BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

MONDAY, APRIL 23, 1973

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
Livermore Falls, Maine.

The subcommittee met, pursuant to notice, at 1:30 p.m., at Livermore Falls High School, Livermore Falls, Maine, Hon. Edmund S. Muskie, chairman, presiding.

Present: Senator Muskie.

Also present: William E. Oriol, staff director, Patricia Callahan, professional staff member; John Guy Miller, minority staff director; and Patricia Oriol, chief clerk.

OPENING STATEMENT BY SENATOR EDMUND MUSKIE, CHAIRMAN

Senator MUSKIE. First of all, may I say on behalf of myself and the committee staff, who come here from Washington with me, how very glad we are to be here on this beautiful spring day to talk to Maine citizens and with Maine citizens about the problems of the elderly in the health field.

I would like to say thank you to everyone concerned who has helped us put this hearing together.

The school authorities, the town authorities, the members of the panel who will testify this afternoon, and all the rest of you, I thank you all for coming.

I would like to say a special thank you to the Livermore Falls senior citizens choral group who have already sung to us for our pleasure a few moments ago, and to Ronald Wyman, our soloist, who sang and led us in "God Bless America."

We have a busy afternoon, I hope an interesting one, and certainly the subject is of interest to all of you in this room, and to millions of Americans like you across this country.

Shortly I am going to read a statement which outlines the nature of the committee's interest, so that you may have in mind the areas of inquiry that we will address this afternoon, but first I would like to say something about this place and this location and its importance.

We will be studying this afternoon a project called Project Independence.

It is a model of areawide planning and services, in the three county areas.

When I say "model," I do not mean just a Maine model, it is a national model.

Those that are responsible for leading the efforts to help senior citizens and the Office of the Administration on Aging consider

this project and regional model of national significance as we plan to improve our services for senior citizens across this country, so that is the national reason why we are here this afternoon.

The personal reason is I wanted to come back to Maine and talk to my neighbors here, in an area not very far from my hometown.

[Applause.]

I know that Senators should be listeners more than talkers in a meeting of this kind, but I would like to lay out some facts for the benefit of the media, and for the benefit of the rest of you.

Incidentally, these proceedings will be published. They will become part of the record of hearings which will be extended into other States and which will continue in Washington, D.C.

At our first hearing last month in Washington, we heard from witnesses who told us quite bluntly that for many older Americans, barriers to health care are formidable and often insurmountable.

They told us that health care costs are too high for the budgets of many older persons.

They told us that health care is often unavailable or too far away for elderly residents of cities or remote rural areas.

And they told us that Medicare, essential and welcome as it may be, is far, far from adequate.

On the matter of health care cost, incidentally, I have an announcement to make, an unhappy announcement.

In preparation for this hearing, I wanted to know how much older Americans pay out of their own pockets for medical care, as compared to what they were paying before Medicare went into effect almost 7 years ago.

The answer to that question is very disturbing.

Medical Care Costs Increasing

New tabulations, to be officially announced next month, show that for fiscal year 1972 the average out-of-pocket expenditure by the elderly for health care was $276 per person.

That figure is $42 more than the average elderly person paid in 1966, before Medicare paid any of their health costs.

In other words, you have not kept up with the rising costs. These figures confirm what many elderly know from personal experience—that health care costs generally are rising faster than they can keep up with.

It is no secret that out-of-hospital prescription drugs for persons of age 65 and up average about $86 a year, almost three times higher than for younger people.

It is no secret that nursing home costs continue to rise, and that in many cases Medicare and Medicaid are far from sufficient to meet those costs.

And it is certainly no secret—certainly not to older Americans—that Medicare pays only about 42 percent of all health care costs of persons of age 65 and over.

Yes, Medicare has its shortcomings; and in some cases they are tragic shortcomings. I believe that Medicare must be improved.

Unfortunately, most of the recent discussion about changing Medicare has centered around proposals which I believe would make Medicare less effective.

ADMINISTRATION'S PROPOSAL

I am referring to the administration proposal to increase the charges that Medicare participants must pay.

As things stand now, an elderly person pays $72 when he or she enters a hospital under part A of Medicare. The patient then pays nothing until the 61st day, and even then only $18 a day until the 90th day.

The administration wants the elderly to pay more. Under the plan advanced by the President in his budget message, a patient would pay the first day's hospital charge—whether it was $40, $90 or $150—and then 10 percent of each following day's charges.

For instance, a stay in the hospital of 21 days now costs the Medicare patient $72. Under the administration's proposal, the same stay might cost about $330 in a typical case, a 358 percent increase.

That's not all that the administration wants to do to Medicare.

They also want to increase costs under part B, which pays for physicians' services.

Today, a Medicare patient pays the first $60 of his doctor's bill, and 20 percent of the rest of the bill.

The administration wants to raise the $60 to $85 and the 20 percent to 25 percent.

How does the administration attempt to justify its proposal?

It says that increased fees will reduce what they call "over-utilization."

I have yet to meet any person—young or old—who goes to a hospital or to a physician's waiting room for fun.

I have yet to meet any person—young or old—who shops around for the least expensive hospital; they go where the physician tells them to go, when he tells them to go.

This subcommittee dealt with these administration proposals in its first set of hearings in Washington. Our witnesses and our record, built, what I believe, is a solid case against the proposals.

Senators on both sides of the aisle, Republicans and Democrats, have spoken out against them on the Senate floor.

These proposals cannot be implemented by the President alone. These must be approved by the Congress, and I would be amazed if they were.

That is one way of asserting congressional prerogatives and congressional responsibility.

I have spoken against the administration plan on the Senate floor, and so have other Senators, Republican as well as Democratic.

All in all, the administration proposals are unpopular, and I would be very much surprised if they got anywhere.

I would expect instead that Congress will gradually attempt to improve Medicare by adding to, not substracting from, its coverage.

Surely one of the first of those improvements would be to include some out-of-hospital prescription drugs under Medicare.

I expect to see some progress in this area during this Congress.

But Medicare is in some ways the victim of shortcomings in the health care system of this Nation.

We must, therefore, turn our attention to the context in which Medicare must operate: the system itself.

Deficiencies of the Medicare System

To citizens of Maine, the deficiencies of that system are obvious. I would like to give you a few excerpts from mail I have received from Maine citizens.

A Fryeburg woman, for example, said that Project Independence is critical to senior citizens in her county.

She wrote:

> There are a lot of our senior citizens who do not have cars and have to depend on the minibus to take them to the doctors, or to the store.

Illustrating further the problem of health care delivery in rural Maine, a physician in Union wrote this in a recent letter to me:

> The people in the country do not understand Medicare. . . Added to that, most hospitals present to them unitemized, confusing bills which the patients are not sure whether or not they should pay. And many elderly patients in the rural areas do not have telephones . . . which confuses the matter even more.

Another evaluation of certain defects in the system was powerfully expressed right here in Maine as part of the report of the Governor's Committee on Aging in August 1970. I will read that paragraph to you now:

> The range of health services for older persons is inadequate since some elements are available only in certain parts of the State, while other elements are misused or overused. Today group care facilities cannot provide the level of service demanded of them, while general hospitals are overburdened, and home health care is drastically insufficient. The question of the quality of service and the high cost of drugs complicates problems throughout the entire range of health services. One of the most persistent, yet difficult to verify, complaints of the task forces was poor quality care, especially in group care facilities.

The task forces to which that excerpt referred, of course, were the groups of citizens who worked so long and so hard in 1970 and 1971 to prepare Maine for its role in the White House Conference on Aging almost 16 months ago.

In other States, the task forces met, made their recommendations, and then disappeared from the scene.

But in Maine the task forces not only stayed alive; they are apparently flourishing. They are working to make their recommendations become realities.

And it is largely because of this strong, grassroots structure that we are here in Livermore Falls today.

One of our primary purposes is to receive direct, firsthand testimony about the work done over the past year by Project Independence, which serves approximately 80,000 persons in Androscoggin, Oxford, and Franklin Counties.

Organized Neighborliness

The project draws its strength from what might be called organized neighborliness—people who care about people and who work for people.

I am especially interested in the project because it clearly demonstrates that health services cannot exist in a vacuum. They must be related to other programs, and they must draw strength from the insistence of the citizenry that no person, no matter what the age, can be forgotten or even denied the help needed to live at home independently, unless institutional help is absolutely necessary.

And so Project Independence has developed its five components—health, nutrition, transportation, information and referral, and recreation—for a three-county area in a coordinated effort to provide services that make sense.

I am especially interested in the fact that the major source of Federal funding for Project Independence comes from the Older Americans Act.

And I am happy to report that both Houses of Congress acted last week to broaden and extend the act.

I hope to say more about this as the hearings proceed. I will say no more about Project Independence, however, because our first panel of witnesses are admirably able to tell that story.

Other witnesses will tell us of statewide issues and proposals for improvement. And we will conclude by hearing from leaders of SCOOP, the State Council of Older Persons, now—I understand—about 5,000 members strong.

It is good to be here today in Maine talking to neighbors about matters of concern to the Senate Committee on Aging and to all citizens of this Nation.

With that, this Senator is going to start listening, and so are the rest of you.

We have here three panels, and then a closing speaker. The first panel is a panel on Project Independence and related programs, and the first to speak will be Mr. Daniel W. Lowe, vice president, member of the project executive council, and then following him will be Mr. Harold Collins, who is the project coordinator, and an indispensable man if I have ever heard of one, who will present the rest of the panel for a discussion of Project Independence.

May I at this point present to you Mr. Daniel W. Lowe.

[Applause.]

Incidentally, we have with us two members of the committee staff in Washington, Mr. Bill Oriol, staff director, on my right, and the staff really is not a partisan staff, but we sort of have a rule that both parties will be represented on it, and Mr. Oriol is of my party, which will remain unmentioned this afternoon, but then we have Mr. John Guy Miller, minority staff director, who is also here from Washington, so we have both parties represented here.

Mr. Miller represents the nine Republican members of this Committee on Aging. I am surrounded, so you can be sure I will be kept under proper control.

[Applause.]

Now, Mr. Lowe, you may proceed.

STATEMENT OF DANIEL W. LOWE, EXECUTIVE COUNCIL VICE PRESIDENT, PROJECT INDEPENDENCE, AUBURN, MAINE

Mr. LOWE. In the spring of 1970 a survey was initiated by the State of Maine Health and Welfare Department under the direction of Mr. Robert Frates.

As directed by Governor Curtis, five area task forces were formed.

A large portion of the personnel for these task forces was made up from the members of the State's senior citizen centers.

These task forces did a very thorough survey to determine primary needs of the elderly.

The results of this survey revealed that there was an urgent need for services in the following categories:

First, home health care; second, transportation; third, meaningful tax relief; and fourth, adequate housing.

This survey also showed that in the tricounty area, made up of Androscoggin, Franklin, and Oxford Counties, there was a large percentage of low-income elderly who were in need of health care and home health care.

These people also needed transportation—to go to the doctor's office, to the grocery store, and to do other necessary errands that come up in everyday living.

They also needed leisure time activities, such as senior citizen centers. They needed to get out from those four walls called home.

At the request of Governor Curtis, the Blaine House Conference on Aging was held in the fall of 1970 and these resolutions were adopted:

First, meaningful property tax relief for the elderly.

Second, expansion of the Medicaid program to include the cost of prescription drugs and accessory services such as eye, dental, and foot care.

Third, the development of both urban and rural transportation programs for Maine's elderly citizens.

Fourth, that income maintenance be achieved through the upgrading of the old-age assistance program.

Fifth, that housing programs for the elderly be developed to provide both for new units and the rehabilitation of those that are now substandard.

Sixth, that the system of regional coordinators of older peoples' activities be developed.

Some of these objectives have already been met and forces are at work to bring the others to reality.

To digress a bit, the Western Task Force on Aging became a reality in the late fall of 1969 and was incorporated as a nonprofit organization in December of 1971.

Project Independence Grant Approved

Also in June 1971 the task force applied for a grant from the Older Americans Act and shortly thereafter the grant was approved for the program designated as Project Independence.

In fact, we were the first organization to receive such a grant under this act. It was then a pilot program.

Under this grant, the following services to the elderly were to be available:

First, transportation; second, outreach services; and third, information and referral.

The CAP (Community Action Program) agency was contracted to perform some of the phases of the services involved.

Mr. Harold D. Collins was chosen as coordinator of the Western Maine Task Force on Aging in November of 1971.

Personnel to man the several components named above was chosen in early January of 1972 and in late January some of these services were available.

Project Independence then became a reality.

By correlating the services of Project Independence with the services of other agencies, it has been possible to operate a much broader scope of assistance than was originally hoped for.

Those agencies include the following:

First, Androscoggin County Home Health Services.

Second, Tri-County Health Planning Agency.

Third, health and welfare offices.

Fourth, volunteer services—RSVP, meaning retired senior volunteer program and VISTA, meaning Volunteers in Service to America.

