trends in the Consumer Price Index.

It is difficult to say with confidence how much impact medicare had on physicians' fee increases in 1966. There was no marked acceleration in physicians' fees after medicare came into effect on July 1; increases in the third quarter were in line with those in the first half of the year.

If anticipation of medicare were a major cause of fee increases, one would expect to find fees charged the elderly moving up faster than fees charged to younger patients in the period just before medicare went into effect. A special tabulation showed, however, that the price indexes for child and adult care moved up more rapidly, during the 6-month period ending June 1966, than five special indexes of surgical and medical procedures particularly applicable to aged persons. Furthermore, for those physicians who increased their fees during the first half of 1966, the average percentage increase was somewhat lower than for those who increased their fees in 1965. The major impetus for movement in the Consumer Price Index for physicians' fees came from the fact that more physicians were adjusting their fees than in earlier periods, not from larger percentage adjustments. During the

first half of 1966, physicians who raised their fees for office visits (19 percent of all physicians) raised them by an average of 24 percent. The majority of physicians did not raise their fees for the services measured.

Thus, the available evidence leads to the conclusion that medicare has not had a significant effect upon the recent acceleration of the rate of increase in physicians' fees.

It should be strongly emphasized that the above conclusion relates to physicians' customary charges—fees the physician charges to most of his patients for given services. Starting July 1, 1966, the average fees of physicians, and their incomes, have increased because of the payment of customary charges under medicare for the aged, many of whom were previously paying charges lower than the customary charges of physicians. Therefore, many aged persons will now find that they are being charged more for a given service, since their physician is now charging them the same fee he charges to the majority of his patients.

Also, certain groups of physicians have raised their customary charges significantly in recent months. In particular, the impressions of a number of hospital administrators and medicare carriers lead to the conclusion that some hospital-based pathologists and radiologists have raised their customary charges by substantial amounts. The medicare law requires separation of professional charges from hospital costs and payment from separate sources. The law has led some hospital-based physicians to bill their patients directly rather than through the hospital billing system. Some pathologists and radiologists have taken advantage of this provision in the medicare law to establish new higher levels for their customary charges.

Outlook for the Future

In the years ahead, the demand for physicians' services will increase. Between 1965 and 1975, population can be expected to grow by about 17 percent. Rising income can be expected to add another 12 percent to demand. Demographic changes will also add somewhat to the growth in demand. Medicare will increase the utilization of physicians' services by the elderly—the impact of this program on total demand might be on the order of 2 percent. An analysis of the impact of title XIX of the Social Security Act Amendments of 1965 must wait until more of the States have implemented this new legislation.

Total demand seems likely to increase by about one-third, exclusive of increased utilization which may result from changes in the desire for physicians' service, the impact of title XIX, and the growth in private insurance coverage. The U.S. Public Health Service estimates that in the 1965–75 decade, there will be an increase of only 17 percent in

the total number of physicians. If the current trends continue, the rate of increase in the supply of "family physicians" (general practitioners, internists, and pediatricians) will certainly be less than the rate of increase in the total supply of physicians. In the absence of major productivity increases, a substantial gap will exist between the amount of medical care Americans will try to purchase and the supply physicians will be able to offer.

The pressure of demand on a slowly expanding supply is likely to result in price increases. These pressures will be especially large in the area of child care where there has been decline in the number of physicians (pediatricians and general practitioners) available per 100,000 children.

Since the time lag in producing physicians is considerable, a major increase in the supply of physicians beyond the projected levels could not be achieved by 1975. It is not clear, moreover, that any feasible expansion of physician supply would have a significant impact upon the price level for physicians' services or assure that those receiving insufficient care would get better care.

For the near future, primary emphasis should be given to mechanisms to increase the efficiency of existing physicians. Such changes would be less costly, could be implemented more rapidly, and would have significant impact because they involve all existing practicing physicians. A 4 percent increase in physician productivity in 1966 would add the equivalent of 11,700 physicians to the supply—more than the annual output of all American medical schools.