Now the big question is—how have we done?

How have we done—I do not wish to bore this committee with a lot of statistics, but I would like to give some projections made as to the number of individuals to be served during this second project year, June 30, 1972, to May 31, 1973.

With some history and experience behind us, we were able to project these figures.

I will list the components and the number to be served under the component:

Information and referral and outreach	18,400
Transportation	18,150
Home care	2,750
Health screening	1,000
Recreation and leisure time activities	2,200

These projections may give you some idea of the scope of the activities covered and the individuals served under these components.

Our opinion based on these projections is that we have done a satisfactory job. We were not content to accept our own opinion as final, so a private concern was hired to evaluate the results of our efforts.

This concern, after a lengthy and thorough evaluation, gave us a very satisfactory rating.

There were a few problems in this evaluation, but steps have been taken to correct these deficiencies.

This is the history of Project Independence to date. With the blessing of the Congress, we hope to be able to carry on these worthwhile services to the elderly.

Harold Collins came to my rescue, and said I left out one important person here and we cannot do that, Mr. Steven G. Polederos was appointed director for Project Independence in June 1971.

With those last remarks, I close my statement.

Senator MUSKIE. He is the fellow who has been fixing the microphone.

Mr. POLEDEROS. Right.

Mr. COLLINS. Any questions, Senator?

Senator MUSKIE. Harold, I think it might be helpful, I am not sure how well versed these people are on these programs, and I think it would be of interest to them in having the home care program described a little, or will that come out in the panel?

Mr. COLLINS. That will come out.

Senator MUSKIE. Then go on, and I will reserve my questions for later.

These fancy words do not always go into conveying how these things work.

Mr. LOWE. I have one other duty, and that is to introduce Harold Collins, coordinator for Project Independence.

STATEMENT OF HAROLD COLLINS, COORDINATOR FOR PROJECT INDEPENDENCE, WILTON, MAINE

Mr. COLLINS. Thank you. In any organization such as our task force which embraces the three counties, Androscoggin, Franklin, and Oxford, cooperation and coordination are key words to success.

Each senior center throughout this area is linked through representatives of the tricounty areawide task force.

Let me explain the county organization.

In each county we have many senior centers scattered over the area.

Some of these are in small towns, some in large towns, some in cities.

To effectively reach all centers and areas, a county organization representing every center is needed.

Thus, we formed a council, a county senior citizen advisory council.

As the program develops and becomes more complex, the advisory council elects a steering committee, with one representative from each center—generally the chairman.

The steering committee discusses possible solutions to the county problems, also community problems, future programs and activities, and they present their findings to the county advisory council for approval or change as may become necessary.

In this way each of our three counties have an organization to deal with county activities and a nucleus from which to work with the tricounty task force.

So our task force here is composed of all senior citizens in the tricounty area. To have an effective governing body each county is equally represented on the task force advisory council.

Now, we have gone up one more step from the meetings of the senior citizens to county organization to a tricounty organization, which is composed and comprised and made up of the same type of structure.

This involves about 70 to 80 people as a working nucleus. From this council officers are elected plus three representatives from each county which make up the task force executive committee.

This committee became incorporated as the Western Older Citizens Council.

We are going to go back to the full task force. This task force has worked effectively to help with the survey of the needs of senior citizens, which resulted with the blue book, "Steps for Maine's Elderly."

Our task force has taken part in all Blaine House conferences and was represented at the 1971 White House Conference of Aging.

590 VOLUNTEER FREE HOURS

In our tricounty area the senior citizens have given hundreds of hours in service helping each other.

Two months ago one small town tabulated 590 volunteer free hours.

This is from one center alone.

The seek and find program pinpointed many elderly who were isolated, ill, or living alone with no one to turn to for help.

The telephone reassurance program provided a person-to-person contact for such help, gave the ill and lonely the assurance that someone cared and would check with them on a regular basis.

Some transportation was provided by neighbors and friends for doctor appointments or to go to the hospital and for shopping and personal needs.

One town made a record of 181 such telephone calls, and they have in some instances had the shut-ins calling other shut-ins.

They are doing a tremendous job. Not enough is being said for the work being done for us by our senior citizens, and the chairmen of these programs are also doing a tremendous job.

This is the basis of everything. We could have all of the organization in the world but we cannot get anywhere without their help.

Thus, the list of needs became endless. The area of these contacts was ever-widening and literally became the neighborly way of life of helping each other.

Our senior citizen response was very heartwarming, the need to be needed has its own therapeutic value.

When Project Independence became available to our task force it enabled us to provide needed services on a much broader scale.

It provided the financial aid for six minibuses, as you may have seen as you came in today, to transport many more of the elderly to needed services.

We just could not go on a volunteer basis to keep up. We cannot today with the buses we have.

It provided information and referral specialists, outreach workers and much needed health services, plus health screening as is being demonstrated here today.

Agencies partially under the Project Independence umbrella include Androscoggin Home Health Services, Tricounty Health Planning Agencies, Rural Health Associates, Model Cities, community action agencies, health and welfare organizations in our tricounty area, and other local agencies who became involved in our enterprise.

As in most pilot projects, we learned by our mistakes as well as by our successes. We tried to adjust our programs to fit the needs of our senior citizens. With their help, we are trying to improve the quality of their lives.

Have you any questions you would like to ask?

Senator MUSKIE. Thank you. I think if we go through the panel, some of them will get answered.

Mr. COLLINS. Thank you. The first young lady I would like to introduce is Sylvia Cummings. She is an outreach worker over in South Paris.

STATEMENT OF SYLVIA CUMMINGS, OUTREACH WORKER, SOUTH PARIS, MAINE

Mrs. CUMMINGS. I am Sylvia Cummings, from South Paris, an outreach worker for Project Independence. I cover eight towns in the Norway-Paris area.

I call on the average of 90 to 100 people in a month. I travel from 600 to 700 miles a month. Much of this travel is done on rural country roads, under all kinds of conditions.

Many of the people I call on live alone in isolated areas. Some have no central heat, modern plumbing, or other conveniences.

I average at least 50 referrals a month for health and medical needs. Most of those people lack transportation for health purposes, getting to the stores and taking care of their other needs.

Many of these people have only small Social Security checks of less than $100 monthly, which in some instances is supplemented by State assistance. Applying for this assistance has been a great blow to these proud and independent individuals.

Some of the proposed cutbacks will force more of our senior citizens to apply for welfare in order for them to exist.

I have assisted over 100 people with their tax and rent relief forms; also, I have been called on to fill out applications for State assistance; and other forms, such as those for getting the visual aids for the visually handicapped, plus forms for getting glasses from the Lions Club.

I feel that the services of a program such as Project Independence are very important for these elderly people, as they can call on us and we try to help them with their problems.

Incidentally, last year, I was able to get 10 pair of glasses for people who could not afford them, from the Lions Club.

I gave out 30 visual aids and four talking book machines during that year.

Mr. COLLINS. There were a lot more, but we will keep on going.

Senator MUSKIE. I did not realize this program had a sponsor, Harold.

Mr. COLLINS. We have to get paid by somebody. You mentioned the word "homemaker." We are very fortunate to have a homemaker with us, right next to Sylvia, Mrs. Frances Ouelette.

Will you tell us something about your duties as a homemaker, Frances?

STATEMENT OF FRANCES OUELETTE, HOMEMAKER, WILTON, MAINE

Mrs. OUELETTE. Thank you.

Mr. Chairman, I find in going into these homes that we have a lack of staff.

I have one man I would like to bring up, he lives in the rural areas. I am only able to go to him once a week and to give him approximately 2 or 3 hours.

In the 2 or 3 hours, I am expected to clean his trailer, do his errands, do his groceries, do his laundry, and cash checks, and see that he gets a haircut, and plan his meals.

This man is very lonesome, he is about 83 years old, he is a widower, and his only son died about 2 or 3 years ago.

I am probably the only person he sees weekly. He has neighbors, but the neighbors get tired of waiting on these people, and stay away.

So this man actually needs me probably at least 1 day a week, at least 8 hours.

WINTER BOARDING HOME

This man decided this winter, I talked him into going into a boarding home.

This man is not a nursing home person, and so he decided the boarding home might be what he wanted for the winter, so in January he went there with the understanding that the 1st of April he would return home, but he has been so happy in the boarding home, that he plans to stay there.

This man, once a week, would shave his beard because he thought I was coming, and he was very lonesome, and we did a lot of talking, and this pleased this man very much.

I had another case where I had an elderly couple, the man was 95, and the lady was 84.

They had been married for approximately 48 years, and this little lady weighed 85 pounds and took care of her husband who probably weighed 180 to 200 pounds.

She did all of the housework and the house was an old home, but it was their home, so at first, I believe we went in three times a week, probably for 2 hours.

We did her cleaning, and we helped her with her meals, and we did errands for her.

This gave her confidence that she probably would not have to go into a nursing home.

As it turned out, we did have to go, probably six times a week and help her 2 or 3 hours a day, and we maintained this family in their home.

They had only one son, and he wanted to place them in a nursing home, but father and mother said "No, this is our home, and we love it, we plan to stay here."

With our going in, I believe the son realized how much a home meant to these people, and so as it turned out, the man had to be placed in the hospital, and I believe for 5 days, the lady is still in her home, and the daughter-in-law decided she loved her home so much, this is where her mother-in-law should stay, and they, the daughter-in-law and son, moved in with them and said they were happy.

Senator MUSKIE. You said they did not want to go into a nursing home.

What does that reflect?

Mrs. OUELETTE. Physically, they needed a nursing home, but mentally they are very alert, and if you have been aware of the nursing homes, the people are mixed up mentally and physically, and it is very deteriorating for those older people that are intelligent to be placed in these nursing homes.

Senator MUSKIE. Is there a general attitude of reluctance to go into these nursing homes?

Mrs. OUELETTE. Definitely. I have worked 3 years in this capacity, and everyone fears the nursing home.

Senator MUSKIE. What is it they are afraid of, just the fear they will have nothing to do and they will deteriorate?

Mrs. OUELETTE. Well, they feel institutionalized, and they feel that their meals are prepared, they have to eat at a certain time, they have to go to bed at a certain time, they can only smoke in one place, and it is just not home to them.

Senator MUSKIE. Thank you very much.

Mr. COLLINS. One of the big problems, because of the distances, is transportation.

Fortunately, Project Independence provided us with buses, and we have one of the drivers right here who has had considerable experience, has ridden with the elderly, and I am going to ask him to tell you his story, Eugene Tardif.

STATEMENT OF EUGENE TARDIF, BUS DRIVER, PROJECT INDEPENDENCE, WILTON, MAINE

Mr. TARDIF. I am a driver, and I travel approximately 500 to 700 miles a week, and a lot of this mileage is done through towns in Franklin County or the surrounding area.

A lot of this mileage is like going 50 miles one way, and we have to do it twice, we have to bring them in to the hospital and bring them back.

This is a lot of our mileage. We hit weather conditions different up there than we do down here. It could be sunshine down here, it could be snowing up there.

This is what we run up against on these long travels, back roads, muddy roads, and then we have to hunt them up once we get there.

A lot of times they give us the addresses backwards. They give us the addresses where they want to go, and not where we can find them, and then a lot of times, the people that live off the road, they give us the address which makes it easier, and the duty of the bus driver is to keep the buses maintained and we have all had defense driving and first aid, and the priority on the bus is medical, which comes first, either for the senior citizens or other, and then personal, shopping, cashing checks, and hair dressing, et cetera.

And then recreation, visiting with friends, and attending senior citizens meetings.

We have to assist mostly senior citizens on and off the bus. Or else they cannot even get in.

And a lot of them calling for prescriptions which ties up the bus a lot, we have to get a prescription, deliver it, walk in, stuff like this, and we have a lot of emergency calls, somebody falls down, they have to get X-rays, somebody has a toothache, and so on, and we do take out-of-town trips once a month, medical comes first, and then we do fill the bus up for shopping, and so forth, and we do have delays as far as going out after some people, because we are not in touch with the dispatchers any more, we are on our own once we leave.

If we get behind schedule, there is no way for them to contact us. We cannot tell the person that we will be arriving late.

This confuses us and the doctors.

Senator MUSKIE. There are six of these buses to cover the three counties?

Mr. COLLINS. Yes.

Senator MUSKIE. I understand you have one dispatcher.

Mr. TARDIF. We have two.

Senator MUSKIE. But one headquarters?

Mr. TARDIF. Yes.

Senator MUSKIE. Each county has one?

Mr. TARDIF. Each county has the same number of buses.

Mr. COLLINS. No, two each. Three of them in one, two in another, and one in another, six buses.

Senator MUSKIE. Are they all kept going pretty well on a steady schedule?

Mr. TARDIF. Yes. Franklin County has two buses under the Rural Health Association which is tied in with Project Independence, which covers a bigger area by having the two buses working together in the Franklin County area. If the buses split up all it will do is confuse the senior citizens. They will have to start all over again.

Senator MUSKIE. Would two-way radio improve your communication, your service?

Mr. TARDIF. Yes, as far as going down the back road, a lot of times the people think the weather is too serious for us to go back, like they probably call in a week ahead.

The sun could be shining down here, but in the up-country, we do not know what the weather is until we get there.

Senator MUSKIE. Are any of your trips on regular schedule or on call?

Mr. TARDIF. Most of them on call. We try to get it set up the day before, so we know when we leave the office in the morning, we know what to do.

When we get on the road, there is no way for the dispatchers to contact us, unless we call in.

Senator MUSKIE. Thank you very much.

Mr. COLLINS. Thank you, Gene.

Our next witness is Miss Sue La Fleur, she is a social worker, and has quite a lot to do with getting us in the hospital, but also getting us out, plus completing a few forms.

Sue, go ahead.

STATEMENT OF SUZANNE LA FLEUR, SOCIAL WORKER, RUMFORD COMMUNITY HOSPITAL, RUMFORD, MAINE

Miss LA FLEUR. People are living longer today than ever before and most are enjoying relatively good health; aging, however, does take its toll. At this time most people over age 65 are enrolled in Medicare.

One problem facing all people who are enrolled in Medicare is the completion of forms to request payment when they receive medical care.

When one is admitted to a hospital or has out-patient tests done at a hospital, the facility makes the claim and receives the payment. The individual involved simply signs the form and it is the responsibility of the institution to submit it.

However, when one receives medical care which is covered under part B of Medicare, the provider or supplier may or may not complete the request for payment form.

If the individual does not understand how to complete the form, he may request assistance from someone else, or he may pay the bill without bothering to apply for benefits.

I feel that people do these things not because the form is complicated or difficult to complete, but rather from a fear of not doing what is right.

Some people panic when they look at it and decide that they cannot do it.

On the other hand, illness is generally an anxiety creating situation and multiple worries and problems arise.

An array of bills and statements are received by an elderly person following hospitalization or illness. These can be confusing to someone who is in good health, and to the apprehensive convalescent they can be easily misunderstood.

One may receive a notice from Medicare of payment, a statement from the hospital, a bill from the doctor or doctors, et cetera.

People frequently return to the hospital with all these papers, drop them on someone's desk, and say help.

"Benefit Period" Misunderstood

It has been my experience that these people are capable of understanding these statements and notices if someone is able to sit down with them and go over these papers.

One of the most misunderstood terms on these forms is "benefit period." Often a patient is discharged from a health facility and is told that his Medicare time is up.

At home he receives a notice from the Social Security Administration which says that he still has 30, 40, or 50 days of hospital coverage left.

What most people fail to realize is that they have received in almost all cases the maximum number of hospital days allowable for their "benefit period."

Too many still assume that admission to a hospital guarantees complete coverage for 90 days regardless of their condition.

I feel that a clearer definition of the term "benefit period" might reduce problems of this misconception.

At Rumford Community Hospital, Medicare patients are not sent their complete bills unless they request them. They are sent a bill for noncovered charges after payment is received from Medicare.

I am not aware of the policies at other hospitals in this area and can only assume that this is the general practice.

Elderly Face Transportation Problem

Another problem facing the elderly is transportation.

In this area where there is little public transportation other than taxi service, the minibus service provided by Project Independence has been invaluable.

On a relatively low, fixed income, it is a hardship for most to afford to use taxies. This transportation service has made it easier for elderly persons to keep doctor's appointments for routine checkups and follow-up care.

It has also been used by patients coming into the hospital for physical therapy, lab work, and out-patient X-rays.

At times it has been the one mode of transportation for a spouse to be able to visit his mate while the other is hospitalized or in a nursing home.

I have felt free to recommend this service to my patients at all times.

For the most part, my contact has been indirect with this agency. However, I feel that it is a worthwhile resource which is essential to comprehensive health care planning for the aged.

Mr. COLLINS. Sue, who do you feel should assume responsibility of explaining of the Medicare coverage to a patient?

Miss LA FLEUR. I feel it is the responsibility of the Social Security Administration to get somebody who will be available in a so-so type of basis to people who have questions about Medicare on a regular basis, because I do not really know of anyone who is a Medicare expert, either in the hospital or outside, who can answer everyone's questions.

Mr. COLLINS. Let me ask you one more question.

Can you explain the difference between the days used reported by the hospital, and the days used reported by the Social Security Administration?

Miss LA FLEUR. I think I will let Dr. Brinkman answer that one.

Mr. COLLINS. Good. Fine. Dr. Brinkman, will you answer that question right there now?

Dr. BRINKMAN. Will you please repeat it?

Mr. COLLINS. The question was there, she reported that a person who goes to the hospital, they assume they have a certain number of days left, or they use them all up, and yet a report comes through, and say the administration of Social Security, saying they have 30 or 40 more days, and there is bound to be a confusion.

How can we justify this?

ALLOWABLE HOSPITAL DAYS

Dr. BRINKMAN. Let me say that when a patient is admitted to a hospital, in addition to giving his identification, the referring patient must also present a provisional diagnosis and with each provisional diagnosis, there is a specified number of days that this patient is normally allowed to be in the hospital; for instance, if he has pneumonia, he may be allowed normally 10 days in the hospital.

When these 10 days are up, he is either discharged, he is well, or if he is not well, then the utilization review committee will go over this chart and determine whether or not this patient should be in the hospital for a longer period of time.

This must then be certified on the chart by the reviewing committee that this is necessary, or otherwise after this period has elapsed, Medicare will cut off payment, and the patient must then personally carry the bill, so that this is the thing that I think is frequently not made clear to people when they come into the hospital.

A specific diagnosis is normally given a specific number of days.

Now, if there is some complication, or some slowing in convalescence, or some other diagnosis has been disclosed, then this period of hospitalization may be extended and Medicare will carry on.

Mr. COLLINS. Thank you, Dr. Brinkman.

Most people do not understand that in our tricounty area we have in the city of Auburn a model city project, and we have with us here today the director of senior citizens activity, and her name is Mrs. Eloise Moreau.

STATEMENT OF ELOISE MOREAU, PROJECT DIRECTOR, LEWISTON SENIOR CITIZENS, LEWISTON, MAINE

Mrs. MOREAU. In Lewiston, we are talking about a situation which is very much different from the situations we have been hearing in previous testimony.

Now, we are in an urban situation, with the urban problems that Model City has tried so very hard to combat.

With the support of Model City funds, we have been running in Lewiston a senior citizen hot lunch program for 3 years at the Trinity Episcopal Church.

Once the program was established, we found the impact on the lives of our local senior citizens to be very dramatic, and this is the type of thing we are encouraging, and hoping that other agencies will be able to have for their own particular communities. The impact has been so great that we feel that this is an extremely worthwhile program.

For some in our city, it became an opportunity for part-time employment to suplement their income.

For others, it is the focal point of their day, and for many, it is the only well balanced, nutritious meal they eat on a regular daily basis.

The problems of eating alone, preparing meals for one, the inability to shop in large markets, and the tendency to eat things that are easy to prepare and to chew, all add up to very poor nutrition for the elderly.

An elderly man left alone may simply not know how to prepare food properly. Many of them are living in one room with a hotplate.

With families today being so mobile, many of our senior citizens find themselves alone. They reach a point in their lives where they have retired, many of their friends have passed away, and their children live far away. The depression and loneliness that follow are easy to understand.

HOT LUNCH PROGRAM

We have found with our hot lunch program at Trinity Episcopal Church, that the companionship of eating with others is almost as important as the nutritional aspect.

It is obvious if you give a person a good nutritious meal 5 days a week, that they will respond physically, it is good for them; but the unusual thing about this program has been the kind of camaraderie that has come to these people from being together on a day-to-day basis eating with other people that they know and the new friends they have made and so on.

Our meals are served at the Trinity Church from 11:30 to 12:30 Monday through Friday, and in many instances, senior citizens start arriving at the center at 9:30 in the morning. The center is open until 4 p.m.; there they have cards, meetings, and all of the things we do at our other recreation centers, but the feeling that comes across to anyone who has visited us at the center, has been how much good the program has done for these people.

It is an excuse to get out, to get dressed, the women fix themselves up a little bit better, the men have met other men their own age, and sit and talk and play cards, and that sort of thing. It is really something I wish all of you could see.

We have approximately 220 people, senior citizens, who are fed daily at this center.

The cost of the hot lunch to the people who participate is 50 cents. It is estimated by the fiscal department in the Model Cities that the entire cost for this meal is approximately a maximum price of $1.85; this includes the cost of the food, cost of the labor, cost of the utilities, et cetera.

We are working out of a very makeshift situation, out of a small church in Lewiston, with a small kitchen.

There is none of the streamlined stainless steel equipment we find in so many of our school cafeterias that do such professional jobs, but the staff does an outstanding job with the equipment that they have, and the fact that we did not have too much money to spend on equipment has made us invent many things, which have served the purpose and served it well, and I think that is all to the good, really.

The need for the nutrition program and other social programs for the elderly is very clear.

When we started with our Model Cities program in September of 1970, we had a membership of 800. We are now at the end of our third action year and have a membership of 4,000.

So the need and response to programs of this sort is a fact.

Meals-on-Wheels Program

As important and necessary as the lunch program is, it was not long before we realized that the shut-ins were being sadly neglected.

We then proceeded to apply for a title III Older Americans Act grant to start our Meals-on-Wheels program.

Our clients are screened through the Androscoggin Home Health Agency, and approximately 60 shut-ins are served the same meal that is served at the Trinity center.

This program costs approximately $2.35 per meal and is a fantastic success. Our referrals come from families, hospitals, and other agencies. For many, this is a lifesaving contact with the outside world. We always keep a few openings for temporary emergencies.

This program is also responsible for keeping people at home rather than in a nursing home. With this meal Monday through Friday and the homemaker during the week, many are staying at home in surroundings that are familiar to them. Cost for this meal is determined by the client's ability to pay: 60 cents, 30 cents, or nothing.

Our meal is delivered in a station wagon by a driver and a deliverer. Both of these women are mothers of school-age children who find the hours from 10 to 2 ideal. Both enjoy the contact with the clients.

Working with senior citizens, we become very involved in their day-to-day lives. This is the joy of working with people in a program that serves their needs.

Are there any questions?

Senator Muskie. Thank you very much, Mrs. Moreau.

What is the status of your Model Cities grant as to the future?

Mrs. Moreau. There was a meeting last week before the board of aldermen in Lewiston. We are all set for our fourth year; but our fourth year, which will be starting June 1, is our last year.

We had 1 full year cut off our Model Cities grant in the city of Lewiston; and then, of course, the grant was cut in half, but our senior citizens opportunity program fared very well through the cut, and we will be able to continue our different services for the elderly for the next year.

The year after that is the year we are worried about.

Senator MUSKIE. What are the prospects at the moment?

Mrs. MOREAU. The prospects are one you just mentioned, the Older Americans Act which has a good possibility of passing, and then something we have been hearing about a lot, because we are losing our Model Cities money, something called special revenue sharing. We have not gotten any specific information at this time. Then there is a good possibility the city of Lewiston itself may be able to pick up a small portion of this; so between the city, State of Maine, and the Federal programs, we are in hopes of being able to keep our program going.

Mr. COLLINS. Could I ask you a question?

NUTRITION PROGRAM IN RURAL AREAS

Eloise, would you mind taking a half a moment and explain what you are doing on the nutrition program in regard to the rural areas.

Mrs. MOREAU. We have been working with Project Independence on the possibility of something coming through called the Nutrition Act, and the committee work that we have been doing is to involve the rural areas in this type of nutrition program; we have been talking mostly about consolidating different areas and earmarking different areas in the tricounty area where a large facility could be found to prepare a large quantity of food.

The basic expense and the biggest expense in all of this is the staff to prepare the food; and if we could have different, large kitchens scattered here and there throughout the tricounty area, then we would be able to feed senior citizens at their own centers by delivering these quantities of food. Not delivering them in trays the way we do for Meals-on-Wheels clients, but delivering them in these large containers that caterers and so on usually use, and that way we would be able to stretch our dollar a lot further. This is the kind of planning that we have been working on.

Senator MUSKIE. I would not count too much on special revenue sharing.

Mrs. MOREAU. Well, it is very vague.

Senator MUSKIE. Unless we can get something straight. I have a——

Mr. COLLINS. In our tricounty area, we are serviced by the Androscoggin Home Health Services; and with us is Mr. Richard Hooper, the director.

STATEMENT OF RICHARD H. HOOPER, EXECUTIVE DIRECTOR, ANDROSCOGGIN HOME HEALTH SERVICES, INC., AUBURN, MAINE

Mr. HOOPER. The year 1946 was a happy one for most Americans. Such was not the case with Mrs. John Jones, for it was the year she discovered her affliction with multiple sclerosis.