Although special efforts will be required to raise productivity in order to fill the predicted gap between supply and demand, there is some evidence that there exists a significant potential for further increases in the productivity of physicians. For example, while 23 percent of all physicians in private practice in 1964 employed four or more auxiliary workers, almost half of them employed less than two auxiliary personnel.

Increases in efficiency might be achieved through new types of organizational structures, the growth of group practice plans, and through the use of new types of personnel that would relieve the physician of duties that individuals with less training could perform.

IV. Hospital Costs and Charges

Hospital services are the most expensive form of medical care. A patient in a modern, general, short-term hospital gets a tremendous variety of services—room and board, laundry, pharmaceuticals, laboratory tests, access to highly specialized facilities and equipment, and the services of house physicians, nurses, technicians, and an army of other personnel. These services do not come cheaply; average expense per patient per hospital day in 1965 was $44.48.

In recent years, an increasing share of the consumer's health dollar has been spent for hospital care. Hospital care accounted for 24 percent of private medical expenditures in 1950 and 30 percent in 1965. The proportion of personal income after taxes which was spent on hospital care almost doubled between 1950 and 1965 (going from 0.95 to 1.80 percent), while the proportion spent on physicians' services increased 32 percent (from 1.26 to 1.66 percent of personal income after taxes).

The rise in the proportion of consumer health budgets being devoted to hospital care reflects both increased use of hospital services by the population and the rising price of these services. The per capita demand for hospital services has been rising faster than the demand for other medical services (except drugs). The supply of hospital beds and other facilities has also increased but, at the same time, the cost per patient of delivery of services has gone up. Increasing demand and rising costs have led to sharply rising prices.

The consumer would benefit if ways could be found to make hospitals operate more efficiently without reducing the quality of care. He would also benefit if less expensive types of medical care could be substituted for hospital services without reducing the effectiveness of the care, or at least if the present trend toward increasing use of hospitals in preference to other medical services could be halted.

The Hospital Sector of the Economy

This report is concerned with short-term, non-Federal hospitals; the kind of hospitals that most private citizens use. It excludes long-term care facilities, such as psychiatric and tuberculosis hospitals, as well as military, veterans, and other Federal hospitals. The 5,700 non-Federal, short-term hospitals vary greatly in size; many are small, but average size is increasing.

Percent Distribution of Hospitals by Size and Number of Beds

Number of beds	Hospitals		Beds	
	1953	1965	1953	1965
Under 50	44	33	12	8
50–199	42	45	43	35
200–499	13	20	38	45
500+	1	2	8	12

Some are run by State or local governments, some by churches and other private nonprofit groups; relatively few are proprietary.

Percent Distribution of Hospital Beds by Control, 1965

All	100
State and local	24
Private, nonprofit	70
Proprietary	6

Hospitals are complicated institutions with objectives going beyond the treatment of medical conditions. They sponsor research, provide training, and sometimes serve as bases for religious works. Their control, moreover, is divided among administrators, trustees, physicians, and technical personnel. The relationship with the community is no less complex, for hospitals must be responsive to validating agencies, including insurance companies; other professional organizations; local, State, and Federal governments; and philanthropic supporters.

Hospital Costs

Wages and salaries are major factors in hospital costs. Payroll accounts for 62 percent of total hospital expenses. This percentage rose steadily in the immediate postwar period (from 53 percent in 1946 to 62 percent in 1956) but has stayed remarkably constant for the last decade.

Hospital wages and salaries per patient day have been rising steadily since World War II. Between 1960 and 1965, wages and salaries per patient day rose 6.4 percent per year—almost exactly the same as the rate of increase in hospital charges.