During the past 27 years, she, more than most of us, has come to know the American health care system in a very personal way. Now in

her 67th year, this ex-schoolteacher is confined to wheelchair and bed.

Despite her long and arduous struggle against the well-known debilitating effects of her particular disease, she remains mentally alert and continues to contribute to her rural community through frequent telephone communications with former pupils and fellow senior citizens.

The Androscoggin Home Health Services entered Mrs. Jones life in March 1971. The precipitating event was her discharge from a Lewiston hospital where she had been confined for treatment of a leg fracture, complicated by a cardiac problem.

On referral to us, a mild exercise program was established by our physical therapist. A nurse was assigned to the case to carry out the established therapeutic program and keep a watchful eye on her cardiac condition.

Given this professional assistance, plus a high degree of moral and physical support from the elderly couple with whom she resides, Mrs. Jones has progressed very well, relatively speaking. In July 1971, her full leg cast was removed, and by December of that year her fracture was healed.

Through a progressive upgrading of her therapy program, there was an improvement in her balance, and her leg strength increased. Early in 1972, Mrs. Jones, with the help of a walker, stood on her feet for the first time in many months.

At the present time, Mrs. Jones is living at home. To help maintain her rather tenuously stabilized physical condition, we provide, on a monthly average, 15 visits by a home health aide, 4 visits by a professional nurse, 1 evaluation visit by the physical therapist, and various supplies and equipment necessary to her care.

In the past 12 months, this service has cost $2,903.17, or an average $241.93 per month. Any of you people who know what multiple sclerosis is about, certainly would not dispute the tremendous needs this woman has.

I think no one would dispute Mrs. Jones' need for health care. And I am equally sure that the average citizen would comfortably assume that Medicare is doing the job for Mrs. Jones.

PROJECT INDEPENDENCE—HOME HEALTH SERVICE

This assumption would be not quite correct; it is Project Independence which is getting the job done. Of the 2,903 home health care dollars expended in the last year, Project Independence provided $2,288; the remaining $615 came from title XVIII prior to Mrs. Jones' case being ruled ineligible for reimbursement in September 1972.

We at the agency believe there is little doubt that should home health care be withdrawn from Mrs. Jones, nursing home placement would become essential. Using the present Medicaid reimbursement rate of $440 per month to qualified nursing homes, her care would thus cost in the vicinity of $5,280 per year.

While this case certainly cannot be classified as typical of our patient load in all respects, in one significant respect it carries a ring all too familiar to us and to hundreds of home health agencies struggling to build adequate, comprehensive home care programs—the refusal on the part of the Social Security Administration to extend Medicare

coverage to those elderly suffering from long-term, chronic, debilitating, and frequently terminal illnesses.

Your committee, Senator Muskie, has published a very articulate and thorough report, published in April of 1972, entitled "Home Health Services in the United States," and this certainly documents and articulates the problems and shortcomings of Medicare as well as anything I have seen.

Only because of Project Independence and its commitment to meeting home health care needs in this region have we been in a position to address needs similar to those confronting Mrs. Jones. Without such support, we would be forced to reduce services by some 30 to 40 percent.

Plainly put, Mrs. Jones and several hundred other senior citizens would likely find it necessary to have their health needs met elsewhere, in many cases at higher cost to themselves and to the community at large. In a day and age when we are earnestly seeking to build a more rational health care system, one that is capable of providing the most appropriate type and level of care at the right time, to the right patient, it is seemingly anachronistic that the Social Security Administration should carry out such restrictive policies with respect to home health services.

Health Screening Program

Within the few remaining minutes available, I would like to mention briefly the Project Independence health screening program which our agency conducted last year and is in the process of doing again at this time. I think a major reason for the apparent success of this particular program is the fact that the idea for it came from the grassroots, the senior citizens themselves.

Accepting their challenge, we met with a number of physicians in order to determine which tests would be feasible to give and would offer the best return in terms of identifying those physical health problems most common to the elderly.

Out of such considerations evolved a battery of some six tests including a blood pressure, hemoglobin, hematocrit, occult blood stool, and a urinalysis for the presence of sugar and albumin.

With the blessings of the county medical societies we proceeded to conduct 29 clinics throughout the region.

Of the 900 who took part in the first series, 204 were identified as having one or more possible problems.

These people were so notified, as were their private physicians.

Subsequently we sent a followup questionnaire to these 204 people and almost immediately received back 125 responses. That is a very good return.

These indicated that most had heeded our advice and contacted the physician of their choice.

This, we felt, was a most important part of the project—getting people, many of whom reported never having been to a doctor, to seek out medical attention.

We also learned that 45 of the 125 questionnaire respondents discovered a previously unknown health problem when examined by the physician.

Incidentally, we even had a few people, some half dozen, if my memory is right, who reported that the health screening saved their life. Just before coming up here today, I was talking with Keith Dexter, and he told me about a case that I was not aware of. A woman in his rural community was one of 75 screened at that test site last year.

There was some problem discovered, I am not sure exactly what it was, but she went to the doctor as we asked her to. She was discovered to have curable cancer, and was operated upon. Keith said today this gal, who is still of working age, is back on the job. That almost makes the whole screening program worthwhile. It does make it worthwhile.

I think it is difficult, without getting into some relatively detailed and sophisticated research, to determine the true cost-benefit of a screening program given to such a limited sampling of the population.

However, at a cost of roughly $7 per person, we feel this project is worthwhile and certainly merits additional study.

In conclusion, I feel I owe an apology to the committee for touching so briefly and inadequately on a number of points which I consider to be of paramount importance.

At the same time, I would offer to submit additional documents for the committee's review subsequent to this hearing, if that should be desired.*

Thank you very much.

[Applause.]

Senator MUSKIE. Any documentation you can give us, Mr. Hooper, we would welcome.

I cannot think of any service in all of these services addressed to real human needs, I cannot think of any service that is more relevant in terms of the sheer humanity of the problem we face here than home health care.

You can cite it for those who are not concerned about that aspect of it in economic terms, how much cheaper it is to deal with the health programs involved at home than in a nursing home or in a hospital, but basically, what appeals is that this kind of service represents the community going into homes, where people otherwise might well be isolated from the outside world to deal with their health needs, and I cannot think of any one of these services that moves me more than this one.

FINANCIAL SUPPORT FROM MUNICIPAL GOVERNMENT

I understand that you receive some financial support from municipal government to increase the scope of your service.

Mr. HOOPER. Yes, we do, Senator.

We have been extremely fortunate in this region.

We began our agency in 1966, or actually January 1967, and from the outset, we realized if we were going to even attempt to provide this service to people on the basis of need, and not basically on the ability to pay, and let's face it, some of us providers are in that kind of a bind, we would have to go to communities and solicit their financial help. They have been most helpful all through the past 7 years and

*See appendix 1, item 3, p. 269.

this support, incidentally, was extremely helpful at the time Project Independence came along, because it served to meet the local matching requirements for obtaining Federal funds.

Senator MUSKIE. Do you have any way of measuring what proportion of the need you are providing?

Mr. HOOPER. Not really. I am always asked that question and, while I think this is probably a rather facetious answer, I have always said the need is so tremendous, that we have just got to keep digging at this point, and we cannot worry about the bottom of the pit. I feel we are meeting a very small portion of the real need.

I think the potential for home care is enormous. I think the way it is being utilized in most parts of the country today proves to be a very limited use of the home care concept.

There are many things that can be done in homes. For example, something like an electrocardiogram can be very inexpensively done by a telephone mechanism, and in a rural area, this may be the most expeditious way to bring that kind of special service to some people. I do not think we have even scratched the surface of potential for home care.

The scope of it will broaden as time goes by.

Senator MUSKIE. To what extent are you involved in your experiment for innovating ideas for improving home health care, or are you so overwhelmed by the caseload that you have, that you cannot really get into innovative or creative ideas?

Mr. HOOPER. Well, we have not really expanded in terms of service functions that much.

We provide physical therapy, some speech therapy although speech therapists are in short supply in the area, occupational therapy, nursing, and so forth. We have recently launched, in cooperation with Maine's regional medical program and the Veterans' Administration, a special program which we have entitled the team nursing project. This is an organizational design which I think is somewhat innovative whereby we break down our staff into five area teams.

In a region as large as this, communication in our kind of program can be difficult.

It is not like a hospital where supervision is close at hand, so we feel that through a very careful decentralization process, we can improve the quality of the care that we now give and also use this as the basis of expanding the functions of the agency.

Senator MUSKIE. Now, what are you doing? I know we have the referral service as a separate part of this panel, but are we really doing an effective job of reaching all of the people who might need or be able to use this service, and how can we improve our effort to reach them?

Mr. HOOPER. The answer to the first question is no, I do not think that any home health agency would claim today to be doing the whole job the way they would like to be doing it.

As to the question of how we get there, I think there is a number of answers that one would have to give here.

I guess the first one is funds. We had been fed initially, many of us by Medicare, and now funds in terms of Medicare reimbursement have pretty well dried up.

I think the case I have cited as a good example of the stringent policies of Medicare.

It seems to me that either through the Social Security Administration or the Health Services, Mental Health Administration, there needs to be funds so available that home care programs can be allowed to expand and experiment and do some of the research that we need to do, to see what ways we can grow in our communities.

Senator MUSKIE. I would like to get, it seems to me we have got to get some of these ideas out on the table so we can have something to sell.

NATIONAL HEALTH INSURANCE

We are talking about national health insurance in the Congress now.

Well, national health insurance is a way of providing the funds to pay for services, but we learned under Medicare, that simply providing the funds is not enough, that the result can be escalating costs and the figures I gave earlier this afternoon demonstrate the costs outstrip the funds we have provided to pay for the services.

That is a merry-go-round to nowhere, if we continue to follow that route, and it seems to me that one of the reasons we hold these hearings is to try to stimulate creative ideas for improving the services so that the money we provide, the additional moneys we provide will actually go to improve the health care itself, and I am a strong believer in the home health program, and I think we need to get some input here, maybe the additional information you can provide for us would help.

It is all linked to transportation as well, it is linked to organization of the kind on a regional basis, so you can get some economies of scale, and the human effort you have to exert as well as the money you have to spend, and you want to develop regions in which the spirit of neighbors, and this comes naturally with people who are close to each other, but then we have to learn how to use new techniques.

Mrs. Ouelette's experience, there are only 24 hours a day to Mrs. Ouelette, and if she has to spend 2 to 3 hours with the old gentleman who needs aid, how is she going to get to the other six?

Now, I suppose you have got to have human hands to wield a broom or vacuum cleaner, you cannot do that by telephone.

Mr. HOOPER. You cannot be an octopus.

Senator MUSKIE. But it is a question, somehow making up for the deficits of bodies and manpower by new and more effective ways of using time and resources and care and so on.

Well, I wanted to get into where everybody else was talking here. I thought I ought to get in a word edgewise.

Mr. COLLINS. Thank you.

All of us have been very, very fortunate and we feel very proud that we have been able to have a medical man, a very experienced one to whom we could go to for lots of help, such as organizing clinics, and help on this screening.

In other words, we feel very proud to have with us and have our interest at heart, Dr. Henry Brinkman.

STATEMENT OF DR. HENRY BRINKMAN, FARMINGTON, MAINE

Dr. BRINKMAN. I came here largely as a representative of the medical profession, and having reached the age group where I personally may be more interested in the problems we have today, it is only natural that I am here.

I am sorry, I have no formal statement to make, Harold, but there are a few points I would like to bring out if I may.

First, regarding the question that you raised, Senator Muskie, regarding the reluctance of people to go to nursing homes.

I think for many people this is for them the last ride, and this is tragic, and for this reason, I think the home health care is so important so that people can stay in their own home.

I think I can illustrate this by reciting an incident I had with a patient several years ago, a lady who lost her husband, she had her own home, she stopped into the office one day and said she was pretty lonesome.

I said to her, "Why don't you get some other lady to live with you and keep you company," and this is what she said, and this is verbatim, she looked me in the eye, and she said, "I have reached that period in life where such as would live with me I would not live with."

So that these people really become accustomed to a certain manner of living, which ought not be interrupted any more than necessary, and for this reason, I think all of these services of home health care are so important.

Now, with regard to Project Independence, obviously, this transportation has helped a lot of people, but there still remains a small increment of patients who even find that an imposition because they are bedridden, they are crippled, their homes are inaccessible, and for these few people, I still insist that we of the medical profession should make home calls for these people.

Medicine, the practice of medicine, has become very sophisticated, but it does not take long for one who has had some experience to go into a home and size up the situation as to whether or not hospitalization is necessary for this patient.

In a vast majority of the cases, the only thing that is necessary is a bit of reassurance, and this is all they need, that everything is being done at home and this is what the family needs for reassurance, and for their own comfort.

Now, with regard to the hospital, as I mentioned before, these patients, many of them in the elderly age group, after they have had their hospital care, they must be sent out in the world again.