This rise in wage cost per patient day has two elements:

1. *The number of patients cared for per employee has been falling.*—Many industries in recent years have been increasing output by substituting automated equipment for manpower. Some examples of such substitution can be found in hospitals but, in general, more elaborate equipment and increased standards of care have meant an increased demand for skilled manpower. At the same time, hospitals have been hiring an in-

creased number of unskilled and semi-skilled workers to fill in for skilled personnel in short supply. As a result, the productivity of hospital manpower by any *conventional* index (patients cared for per employee, employees per patient day, etc.) has been falling, not rising.[2]

2. *Average earnings of hospital employees have been rising.*— Average hospital payroll per employee went up 4.7 percent per year between 1960 and 1965. Average wages of all employees in the service industries went up 3.6 percent per year in the same period. The rise in hospital wages resulted both from increasing skill requirements in hospitals (more technicians and professionals) and from increased wage levels for traditionally low-paid hospital jobs. Despite rising average wage levels, a large proportion of hospital employees still earn only very low wages. In mid-1963, the Department of Labor estimated that 29 percent of all hospital employees earned less than $1.25 an hour.

Nonprofessional service occupation	Percent earning less than $1.25 per hour
Nursing aides	43
Maids and porters	48
Flatwork finishers (machine ironers)	54
Kitchen helpers	55
Machine dishwashers	58

In 1963, there were ironers earning less than 45¢ an hour in Memphis; maids and kitchen helpers earning less than 50¢ an hour in Atlanta; kitchen helpers, less than 70¢ an hour in Dallas; ironers, less than 75¢ an hour in Baltimore.

The new minimum wage law, which covers hospital employees for the first time, provides that hospital employees must be paid a minimum of $1.00 per hour starting in 1967, $1.15 per hour starting in 1968, and $1.30 per hour starting in 1969. The new minima are being phased in so slowly that they are unlikely to raise the wage bill much above what it would have been anyway. If hospital staff per patient continues to increase at recent rates, the total wage bill per patient day seems likely to increase from $27 in 1965 to about $38 by 1970, or 7 percent per year.[3]

[2] See page 30 for qualifying remarks with regard to the measuring of hospital productivity.

[3] Assumes 4 percent per year average wage increase for workers above minimum wage.

Non-Wage Costs

About 37 percent of hospital costs are non-wage costs—expenditures for food, drugs, and other commodities—which vary with the number of patients in the hospital and the price level of the commodities in question.

A large share of non-wage costs, however, are fixed charges or readiness-to-serve costs, which do not vary with the number of patients in the hospital: maintenance, heat, light, and power as well as depreciation charges which represent the annual consumption of capital by wear and tear and obsolescence. Generally, about 5 percent of hospital costs are for depreciation and at least 20 percent are for other non-wage readiness-to-serve costs. Such costs, predetermined by the magnitude of capital investment rather than the volume of services provided, reflect the size and elaborateness of the hospital's plant and equipment.

Over the years, hospitals have become better equipped with specialized facilities. The following table shows increases between 1960 and 1965 in the proportion of voluntary short-term hospitals which had certain specialized types of facilities.

Percent of Voluntary Short-Term Hospitals with Selected Facilities

Facilities	Percent	
	1960	1965
Pathology laboratory (with pathologist)	60. 5	67. 1
Premature nursery	61. 0	63. 7
Intensive care unit	11. 1	32. 5
Electroencephalography	17. 7	31. 7
Rehabilitation unit	(1)	8. 4
Dental facilities	30. 6	36. 4

[1] Not listed.

Source: American Hospital Association, "Guide Issue" of *Hospitals*, August 1961, 1966.

In addition to specialized care facilities, hospitals have been placing increasing emphasis on such nonmedical comforts as private rooms, air-conditioning, and individual baths or toilets. Some of these features bring operating economies which at least partially offset their operating costs. Air-conditioning, for example, increases employee productivity and reduces airborne dirt, as well as making patients feel better. Single rooms facilitate higher occupancy; other items save some nursing time. Many of these amenities, however, add to operating costs as well as to patient comfort.

New hospital construction has become steadily more expensive. In the 5-year period, 1960–65, building and fixed equipment costs per square foot in new hospital construction went up about 4.1 percent per year. In the same period, prices for nonresidential construction in general rose about 1.9 percent per year. The faster rise in hospital construction costs reflects increasingly expensive equipment and design.