Now, those that have Medicare, and those that can be rehabilitated can be sent to a Medicare-approved nursing home for a protracted period of time, for treatment, physiotherapy, what not.

Those who cannot be rehabilitated, and this is a tragedy, cannot be sent to a Medicare-approved nursing home, they have to provide some nursing home facilities on their own, they have to find a place to live, and this is extremely difficult.

Nursing Home Standards

Many of our private nursing homes are going out of business, because some of the standards are set so high, they no longer can meet these standards.

I submit that many of these nursing homes which have closed, have done in the past an excellent job, but standards are set up so high, that they cannot meet the standards, and there are plenty of elderly people who love elderly people, and would be happy to care for

them if the standards were not set so high, with regard to safety features, for instance.

Now, most of these nursing homes that have closed, probably provide better care than many of these patients have had in their own home, and I find it pathetic that we force the closure of so many of these smaller nursing homes that do not quite meet the standards.

I think that is all I have to say at the moment.

Are there any questions?

Senator MUSKIE. Doctor, on that last point, one of the difficulties we get into whenever we try to establish national programs designed to safeguard the rights of the patient, when you are dealing with massive numbers, you tend to set standards that are not open to review, so I wonder if you have any suggestion of how we might get around that problem and meet the point you make, which I suspect is a very valid one.

Dr. BRINKMAN. Senator, I am afraid I have no answer, because obviously, whenever a nursing home has to be approved, certain standards must be met for the safety of the patients, and I am well aware of this, but when you hear in the paper that a certain nursing home has caught fire and burned down or some people were burned to death, this is a tragedy of course, but this ignores the thousands of people who are denied the facilities of an adequate nursing home, but I know of no way around it.

Senator MUSKIE. I know there are other subcommittees of this full committee who have looked into this nursing home situation before.

Incidentally, doctor, I would like to compliment you on what I understood to be your whole attitude about the responsibilities of the profession, before I had the pleasure of meeting you today, and I wish there were more like you.

[Applause.]

Dr. BRINKMAN. May I just say that we have had several young doctors come into this area, largely as a result of the rural health associates, many who are dedicated men, and I think this practice will continue in this way in this area.

[Applause.]

Mr. COLLINS. At this moment, may I say a big, big thank you for all of you who have done so well here today, and to the chairman and the committee, we thank you very heartily for listening to our problems.

Thank you.

Senator MUSKIE. I wonder if I might ask each of them to answer one question I already put to Mr. Hooper.

MEETING THE NEED?

Do you have the feeling that the effort of which you are a part comes close to meeting the need?

I would like to have each of the panel members who are involved in the service, Mr. Collins, Mr. Tardif, Miss La Fleur, Mrs. Cummings, Mrs. Moreau, whether or not you think there are a lot of people not being reached by your program who ought to be.

Do you have any impression at all about that?

I am trying to get some feel as to whether this program is beginning to meet the needs.

Mrs. CUMMINGS. I really feel we are doing a wonderful job.

I am not patting myself on the back. I mean the whole program as a whole, but we really have only just started. We have been working, about the first of February I started going out, as an outreach worker, so we really have only just laid the groundwork.

I feel that there are still a lot of people I have not met in my area yet. There are a lot of little backwoods roads I have not hit, but I think if they should lose this program after having had it for a year, it would be tragic, because they have become accustomed to know where to call for me, and they know they are going to get it.

Senator MUSKIE. Do most of the people know of your existence?

Mrs. CUMMINGS. Yes, I think they do.

Mrs. OUELETTE. I think this program has been—people have really taken to this program, and we are really quite well-known, and I think we are very depended upon.

I think the older people, I guess it is something like when you have a horse, you think a lot of him, you do not just turn him around and put him out to green pastures, and I think this is one way we have of giving the senior citizens a little bit of green pasture.

Mr. TARDIF. As far as transportation goes, I still meet senior citizens and they pass us on to other senior citizens, and a lot of them feel the bus cannot even get up to their home, they think they need a Jeep because they live so far out in the woods.

A lot of times we drive in, we have to back out, there is no place to turn around once we get in, and lots of senior citizens tell other citizens of our service, and I think eventually we will get them all.

Senator MUSKIE. But the word is obviously spreading?

Mr. TARDIF. That is correct.

Miss LA FLEUR. There is just a feeling that there are needs being met, and that there are still some people not aware, and I think this program should be expanded someway.

I know there are times when the minibus is not available, due to scheduling problems, there are people who cannot get transportation through the minibus, and there are other ways that must be made.

Senator MUSKIE. Thank you very much, Harold, you and your panel. We are very grateful to all of you, and I am sure this audience is too.

Mr. COLLINS. Thank you very much.

[Applause.]

Senator MUSKIE. We have our second panel of the afternoon, the hearing will continue.

We have in our second panel, Mr. Richard Michaud, director of community services for the State of Maine, and Dr. Dean Fisher, commissioner of the Maine Department of Health and Welfare.

It is a pleasure to welcome them both here, especially Dr. Fisher, who was head of the department before I was elected Governor 20 years ago next year, and he is still carrying on his duties, the usual competent high level, in the usually competent high-level way.

It is a pleasure to welcome both of you here.

Either of you may go ahead.

I think maybe Mr. Michaud would fit in with what we were just talking about.

STATEMENT OF RICHARD W. MICHAUD, DIRECTOR, COMMUNITY SERVICES, DEPARTMENT OF HEALTH AND WELFARE, AUGUSTA, MAINE

Mr. MICHAUD. Hon. Senator Muskie and other concerned citizens, my name is Richard W. Michaud. I am director of community services, the unit that administers the Older Americans Act in Maine.

Project Independence addresses itself to reducing the three most important barriers to health care. They are: Lack of information, lack of transportation, and lack of money.

The objective of Project Independence is to increase the accessibility of older persons in the area to health-related services by:

First, through linking older persons to available health services; and

Second, through establishment and expansion of low-cost alternatives to high cost and often unnecessary services such as hospitals and nursing homes.

To meet these goals, a range of services had to be developed to overcome the primary barriers of information, transportation, and money.

These services are information referral and outreach, transportation, health screening, and homemaker-home health services.

During a 1 year period ending February 19, 1973, Project Independence provided 57,200 units of service to older persons in this tricounty area.

Eight thousand different individuals, 43 percent of the total population over 65, received these services.

The number of services that they received are:

Information referral and outreach	20,480
Transportation	32,240
Health screening	3,580
Homemaker-home health	900

For a total of 57,200 units of services.

We feel that these are significant accomplishments for a little over a year of operation.

Three years ago the strategy of the Federal Administration on Aging was areawide planning. To reinforce this concept, areawide model funds were made available at a level of $2.2 million.

States were encouraged to compete for these funds. The citizens and organizations represented in this room and others took up the challenge. The result was that Project Independence became the first funded and the first operational areawide model program for older Americans in the Nation.

It has since become the blueprint for planning and service delivery not only in Maine but nationally as well.

Later, the 1972 amendments recognized as the purpose in providing services to older people, "to secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care with appropriate supportive services; and to remove individ-

ual and social barriers to economical and personal independence for older persons."

It is interesting to note that Project Independence was named before the 1972 amendments were drafted, so that I think even the name Project Independence had a significant input into the national strategy.

The challenge of the 1972 amendments was to create a mechanism which would bring into existence the skills of management and organizations in delivery of social services.

The 1972 amendments envisioned the development of a type of partnership of older citizens, community leaders, State and local government, voluntary organizations, with appropriate assistance from the Federal Government.

This newly developed mechanism would thus act as a go-between, a broker, in bringing together the suppliers and recipients of services.

This mechanism was actually in operation 3 years ago in this area and is known as the Western Maine Task Force on Aging.

Based on the success of Project Independence, and the task force mechanism, and the fact that our State is divided into five similar planning areas for the elderly, survey data was evaluated for the other task force areas, indicating that the barriers across the State are the same as in western Maine and that the same kinds of services are needed in other areas.

Area Planning

Planning has been going on in these designated areas across the State and is at various levels of development by capable representative task forces, similar to the one in western Maine.

Again, in national competition with the help of the Eastern Maine Task Force on Aging, we were able to secure a grant of $53,000 from Washington for area planning.

The headquarters are in Bangor and the planning is a very large four-county area which includes Penobscot, Piscatiquis, Hancock, and Washington.

Another $53,000 planning grant was received from Washington for the Southern Maine Task Force on Aging based in the Portland area and involves planning for Cumberland and York Counties.

The results of area planning can be seen on the coast, headquartered in Rockland, by operation SEA-ME (seek expanded advantages for Maine's elderly), which is an areawide program modeled after Project Independence, covering the counties of Waldo, Lincoln, Knox, and Sagadahoc. It offers transportation, homemaker-home health services, health screening, meals, and information referral and outreach.

This program, which has been operational for only 6 months, serves over 4,000 persons. It is funded by title III of the Older Americans Act.

In Bangor, meals for Maine's elderly serves 200 older adults daily in a pleasant setting and delivers over 125 meals per day to shut-ins. It is funded under title III of the Older Americans Act and serves over 1,200 different older individuals.

In Portland, project HOME (housing opportunities and meals for the elderly), is our only senior day care program. This program

offers a wide range of services to 80 older people daily at a Federal cost of $16,000 per year.

In York County a transportation service operating 5 days a week on a limited basis serves over 2,200 different older people annually. The first priority of this program is getting older people to health services.

Planning has also made it possible for us to become the grantee of a foster grandparent program, funded for $136,000 for 53 grandparents who work with 106 retarded children in institutions.

We have also been funded for an RSVP (retired senior volunteer program) resource development specialist and four RSVP programs strategically located across the State to serve as many older persons as possible.

We have just finished negotiating and expanding a contract with VISTA which will provide us with a total of 45 locally selected older individuals.

They will be assigned to the area task forces on aging where they will become either planning aides or outreach workers.

Over the past 5 years, 150 senior citizen centers have been developed and are now in operation serving over 35,000 older Maine people through paid staff and over 2,000 volunteers.

This totals up to 47,200 people over 65 receiving meaningful services at an annual Federal cost of $825,000.

I think that this should indicate that these have been times of action, accomplishment, and dedicated efforts at every level.

Funding Sources

The sad fact remains that after having come this far, after communities have been organized, after concrete programs similar to Project Independence have been planned, after the hopes of our seniors have been raised, we do not know now where we will find the money to implement all of the programs that are being developed.

We always felt that moneys allocated under the Older Americans Act would never be enough to fund all of the needed programs on a statewide basis, so in our planning, we have been very careful to include involvement, commitment and funding from sources such as title XVI of the Social Security Act, title VII of the Older Americans Act for nutrition for the elderly, model cities, Office of Economic Opportunity, comprehensive health planning agencies, regional medical programs, and local communities.

Many of these now in one way or another have been cut back, limited, dismantled or abolished.

This greatly concerns me, because it destroys the hopes of our elderly who do not understand all of these technicalities and regulations and limitations.

All they know is the other people were never really given very much and now once they have seen what can be possible, services to help them stay in their own home, where they want to be, even that might be taken away.

For a long time this great Senate committee has been struggling with the problems of barriers to health care for the elderly.

I am pleased that you were able to come to Maine and listen to how the older citizens identified the major barriers to health care that they

could realistically deal with. The problems of lack of information, lack of transportation, and lack of money.

I hope that the previous panel and my statement have impressed on this committee that we have a design that works here and is transferrable to other parts of our Nation.

We therefore urge your support in every way possible to insure that the concept of Project Independence can become operational for all older citizens in our State.

Mr. Chairman, my responsibility is to administer the Older Americans Act which you hear about so often, and which has been mentioned here today.

I am going to skip over some of my remarks and just hit some high points. The hour is getting late.

Project Independence—National Model

I have heard two or three times already the same kind of things that I had in my prepared statement. I would like to say that when the national strategy became areawide planning, I was very happy to have been associated with people in this room that represent individual citizens and agencies that took up this challenge. They formed a partnership of citizens, of voluntary organizations, of local community leaders, and public officials. With some help from Washington, in terms of guidelines and planning funds, we were able to get Project Independence going. I think it is exciting, when a great Senator comes to Maine and recognizes that we have a national model here in the three-county area as a result of our efforts and our working together.

I think this is really a credit to all those in the audience. We have found after about a year of operating Project Independence, when we analyzed all of the data that we have collected across the State, after we looked at the data in the other areas, we were not really amazed, but we were sort of pleasantly surprised to find that the needs that had been identified in this tricounty area. All of the programs developed here, transportation, homemaker-home health aides, outreach, nutrition, all of these were needs shown to be identically needed in all other five task forces throughout the State. With that groundwork, the planning continued, really on a tentative basis for lack of adequate funding but we kept alive, and older people had something meaningful to talk about, and to meet with others and to discuss, and to plan for.