The increased plant and facilities of hospitals show up in hospital asset figures. The American Hospital Association estimates that plant assets of short-term hospitals (land, buildings, equipment, and supply inventories) increased from $12,976 to $16,615 per bed between 1960 and 1965.[4] Other assets (cash, receipts, endowments, and similar items) showed little increase over what would have been expected due to dollar value changes.

Reasons for the Accelerations in Hospital Charges

The 1966 acceleration in hospital prices is hardly surprising. Rising wages in tightening labor markets were bound to exert upward pressure on hospital costs. Several nurses' strikes occurred. Preliminary evidence indicates that nurses' salaries increased somewhat faster in 1966 than in previous years.

In the years 1960 to 1965, consumer prices increased at an average annual rate of 1.3 percent while hospital prices increased at 5.8 percent. If this average relationship had been maintained, the 3.3-percent increase in consumer prices would have implied a 14.7-percent increase in hospital charges in 1966, but hospital charges actually increased 16.5 percent, which meant that 11 percent of the rise in hospital prices was "unexpected."

The fact that hospital charges rose especially rapidly in the second half of 1966 suggests that medicare, which came into effect July 1, contributed to the increase. Medicare raised hospital occupancy rates in many places. The total occupancy rate was 4 percent higher in August 1966 than in August 1965. In general, however, higher occupancy rates would be expected to lower, not raise, hospital costs per patient day. The influence of medicare probably came mainly through the impetus it provided to hospitals to reexamine their costs and charges. In reviewing charges, many hospitals decided to increase them, perhaps sooner than they otherwise would have.

The Productivity Problem

A major obstacle to the analysis of changes in the amount of care received per dollar of expenditure is that there are no generally accepted measures of output, input, and productivity of the hospital sec-

[4] Assets in plant and equipment divided by number of non-Federal short-term beds.

tor. Productivity, the ratio of output to input, may be calculated only if the changes in output and input are measurable.

Length of stay is one possible measure of hospital productivity. Hospitals could be considered more productive if the length of stay, in the face of an unchanged level of illness in the population was shortened.

In the last decade, the average length of stay has remained remarkable stable at 7.6–7.7 days. But there has been a change in the distribution of lengths of stay within the short-term general hospital. The National Center for Health Statistics lists 33 conditions for hospitalization. Within this list, in the period 1958–60 to 1963–64, 23 conditions required shorter stays, while 10 conditions showed increased lengths of stay. Thus, even though within the same period that the cost per patient day increased from $31.30 to $41.19, it may be that the decrease in the length of stay for certain conditions, such as ulcer of the stomach and duodenum, and diseases of the eye and visual impairments, was such that the cost of individual stays for these conditions decreased or rose only slightly.

More systematic studies of hospital records and expenditures will be necessary before conclusions can be drawn about changes in hospital productivity as measured by length of stay.

Ultimately, of course, hospital effectiveness should be reflected in the health of the population. With the present state of knowledge, however, it is impossible to separate the impact of hospital care from the many other factors which cause changes in mortality or morbidity rates.

The Increasing Demand for Hospital Services

Americans have been using hospitals to an increasing extent in recent years. Between 1956 and 1965, admissions to non-Federal, short-term general hospitals rose from 120 to 138 per thousand population. The number of days spent by patients in these hospitals is now slightly more than one per person per year.

The same factors that have increased the demand for all medical care have operated to increase hospital utilization: demographic changes; rising incomes; wider insurance coverage. Four out of five persons now have hospital insurance of some sort and benefit levels have been rising.

Even within insured groups, however, hospital utilization has apparently been rising. A study of one insured population showed an average annual increase of 3 percent in patient days per thousand people over the period 1947–59. Within income groups, hospital utilization rates have apparently also been rising.