Again, with the help of the Eastern Maine Task Force on Aging, we applied for and were granted a $53,000 grant from the Administration on Aging to plan for a four-county area.

We also have a planning grant for Cumberland and York Counties.

I would like to touch very briefly on a few other points.

After giving you this very brief background, I would like to move into a few examples of the results of our area planning efforts in other areas of the State.

First of all, perhaps a lot of you have heard of operation SEA-ME, that means seek expanded advantages for Maine's elderly, and naturally, it is on the coast, and covers the counties of Waldo, Lincoln, Knox, and Sagadahoc.

It offers the same basic services as Project Independence, it is modeled after Project Independence, and it works as well there as it does here. We have only about 6 months of experience in that particular area, and already 5,000 unduplicated individuals have been served by operation SEA-ME.

In Bangor the planning there identified one of the first major needs that could be funded, I think the major need in the Bangor area, needless to say, according to the chairman, Mr. Scammon, and other people, is transportation, as it is statewide.

However, there was an opportunity to develop a meals program, and that is called meals for Maine's elderly.

That serves over 200 adults daily, in a pleasant setting, and delivers over 125 meals every day to shut-ins.

These shut-ins are not simply people that find it convenient to have a meal brought to them.

They are actually screened and the need really determined for this kind of service.

It is not a luxury. Under title III of the Older Americans Act, we serve over 1,200 individuals in this program.

Project Home

In Portland, we have Project HOME, which is an experimental program, it means housing opportunities and meals for the elderly.

It is actually a senior daycare program. This serves over 80 older individuals every day.

In York County, we are geographically limited with regard to a transportation system because of lack of dollars.

The first priority of that transportation system again is getting people to health services.

It serves about 2,200 people annually. Planning has also made it possible for us to become a grantee for foster grandparents program.

This is funded at a level of $136,000, and it provides for 53 grandparents, who work with 106 Maine children. We have never had a foster grandparents program in Maine before. Everybody is really excited about this particular concept, and so am I.

We were funded approximately a year ago for the retired senior volunteer program, a resource development specialist was employed, and we have four funded programs by ACTION out of Washington, strategically located across the State.

That is just a quick rundown. I will not attempt to touch every one of these points, if you do not mind, sir.

The total, I think, might be hit on, and this is that 47,200 older people over 65 received these services that they themselves said were meaningful.

I think it is important to all of us in government to hear the first panel say that these services were meaningful, and it kind of makes us all feel a little bit better.

Total Federal Input

The total Federal input is approximately $825,000, but the local effort in kind in cash is almost three times that amount.

People of all ages are volunteering their time in very concrete activities that enhance or even maintain the actual programs and services. If you add up these activities of over 3,000 volunteers who give their time regularly and assign a minimum value of $1.50 per hour according to the Administration on Aging guidelines, you have $800,000 of value. That alone is enough to match the Federal money on a 50–50 basis.

Beyond this there is well over $1 million of in-kind matching for space, utilities, heat, and equipment donated by local communities, agencies, and individuals in which operate 150 senior citizens centers. Another $250,000 comes from State, county, and local governments and private agencies in cash matching for senior citizens programs.

All of this totals up to $2.2 million which is really 75 percent local match for the 25 percent Federal share. This should indicate that people are doing much more than they need to.

It is not just merely to get the Federal dollar. It is the real commitment and involvement and real concern for the older people that has taken almost 6 years to develop and is now blossoming out across the State.

A couple of more points: One is that we always felt that the dollars that would become available under title III of the Older Americans Act would never be enough to fund all of the programs that can be planned in this fashion.

We have five capable task forces across the State engaged almost daily in planning, coming up with ideas, assessing their needs, and getting together and putting together workable programs.

We knew we would never be able to fund them all under title III. So in our planning, we were very, very certain to involve commitment, involvement, and funding from other sources such as Economic Opportunity, model cities, regional medical programs, and local organizations, but the problem at this point is that a lot of these programs are being cut back, or limited, or being dismantled, and some are even being abolished.

This concerns me greatly, because I think it destroys the hopes of our elderly, which do not understand all of these technicalities, and all of these regulations.

What I know is what older people have told me, they never really have been given much over the years, and now that they have seen what can be possible, they have had a bit of a taste of independence, and they know it is going to help them stay in their own home where they want to be.

Alternative to Institutional Care

Senator Muskie. I wonder if you could tell us more about your senior daycare program, and how effective would it be in preventing needless institutionalization?

Mr. Michaud. Project HOME actually is a program where we talk about developing even another alternative to institutional care.

Project HOME is a new such alternative, it operates through the Park-Danforth boarding home. As you know, all housing arrangements for the elderly have long waiting lists.

The idea here is that the people that would benefit most from home care, boarding care, in a community are given those services, and there

is a nurse on duty half-time that follows up on doctor's prescriptions, talks about nutrition, and includes a meal every day, arts, crafts, recreation, and counseling are made available.

These people are returned to their own homes at night, and they stay there overnight, so they are getting all of the benefits that they would if they were a resident of that facility, yet they stay at home.

Senator MUSKIE. I think your written statement says that Project Independence reaches 43 percent of the total population over 65, is that a hard figure?

Mr. MICHAUD. That is a figure of the number of people that have received services, but I do not think we can really kid ourselves and say they have been fully served.

Senator MUSKIE. How much higher a percentage is your goal?

Mr. MICHAUD. Our initial survey data indicated that over 50 percent in this area rated their health from fair to poor, so that if you went by that figure, and you were concerned about improving the health situations, then you would want to indicate that you would get to 50 percent of the population.

This 40-percent figure we are touching, this is recorded, but the fact is I do not really think we can kid ourselves that we are giving them full service.

They might have had another piece of information, they might have had information as to transportation, and so on, but we are not serving them completely.

Senator MUSKIE. Would this require substantially more funding in your judgment, or do you think you are going to reach a higher and higher percentage by just continuing the program and improving the outreach, improving your communications with the older Americans?

TRANSPORTATION TO HEALTH-RELATED SERVICES

Mr. MICHAUD. I think in time, like if we can go for another 2 years, we will of course have an opportunity to touch more people, but I think if we are going to serve them better, as it is now, I do not think we are meeting one-third of the demand for the first priority of transportation, which is to take people to health-related services.

That simply means if we are going to meet that need fully, we will have to add more buses, so that there would be increased costs, but I do not think substantially; no.

I think the basic design is there, and I think with just a minimum extra, we could do a much better job.

Senator MUSKIE. What is your ultimate goal for transportation for the meal program? I have enjoyed three of those meals, and that is worth spreading.

Mr. MICHAUD. Maybe this is dreamland, but then 18 months ago Project Independence was dreamland, and it is to provide a piece of needed transportation for every older individual in this State that wants and needs it.

Ultimately it is the same with meals. There have been cases documented where you can keep an individual comfortably living at home if he is provided two or three meals a week.

The average cost per home-delivered meal as indicated in this area is about $2. We are talking about $6 a week to help an older individual

stay at home, and that one nutritious meal can make a difference between a nursing home or a boarding home.

Senator MUSKIE. Do you think all of the people who need that kind of assistance know about its availability?

Mr. MICHAUD. I do not believe so.

Senator MUSKIE. You have no way of measuring that?

Mr. MICHAUD. Well, our measurement is sort of biased in that the individuals that speak to us know already about the program, but we do suspect that there is a large number of individuals that we have not yet been in touch with.

Senator MUSKIE. Well, for instance, you have meals programs in Bangor, Rockland, and one in Lewiston.

Is the demand visibly growing for participation in these programs?

Mr. MICHAUD. Oh, fantastically so.

After about 4 months of operations, we had projected that Bangor's meals would serve about 100 per day.

After 4 months of operation, they were serving almost 200 meals in congregate facilities and delivering about 150.

The demand really had to be limited because the source of funding just could not be expanded.

At the time they were playing ping-pong in Washington with the Older Americans Act. One day you saw it, and the next day it was gone.

ADDITIONAL FUNDING NEEDED

Senator MUSKIE. So you are going to need additional funding for the meals program?

Mr. MICHAUD. Very definitely. We are depending very much on the $100 million appropriation, title VII of the Older Americans Act, nutrition for the elderly.

If we do not get that, we cannot expand.

Senator MUSKIE. How many different meals programs will you have when you have the State covered?

Mr. MICHAUD. We feel we will have the meals program centrally operated in each task force area.

Senator MUSKIE. That is five?

Mr. MICHAUD. That will be five, and we see the plan now as preparing large volumes of meals, and then through a transportation system, and hopefully we can establish that, delivering them to key locations in rural areas.

We can perhaps have two or three cooks for a county, centrally prepared and then deliver.

Senator MUSKIE. If you have no funding handicaps, how many meals do you expect to be serving a year from now?

Mr. MICHAUD. I think our figures indicate approximately 7,000 meals per week statewide, based on our State allotment which will be $526,000. 7,000 meals is really not very much when you consider 118,000 individuals over 65, probably 30 percent of which need those meals.

Senator MUSKIE. It is pretty good when you start from zero.

Mr. MICHAUD. It certainly is.

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

We will now hear from Dr. Dean H. Fisher, commissioner, Maine Department of Health and Welfare.

STATEMENT OF DR. DEAN H. FISHER, COMMISSIONER OF HEALTH AND WELFARE, STATE OF MAINE, AUGUSTA, MAINE

Dr. FISHER. Mr. Chairman, my statement is really put together with the expectation that I might touch on some problems that would not otherwise be touched on, at least in this particular hearing today.

I am sure they will be touched on in some of the other hearings.

I would like to point out first that it is a very obvious fact, as a condition, the people tend to forget, and yet to some extent, many of these complicated facts have been touched on today.

There are so many different factors affecting what one might call the health complex, so many different things that contribute one way or the other to the maintenance and preservation of health, that they are really an almost infinite number of choices and options that are available, and at sometime or other, I think many of the choices and options will have to be given for consideration than has been true up to this point, at least in some instances.

When we speak of health care, we are very likely to speak of that portion of our society that somehow rather relates rather directly, specifically, and identifiably with health, which means hospitals, nursing homes, physicians, and the usual collection of factors.

This is a very complicated subsystem, you might say, but it is still nevertheless a subsystem, and as was pointed out, some of the things like meals, transportation, and so on, and so forth, may well in many instances turn out to be more important than medical manpower, hospital beds, and whatnot, so one of the other factors that I sort of had in mind when I put together this little statement was to point out perhaps some of the effects that I think one can see from the current developments that relate rather directly to the health care system itself.

Many of the barriers to health care for the older person are barriers that are equally frustrated and equally difficult for a lot of people, and that are difficult for the low-income families and low-income children and so on and so forth, so I urge people to look at the health care system as to provide for a whole range of people including the elderly, and recognizing the elderly do have some rather peculiar problems and place some rather peculiar loads on the health care system, but nevertheless many of these barriers do exist, and they are economic, physical, social, some political complications, and I think perhaps more far reaching and sometimes recognized.

This is the kind of a system where you cannot really fiddle with one of the parts, unless you are very careful that you know what will happen to some other parts of the system, and I think to some extent, as we move into Medicare, we find we have some rather radical economic repercussions from the institution of Medicare, and perhaps some of our methods of financing of Medicare were not necessarily the kinds of financing that would provide the best benefit throughout the entire system.

Our hospital system now needs a new organization for a good many reasons, some of which I have set forth.

EXCESS HOSPITAL BEDS

In the first place, in general, they have an economically wasteful excess of beds under the present-day circumstances, with average occupancy in the State of Maine probably not more than 60-percent wide.

Now, why do we have some of these excess beds?

Well, the hospitals now seem to be giving more short-term care than they have been giving in the past, under economic pressures. We are keeping in-patient services as short a time as possible, and we are providing out-patient care services in lieu of admissions, and again, from a humanitarian point of view, there are advantages in this change too.

There are increasing third-party provisions, and with failure to achieve the original Hill-Burton objective, in reaching regional hospital systems, that is, a coordinated, planned, tailored, and regionalized hospital system, that States were not able to accomplish this, and at the Federal level it was not mandated, or not made sufficiently attractive financially.

I think it was an unwise decision to expect that States could handle this kind of a requirement with all of the many complications that were involved, and perhaps at the time of the Hill-Burton program's initiation, I do not think the community was ready for it at the time, but nevertheless, I think that is a factor to be taken into consideration as one thinks about any possibilities of the necessity for continuing the Federal participation, and the construction and modernization, and so forth, of fiscal planning.

The development of forces, and resources, homemaker, or home-health services, for example, minimizing the need for institutional care, we now recognize as being fairly well organized, and quite promising as devices for minimizing needs for institutions.

The development of substitute institutional services, nursing homes, now permits care of the long-term, chronic, nondramatic type outside of the hospital.

This development may well have some peculiar occasions for our whole health care system.