Use of hospitals has been increasing faster than visits to physicians. At least two factors are operating to increase hospital use in preference to less expensive forms of care:

1. More patients have hospitalization insurance than have coverage for other types of medical care.

   A doctor may put his patient in the hospital rather than treat him at home or in the office since the patient's insurance company will pay the bill. Elderly or convalescent patients may be put in hospitals rather than nursing homes in order to take advantage of insurance coverage.
2. Hospitals may be overutilized to suit the convenience of physicians. A busy doctor may put a patient in the hospital to conserve his own time.

It has been suggested that increased hospital utilization is at least partly a result, rather than a cause, of increases in the number of available beds. Studies show that doctors tend to keep patients in the hospital longer if beds are available and that the principal determinant of the level of hospital use in a community is the availability of beds, not the price of care or the characteristics of the population.

Also, the demand for hospital services is variable. Few people want to be in the hospital in the summer or over the Christmas holidays—if they have a choice. Epidemics and seasonal variations in illness patterns and birth rates bring wide variations in the demand for hospital beds.

In the short run, hospitals can meet an increase in demand by shortening lengths of stay and increasing occupancy rates. Up to a point, higher occupancy rates mean lower costs per patient. At present, most hospitals are underutilized on weekends and in the summer. Fewer patients are admitted on Fridays and Saturdays than other days and those who are admitted stay longer, presumably because they wait over the weekend for treatment.

Several experiments have shown that substantial reductions in cost per patient can be achieved through improved planning of hospital usage. Cooper Hospital in Camden, N.J., by using its facilities more intensively on weekends, raised the average occupancy rate of a 393-bed medical-surgical section from 340 to 380—the equivalent of adding about 50 beds. Operating costs per patient day were reduced, and capital construction was avoided.

A substantial and sustained increase in demand can be met by adding more beds in new or existing hospitals. The present trend is toward larger hospitals, and there is reason to believe that larger hospitals can provide the same services at lower cost per patient than can small hospitals. The economies of larger scale are often obscured by the fact that larger hospitals provide more services and facilities than do small hospitals.

Regional planning councils have been effective in some parts of the country in assuring the construction of hospitals of efficient size. An effective council will have an impact on three areas: nonwage cost, the level of utilization of hospitals, and the productivity of hospitals. Conceptually, hospital planning councils attempt to influence these three areas by rearranging the level of capacity of the hospital sector. This may involve combining services of hospitals, merging two or more hospitals, refusing support of the construction of unneeded capital facilities, arranging cooperative laundries, and other multihospital facilities, and encouraging, where appropriate, the use of less expensive medical facilities such as nursing homes and extended care facilities.

It is likely that group practice is more efficient than solo practice and that prepaid group practice is preferable to fee-for-service medicine from the point of view of the efficiency of the entire system of medical care delivery. There is evidence that subscribers to prepaid group health plans have considerably lower hospital utilization rates than comparable nonsubscribers. Perhaps they receive more comprehensive medical care. Or perhaps the prepayment of the patient's expenses (nonhospital as well as hospital) may reduce the incentive to overutilize expensive hospital care relative to other services.

V. Drug Prices

Drug prices have not been major contributors to rising medical prices. The drug component of the Consumer Price Index increased 13.3 percent over the period 1950 to 1965, or somewhat less than 1 percent per year on the average. There was no appreciable change in the drug component of the CPI during the 6-year period ending December 1966. The prices of prescription drug items in the CPI (as contrasted with over-the-counter drug items) actually declined by 11.7 percent between 1960 and 1966.

Industry sources give a slightly different picture. The average retail price per prescription, reported in The American Druggist, increased at an annual rate of about 2.3 percent between 1955 and 1965, and at slightly less than 1 percent per year between 1960 and 1965.

The "average prescription price" reflects the use of new drug products, and changes in the quantities and prices of drugs prescribed. In contrast, the CPI reflects changes in the unit price of the same or similar drug items over periods of time. It is difficult to adjust the drug component of the CPI for the rapid changes in the character of the drugs prescribed. By the time a prescription item is incorporated into the index, its price may have fallen to a lower level than in previous years. In the interim, newer drugs are being prescribed at a higher price level, and the drugs included in the CPI may not reflect such price movements. Most of the difference between the increase in the "average prescription price" and the change in the drug component of the CPI can be attributed to the use of new and improved drug products and changes in the quantities prescribed.

Consumer Expenditures on Drugs

Drug expenditures account for a substantial proportion of total consumer expenditures for medical care. However, the rapid increase in hospital charges and physicians' fees has led to a decline in the proportion of the consumer's medical care dollar spent on drugs. Drug expenditures accounted for about 20 percent of consumer medical care expenditures in 1950 and 16.4 percent in 1964.

Despite the fact that drug prices have not risen as rapidly as the CPI, the percentage of disposable income spent on drugs increased

from 0.8 percent in 1950 to 1 percent in 1964. Therefore, there was a significant increase in the use of drugs by the average consumer.

In recent years, there has been a marked increase in the use of prescription drugs as opposed to over-the-counter drug items. In 1959, the average American family purchased 11 drug prescriptions and spent $33 on prescription drugs. By 1965, the number of prescriptions per family had risen to 14, and average family expenditures on prescription drugs were $46.

There are at least five reasons why there has been a sharp increase in consumer expenditures for drugs during the postwar period:

1. Drugs, which have declined in price relative to the prices of other forms of medical care, have been substituted for more expensive forms of medical care.
2. Families spend more on drugs as their income increases. In the year ending June 30, 1965, for example, the per capita expenditure for prescribed drugs in families with incomes over $10,000 was 22 percent greater than the comparable outlay for individuals where the family income fell between $4,000 and $7,000.
3. The efficacy of drugs has improved significantly in recent years. Modern advances in drug therapy have contributed to the control of such diseases as tuberculosis and syphilis.
4. There has been an increase in consumers' desires for certain kinds of drugs. For instance, from 1952 to 1963, the retail sales of sedatives and tranquilizers increased 535 percent.
5. The increase in the proportion of elderly persons in the population has resulted in an increase in the demand for drugs. Average expenditures on all drug items by persons age 65 and over are 2½ times as high as those for the entire population.

Reasons for Concern About the Cost of Drugs

The cost of drugs imposes a major financial burden upon many American families. A large proportion of total drug expenditures are incurred by persons who are high users of medical care. For example, in 1962, 10 percent of those persons over the age of 65 incurred 40 percent of the expenditures on drugs by all persons over the age of 65. But out-of-hospital drug costs are generally not covered by health insurance. In 1965, about 3 million persons were enrolled in plans providing drug insurance coverage. However, 80 percent of these individuals had only partial coverage. Another 53 million persons were enrolled in plans which generally provided partial drug coverage after their drug expenditures exceeded a sizable deductible provision.

Although average drug prices are not rising appreciably, there is ample evidence that they are higher than they would be if there were

greater price competition in the industry, either at the manufacturing or at the retail level. The pharmaceutical industry is characterized by high concentration, high advertising costs, and intense nonprice competition.

Drug manufacturers attempt to differentiate their brand names from the generic name of the drug through intensive advertising campaigns. For the 22 major pharmaceutical companies, the Kefauver Committee found that the selling expenditures of drug manufacturers accounted for 25 percent of the total sales dollar. The drug industry spends about $3,000 per doctor per year in advertising to the medical profession. Since the rapid advances in drug therapy during recent years have made it impossible for any physician in private practice to read and evaluate all of the information on new drugs, doctors obtain a great deal of their information about the efficacy of drugs from the manufacturer. The "detail men" of pharmaceutical companies provide a major source of new information to physicians on the advantages or disadvantages of their drug products.

A physician frequently prescribes a costly brand-name product when an equivalent lower-cost drug could be made available to his patient under the generic name. The doctor may be unaware of the existence of the less expensive drug, or he may be more familiar with the effects and dosage of the brand-name product. He may also be uncertain about whether two drugs with the same generic name are actually equivalent in therapeutic value. Although there are a number of different sources and formularies which describe the merits of many drugs, there exists no official or authoritative compendium which a doctor can consult for information about the efficacy of a drug. Moreover, even if the doctor prescribes a drug by its generic name, the pharmacist has no incentive to give the consumer the least-cost generic drug.