In the future, in the end, rather strangely, the development of these kinds of facilities, of nursing homes and its peculiar place in the medical system, this may all prove to be a rather strange development, but then here again, I think we have to trace it back to failure of the original design of Medicare to recognize this is probably one of the side effects of the choices that were made at that time.

Next, the whole process of utilization review processes and requirements far minimizes in-patient care primarily for current economic reasons.

Combine Multiple Hospitals

Next, in terms of the necessity for redoing hospital plants, there has been some rather striking technological advances in the last few years, and there are some new needs for services such as much better emergency medical care services than we have in the past.

We also have the residual need, to combine multiple facilities into fewer, larger, and more efficient units.

We have the provision of H.R. 1, and the certificate of need laws, economic pressures, health planning agencies, and some attitudinal changes that would all now give some promise that the regional concept can become reality.

Houlton is an example. Two, and perhaps three, small hospitals are willing to merge. Community plans are agreed upon and complete.

However, they will need $6 million for a new physical plant. Without Hill-Burton funds, or interest subsidy, they now need to borrow about $5 million in the open market. This means some $200,000 per year of interest charges, and another $250,000 per year of debt retirement.

The facility might expect to provide some 30,000 patient days of care per year. This means some $15 per patient day for 20 years for interest and debt retirement alone.

In the long run titles XVIII and XIX will be paying for half of it. Further, some $5 million will be taken out of the Maine capital pool, and it might otherwise be used for industrial development or other investments.

It perhaps could have been done more gracefully had we had 2 or 3 years' warning.

Most hospitals have a length history of 7 years, from the time the community is ready to move and the time the facility is completed.

In the instance of my home, we are talking about two hospitals, and a third hospital, and the people are concerned that such an infusion is not a wise economic move.

I am sure you can understand the mere fact of reaching this point, where this represents about 5 years of hard work on the part of many, many people, and they have the practical problem of financing, building, design, and so on, and so forth, so we are talking about an 8- or 10-year program.

The community has reached the pont where it is now able and willing to proceed, and suddenly the financing they had anticipated evaporates, so I perceive here a little bit of what happens.

They need to borrow about $6 million. This means that they must pay some $15 per patient day for 20 years for interest and debt retirement alone.

This is an attempt on my part to illustrate some of the side effects of the decisions that are made in what might appear to be a rather simple field of health care facilities, and if you are talking about expense of hospitalization, and the increasing cost of hospitalization, and I simply point out to you the $15 a day figure, and that is assuming the interest rates are low, and that is assuming that the loan will be amortized over 20 years.

Here we are talking about a rather small hospital incidentally. We may have something like 90 beds.

Well, enough of that, perhaps.

Nursing Home and Boarding Home Deficiencies

Nursing homes, and boarding homes, are now the facilities to which patients move from hospitals by the nature of their problems, or as a result of utilization review, or economic pressures.

If the total system is to be efficient then these two types of facilities must offer adequate numbers of beds and appropriate services.

Our major deficiencies in both quantity and quality lie here.

Therefore, the system must encourage developments in these areas, and this is dependent almost entirely on the adequacy, and system of payments, for these are largely private enterprises, even though they should be components of the hospital system.

I point out a very simple example, if a patient is in an extremely expensive hospital bed, and there is no other place to which that patient can be moved, even though the move may be entirely appropriate to a nursing or boarding home, he may be forced to continue to pay $75 or $100 a day in the hospital, simply because the other components of the system are not properly balanced in relation to a hospital bed, and yet to some extent, the number of hospital beds are more under a kind of public control, that is true in the instance of boarding home and nursing home beds because the general hospital usually is a quasi-public facility or nonprofit corporation, and there are fewer of them to deal with, and so on and so forth, so to make changes in what is essentially a system of private enterprise, which is not very successful, or through perhaps financial bribery, and that perhaps is the only choice we have.

Now, in this whole problem of adequacy of what you might call of facilities supplemental to a hospital, we have phase III of wage-price stabilization which now has requirements that make it almost impossible to make any changes in the system of paying for nursing home care.

We have the obvious need to improve quantity, quality, and distribution of this level of care.

We have HEW, and others, insisting on the need for these improvements, but we also have another Federal agency making the changes impossible.

Nursing Home Standards

Finally, we supposedly have Federal quality standards for nursing home care, but they are so vague, and wishy-washy as to be almost useless.

Boarding homes are a little more fortunate. They were originally determined under rent control, and that evaporated.

As a matter of fact, this quality of wishy-washiness makes it extremely difficult for a State to build a quality standard that is anything less than wishy-washy, so in effect we are sort of left holding the bag.

Now, in January 1974, the three adult public assistance categories are transferred to the new SSI program.

However, this will leave with the States the problem of financing themselves, the major costs of boarding home care.

I think it is reasonable to expect that this will not easily provide the payment levels which will encourage the kinds of developments that are clearly needed in this service area, particularly with the caseload increases which are predicted under the new SSI program.

Title IV–A funding has encouraged the development of noninstitutional services, designed in some instances, social services, homemaker services, home-health services, and so forth, to prevent or postpone institutional care.

Thus, the conditions of IV–A funding are a factor in this entire discussion.

In Maine, one of our major barriers comes from the simple fact that our legislature has not funded the expansion of title XIX into the medically indigent.

There was at one time a Federal deadline at which point State legislatures would have had to act. This was removed.

Perhaps such moves now will best be accomplished by some kind of Federal financial incentives.

Differing Circumstances in Adjoining States

I really do not know how long you can leave State legislatures making decisions in effect creating different circumstances between people living in two adjoining States.

There is a problem of some sort of minimum level, of minimum quality of service.

There is some problem of equity involved here in quality.

I recognize our legislators have some real problems. I am simply saying perhaps from the point of view of the Federal objectives, that perhaps this needs to be recognized more fully than has been true in the past as a great practical problem.

I think it is a common experience of State legislatures. I am not sure that the matching circumstances necessarily describe or properly recognize the relative ability of the States to pay.

I do not think they do.

Finally, in a summary such as this, one might point out what appears to be a lack of understanding in adequately funding comprehensive health planning, and eliminating the regional medical programs.

In most of these discussions, there still seems to be an obsession with the clearly identified elements of the health system, the hospital, medical manpower, expenditures, payment mechanisms, and so forth.

Very few people talk much about what is expected from this system, or what it is able to deliver, or what makes it the way it is.

Even fewer people talk about other factors that are equally, or perhaps even more important in the long run.

These are factors of diet, income, mobility, socialization, and many others.

I would just like to encourage everyone involved to realize the situation is an extremely complex one.

There are no simple answers, you cannot fiddle with one piece of the system without doing something with the rest of the system.

It is this sort of side effects that can create very, very serious problems if they are not recognized at the time the original decision was made.

Thank, you Senator.

Senator Muskie. Will the termination of the Hill-Burton program leave other communities in difficulties?

You have mentioned Houlton.

Dr. Fisher. Houlton is the only one at the present time that is in this kind of situation.

There are two other projects, one of which relates to this area here, but we think we have both of those funded with currently available money.

The thing that I am really concerned about is the lack of funding for what I see is the absolute necessity for redesign, reorientation of facilities that may have been constructed no more than 10 years ago.

Senator Muskie. There is going to be a continuing need for remodelization?

Dr. FISHER. It would seem to me for the foreseeable future, 10, 15, 20 years, the whole system will have to be almost continuously redone.

LONG-TERM CHRONIC CARE

I do not really know, for example, what will happen to long-term chronic care, whether it will continue to be outside of the field of the general hospital, and in private hands, or whether at some time or other, it will come back into semipublic hands, which is where I really think it belongs.

Senator MUSKIE. I assume you heard Dr. Brinkman's comments on the standards applicable to nursing homes and his fear that many useful homes have been closed because the standards are too high.

I know you are concerned, that you have been concerned with this problem.

I wonder if you might want to comment.

Dr. FISHER. I think perhaps one of the things you are getting into here is a problem of definition of what we are talking about when we use the term nursing home.

I do not really think Dr. Brinkman and I have any real conflict.

We made certain we were not talking about the same facility and the same group of patients.

As a matter of fact, our standards in general are not high enough, or a variety of services are inadequate.

The nursing home and boarding home are the two areas in our institutional pattern that are most in need of a rather extensive modification as of the moment.

Senator MUSKIE. Can they continue to be left pretty much in the private sector as they are now?

Dr. FISHER. Well, I am willing to give it a try, but I think the answer would have to be I would give it a try with a rather jaundiced eye, and in the long run, I think perhaps it may best finally come back to at least semipublic hands.

When you begin to speak of a rather vigorous and extensive licensing standard and so forth——

Senator MUSKIE. Would this require Federal subsidization, do you think?

Dr. FISHER. No, it may not require Federal subsidies, except through existing programs.

We have programs now through title XIX.

Here again, if the case load increases, the State of Maine will have some very real problems in digging up its share of matching money under present-day circumstances and present-day matching, to provide a superior level of nursing home care to that number of people because the projected case load at the present time is something more than a 100-percent increase over our present caseloads.

Senator MUSKIE. I understand the recent maximum payment is $115 or thereabout.

Dr. FISHER. Yes, but our problems with the new program comes with the fact we now include a rather large number of individuals, who will not be eligible for benefits.

For example, what we call the essential spouse, we bring that essential spouse into the grant at the present time.

That individual will not be eligible under the SSI program, therefore, that individual will have to be carried under State money.

Senator MUSKIE. Do you have any projections of what that will cost?

Dr. FISHER. It will cost us considerably more money than before the so-called reform took place.

I do have some figures, yes.

Senator MUSKIE. Maybe we ought to give those to the legislature.

Dr. FISHER. They will be getting them very shortly.

OUT-OF-HOSPITAL PRESCRIPTION DRUGS

Senator MUSKIE. How can Medicare cover out-of-hospital prescription drugs and still keep costs within reach?

I understand you have some thoughts on that.

Dr. FISHER. Medicare, well, I would point out to you that if our legislature were to provide for the medically indigent in our title XIX program, then those individuals who are receiving title XVIII benefits, limited and small benefits, and without other significant resources, would then be included in our expanded program, and would then be provided with all of the drugs that we require, so you are really asking me whether or not you should build in something special in a system where some parts of the system are already capable of handling that very problem.

Senator MUSKIE. What are the prospects of the legislature doing that?

Dr. FISHER. In this session, probably not very much. One of their concerns really is what is going to happen to them with the SSI program, and unfortunately, I am in no position as yet to give them any kind of figures that are reassuring to them.

For this reason, our legislature said they would rather sit back until the dust settles, and then decide what to do, and then I think when you talk in Congress about such a thing as an SSI program, once you realize that these are the kind of incidental effects and perhaps simultaneously, maybe some change in the matching formula, or some other financial incentives to States might then relieve congressional concern over this question of providing drugs under title XVIII.

Senator MUSKIE. Could you send down a more complete analysis of this problem from Maine's point of view for our record? [1]

Dr. FISHER. Yes, I will be glad to.

ADMINISTRATION PROPOSAL TO REDUCE OVERUTILIZATION

Senator MUSKIE. I ought to get your reaction to the administration's proposal that Medicare coinsurance and deductibles be increased on the grounds that such action would decrease overutilization.

Dr. FISHER. Well, if you expect deductions and coinsurance to have much influence on utilization, I think this is a purely fallacious assumption, and what it may well do is simply tend to discourage people from seeking care.

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[1] See appendix 1, item 6, p. 274.

If an initial hospital admission is justified, it is justified, and that is it, and if it is justified admission, then I do not see any sense in penalizing the patient.

If it is not a justified admission, why make the patient essentially be the policeman by providing a financial penalty to the patient, who incidentally is rarely in a position to make the decision for himself, so you make the patient pay the price for a decision somebody else makes.

If we are concerned about the economics, as to utilization, and influence on medical care, then let us direct our attention to what it involves, a utilization review, rather than assuming that if you penalize the patient, he will scream loudly enough so that presumably something will happen.

All you are asking the patient to do is subsidize the system, when you yourself are shirking the responsibility of directing your attention to the actual problem of concern.

Senator MUSKIE. What are the principal factors influencing overutilization?

Dr. FISHER. To some extent, there are factors already suggested, and that is in some instances, the inadequacies of the programs, homemaking services, things of that sort, second, inadequacies in nursing homes, boarding homes, so that the patient has another alternative, inadequacies in payment mechanisms that still exist as far as insurances are concerned, where there are a variety of outpatient services, that are not fully paid for by third party payoffs, and finally, there are some common practices that you have to recognize in many instances that it best utilizes inpatient care rather than outpatient care.

Now, purely from the point of view of the people involved, they can say I can use my time more advantageously in this particular way, and yet from the point of view of the third party payoff, he has a complication in the system, and yet you still have to look at it from the point of view of these other parties.

Senator MUSKIE. The utilization of hospital beds, of 60 percent of beds in Maine, is not overutilization at all.

Dr. FISHER. That 60 percent occupancy builds in automatically another $10 a day simply to pay for empty beds.