Brand-name prescribing raises the cost of drugs not only to patients but also to the taxpayer when drug costs are covered by public programs. There is considerable sentiment in Congress to require or encourage generic purchasing or prescribing of drugs under all Federally financed programs. Before such legislation becomes feasible, however, doubts about the therapeutic equivalence of drugs with the same generic name must be erased. A major study should be undertaken of the most frequently prescribed drugs to determine the efficacy of brand-name products and their supposed generic equivalents.

APPENDIX

Medical Care Price Components of the CPI, Annual Averages, 1946-66

[1957-59=100]

	1966	1965	1964	1963	1962	1961	1960	1959	1958	1957	1956	1955	1954	1953	1952	1951	1950	1949	1948	1947	1946
All medical care, total	127.7	122.3	119.4	117.0	114.2	111.3	108.1	104.4	100.1	95.5	91.8	88.6	86.6	83.9	81.1	76.9	73.4	72.0	69.8	65.7	60.7
Medical care services	133.9	127.1	123.2	120.3	116.8	113.1	109.1	104.8	100.0	95.3	91.4	88.0	85.5	83.0	80.1	75.3	71.7	70.1	67.6	63.3	58.4
Physicians' fees	128.5	121.5	117.3	114.4	111.9	108.7	106.0	103.4	100.0	96.7	92.7	90.0	87.0	84.5	82.3	78.8	76.0	74.8	73.5	70.7	66.4
Family doctor—																					
Office visits	128.7	121.2	116.8	113.9	111.1	107.9	105.4	103.4	100.1	96.5	93.3	90.8	88.4	85.0	82.2	78.9	76.2	75.2	74.0	71.1	66.7
House visits	133.4	124.9	119.9	116.3	113.7	110.1	106.9	103.8	99.9	96.2	90.6	87.3	83.8	82.1	80.3	77.9	75.4	74.0	72.4	70.6	66.4
Obstetrical care	123.0	117.8	115.2	112.5	110.7	107.3	105.0	102.8	99.9	97.3	93.8	90.8	85.2	81.4	79.7	72.0	67.7	66.9	66.0	61.8	57.5
Pediatric care office visits [1]	114.3	106.1	101.5																		
Hospital services:																					
Daily service charges	168.0	153.3	144.9	138.0	129.8	121.3	112.7	105.5	99.9	94.5	87.5	83.0	79.2	74.8	70.4	64.1	57.8	55.7	51.5	44.1	37.0
Operating room charges [1]	113.7	106.4	101.9																		
X-ray, diagnostic, upper GI [1]	105.7	102.1	100.7																		
Dentists' fees	121.4	117.6	114.0	111.1	108.0	105.2	104.7	102.7	100.2	97.2	94.9	93.1	92.2	89.2	86.4	84.6	81.5	79.6	76.5	72.6	67.0
Examinations, prescriptions, dispensing of eye glasses	116.1	113.0	110.7	109.3	108.6	107.0	103.7	101.1	100.0	99.0	95.3	93.8	92.5	93.7	94.7	93.6	89.5	88.7	85.9	82.4	79.3
Routine lab tests [1]	105.7	103.5	101.6																		
Drugs and prescriptions	98.4	98.1	98.4	98.7	99.6	101.1	102.3	102.2	100.6	97.2	94.7	92.7	91.7	90.7	89.9	89.1	86.6	85.6	84.3	80.1	74.6
Prescriptions	90.6	90.8	91.8	93.0	95.3	99.2	102.6	103.0	100.7	96.3	93.2	90.4	89.2	87.5	87.5	86.4	82.4	80.3	78.4	72.4	65.9
Over-the-counter items [1]	102.4	101.3	100.6																		

[1] December 1963=100.

Source: U.S. Department of Labor, Bureau of Labor Statistics.