This is a waste in and of itself.

Perhaps there is some way we should make it financially attractive to use those beds in some other way, or perhaps if you must penalize somebody, rather than coinsurance as far as patients, maybe the questions should be on the hospitals with that low occupancy, maybe they should pay, and maybe that is a community where you have instead of three hospitals, you have one facility, so we get back to where we started, and that was one of the original objectives of the Hill-Burton program, which was to design a more efficient and effective system, and yet we let that one get by, and then when we talk about financing boarding homes and nursing care, again, we let the ball go by, because we did not really look at all of these factors.

Senator MUSKIE. Dr. Fisher, thank you very much for your testimony, and Mr. Michaud.

Dr. FISHER. Thank you.

Senator MUSKIE. Our next panel is made up of Mr. Clinton Conant, chairman of the Governor's Health and Welfare Advisory Committee, and executive director of Rural Health Associates and Dr.

Richard Chamberlin, member of the executive board, Maine Medical Association.

Gentlemen, it is a pleasure to welcome you both. I appreciate your taking your time.

I think Mr. Conant is first.

STATEMENT OF CLINTON CONANT, CHAIRMAN OF THE GOVERNOR'S HEALTH AND WELFARE ADVISORY COMMITTEE, AND EXECUTIVE DIRECTOR OF THE RURAL HEALTH ASSOCIATES, FARMINGTON, MAINE

Mr. CONANT. The barriers to health care for the elderly in this area have been of interest and concern to me for several years.

I welcome the opportunity to convey my ideas to you with the hope that action will be forthcoming to assist in eliminating at least some of these barriers. The first point to make is that we need to keep in mind throughout these deliberations that we are talking about health care, not medical care.

By health care I mean a full range of services, such as preventive health measures, social services, food and nutrition programs, home nursing, homemaker services, health education and transportation, as well as the services needed when a medical crisis arises. A little over 3 years ago, citizens of west central Maine, through the efforts of the Franklin County Community Action Council, got together with a group of four physicians in the area to study this very topic and to work towards workable solutions.

I would like to take a few minutes to tell you of the barriers they identified, what has been done about them, and then express some concerns we have of areas in which you could be of assistance. The barriers identified were:

One, limited availability due to shortage of providers.

Two, limited accessibility because of poor distribution of providers and lack of transportation.

Three, inability on the part of the patient to pay for services, and

Four, lack of a coordinated comprehensive care program being available.

After much study and with the help of the Office of Health Affairs, OEO, Washington, the citizens and physicians formed a nonprofit health services corporation called Rural Health Associates, to deal with the above barriers. RHA was developed with the expectation that it would evolve into a health maintenance organization that would service all of west central Maine.

The following accomplishments have taken place since August 15, 1971, when RHA began operation.

First, the group has grown from four physicians to eight physicians, two dentists, and five physician assistants. There are also two more physicians and two physician assistants scheduled to join us this summer. This growth has helped alleviate some of the lack of available services.

AMBULATORY CARE CENTERS

Second, three ambulatory care centers have been constructed, in Jay-Livermore, Kingfield, and Rangeley. These centers, working in con-

junction with the central facility next door to the Franklin County Memorial Hospital, make health care available within a reasonable distance, for all residents of the area.

Along with these centers a transportation system has been developed with assistance from Project Independence. This arrangement provides for four minibuses whose first priorities are to carry citizens to health services.

Third, OEO established a contract with RHA to purchase from them on a prepaid plan, care for all those citizens meeting the OEO eligibility guidelines.

This part of the program is now serving 899 families that include 107 Medicare recipients. For these Medicare recipients OEO pays for their drugs, deductibles, and coinsurance.

Fourth, coordinated plans have been explored and developed with several other providers in the area to provide for a coordinated approach to providing comprehensive health care to the area.

Through assistance from regional medical program and the University of Maine in Farmington, RHA has established a health education program.

These are a few of the accomplishments. Now for a few of our concerns:

First, that Congress consider HMO legislation that promotes groups like RHA. This will allow rural areas to attract competent physicians as well as establish quality control mechanisms for providing health care to the elderly.

Second, if HMO's are to work in rural areas, there needs to be consideration of legislation to provide a reinsurance plan for the catastrophic illnesses or maybe a major medical plan that all HMO's can join.

The number of families in rural areas available to be enrolled in an HMO does not allow the HMO to establish a large enough base to take the whole risk.

Most of the insurance companies are not ready to contract with small HMO's. Therefore, the need for this to be covered on a national scale.

Third, more involvement by Medicare in contracting with HMO as well as becoming involved in promoting preventive medicine.

Now, as you know, they will not pay for physicals unless something is wrong. This is not the proper approach to keeping elderly citizens well and out of trouble.

Fourth, we need national legislation that will assist those medically indigent citizens to pay for health care. This should be uniform throughout the country.

As you know, Maine only covers those on categorical assistance which leaves many with no way to provide care for their families.

Also, many of the elderly fall in this category and have no way of paying their deductibles and coinsurance.

Medicare Mechanism Costly and Confusing

The Medicare rules and payment mechanism are also very costly and confusing. Many of the elderly do not understand the coverage and coinsurance principal so an enormous amount of paperwork is involved, both by the provider and Medicare.

If a direct contract with both the patient and Medicare can result in the future, it will improve the system for all concerned.

Fifth, promotion of coordination of services on the part of any new legislation will be helpful.

I believe you have heard here today how Project Independence, home health, RHA, and others have worked together to see that some of the barriers have been broken.

Through this cooperation and coordinated approach to health care problems, the rising cost of care can be kept in line.

I would like to thank you for allowing me to express my concerns to your committee and will be willing to provide you with any further information you might request.

I would like to add that there are physicians in our group that do make house calls, and they are very concerned about the people in nursing homes, and especially the elderly that cannot get out to come for health care.

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

Just one or two questions, if I may.

In your opinion, does Medicare pay enough attention to preventive care?

Do you think it would be workable for Medicare to provide more in the way of social services?

Mr. CONANT. First, I believe they do not provide enough attention to preventive medicine.

As I indicated, that we had an example just recently of a 66-year-old person that came in, for a complete physical, nothing wrong, and there is no way that Medicare will pick it up, and it cannot even go toward his deductible, unless you find something wrong for diagnosis, so this either leads toward somebody making up a diagnosis, it certainly does not allow for preventive medicine, and keeping these people out of hospitals, so we think that that needs to be a very definite part of any program.

Social services, I think that is another thing, or another part of your question, and I think if we can manage to continue the kinds of activities that are going on here, that we have made some strides toward meeting the needs of a lot of the senior citizens who need this kind of help.

Senator MUSKIE. It certainly is an impressive thing.

Have you established your standard fee schedule?

STANDARD FEE SCHEDULE

Mr. CONANT. We have a standard fee schedule which I think is in line with all of the other providers in the area.

We also have, of course, the contract with OEO for the prepaid plan which is at the rate of $50.61 per family per month to provide comprehensive care which includes inpatient, outpatient, drugs, glasses.

I think this compares with the Harvard Community Health Plan of Boston which is $68.

Senator MUSKIE. How many do you now have enrolled?

Mr. CONANT. We have around 2,800 individuals, 899 families.

We expect this to go to around 4,000 people who are eligible under our OEO guidelines.

We would like to see some form of national health insurance so that this was not dependent upon OEO funds, and was available to everyone regardless of income.

Now it is only available to the people living in west central Maine.

Senator MUSKIE. You now have eight physicians. Are these all newcomers?

Mr. CONANT. No, there were four that are here. We have four new ones, and we have two new ones that will join us this summer, a pediatrician and an internist, and we have had three family practitioners and a general practitioner, one other internist, two family practitioners and a general practitioner have joined us.

Senator MUSKIE. Was RHA instrumental in getting these doctors to come here?

Mr. CONANT. I am sure that they were.

In fact, we have had many other inquiries, and I think that this is the way that you can attract physicians to a rural area.

It does allow them, at least the new ones coming aboard tell us the things they like as having definitely someone they know to take care of their patients on their day off.

It does allow, for one thing, we require in contract at least 10 days to 2 weeks a year of further study, it allows them to keep up with what is going on, they do hospital rounds together, which I think has a lot to do with quality control, and we think it attracts the kind of physicians that we would like to see come into a rural area.

Senator MUSKIE. It may be a parochial question, but do they come from Maine originally, or from all parts of the country?

Mr. CONANT. Some from all parts. We have some from Pennsylvania, we have picked up one or two from Vermont, some from Maine. Some from all over.

Senator MUSKIE. As you know, I discussed this with you earlier, we have some nonscheduled witnesses who have slightly different views about RHA than you do, and I thought it was only fair if we could give them an opportunity to speak, so I understand that Dr. Roger Perron, a dentist from Livermore Falls, is here, prepared to make some comments on RHA, and he is accompanied by Mr. George Palmer.

I wonder if they would be willing to come up now and give us their views.

Please proceed, gentlemen.

STATEMENT OF DR. ROGER PERRON, LIVERMORE FALLS, MAINE

Dr. PERRON. I would have to admit facing you here is a little less frightening than it was 2 years ago.

First of all, we wanted to go ahead and possibly correct some misconceptions that have been alluded to here by the statements made by the representatives of RHA and other members of the panel.

Second, we do want to show concern for providing free choice for these individuals, especially these elderly persons.

Third, they have been rather successful individuals, and the fact that they are here shows that they have shown in the past an ability to take quite good care of themselves.

The physicians in the area wanted to go ahead and be sure that these people have free choice of physicians, and some of the practices that

have been encountered by not necessarily the physicians, but the employees of Rural Health, in a great many instances, are patients that have been going regularly, and have been satisfied with the care of their private physicians, have been urged to go to seek the care or have been recruited in the ranks of Rural Health where they had no other choice, but to take their care from them exclusively.

We also feel that there has been a threat to private enterprise here insofar as taxes which have been paid for by many of us practitioners, has been used to go ahead and buy equipment, and set themselves up, set these people up in business in such a way that by charging fees that are lower than many of us charge, they are able to still make more because of the tremendous reduction in overhead by not having to pay for their own equipment to begin with.

In other words, the Government has gone ahead and subsidized the business, and to come in direct competition with private practitioners who used their own funds to set up their practice.

In the past, when Rural Health came on, the usual and ordinary ethical thing for a physician to do or any group of physicians coming into an area is to go ahead and introduce themselves to those already in the area, to go ahead and make themselves known, make their objectives known, and it is a practice in such a way that they could be complementary to the services that are already available in the area, rather than coming on in, or suggesting that perhaps the care rendered has been below or subnormal.

The physicians, of which I am not one, I am a dentist, the physicians in the area want to go ahead and reassure you they have all been doing house calls, and are still doing so.

Now, they do urge that Medicare does not cover out-of-hospital prescription items, and I think this has been covered by others, so this should not be gone into.

The other factor I wanted to bring out, is that in any scheme of Federal health insurance which obviously is eventually going to be coming in, they recommend that rather than a fixed deductible amount being levied on all individuals, that those people with limited or with little resources, those with incomes below $3,000 should have a deductible of even $25 or nothing, in order to go ahead to be able to live with something and still be getting the health care that is coming to them.

Recruiting Medical Help

Now, concerning the ability of Rural Health Associates to recruit medical help for the area, we have found that private practitioners are able to do this themselves.

I myself have been successful in getting another young dentist to come and practice in the area.

This man is coming up from Pennsylvania, and he will be setting up a private practice of his own, however, using my own equipment, therefore, making use of facilities that are currently here and are not being used full time simply because they lay idle for 16, 18 hours a day when I am not in the office.

This is one of the methods that we have of getting additional dental and medical help in the area.

The dental and medical schools in the Boston area have satellite teaching programs which in the past 3 months I have become recognized as eligible to teach on the staff at the university, and function as a satellite teacher of theirs which will enable them to take senior dental students from the school and place them in our office, and they will be available to render care for indigent persons, persons of limited means, and those who are crippled that have other specific problems that cannot be treated, and these people would receive care at very nominal cost, or no cost at all to them as part of the teaching program of these schools.

I believe that probably Mr. Palmer and another gentleman who was here with him will be available to go ahead and speak further on this problem.

I have given you a statement by Dr. F. Ekinci, one of the physicians in the area who was not present in the community today, and he would like to have you read his views concerning the effects of rural health on the medical practitioners in the area.

Senator MUSKIE. His statement will be made a part of the record.

[The statement follows:]

STATEMENT OF F. EKINCI, M.D.

I totally reject the present program of RHA. because it is defective, the concept of values does not serve the purpose for which it was intended.

As you know, federal money was allocated to help the low income people who are residing in the remoted areas of West Central Maine, where doctors are not available.

The RHA group of doctors ignored the definition and purpose for this grant in favor of their personal benefits. Instead of opening clinics in so many localities and villages where no doctor is residing, they choose a malicious, profitable strategy by opening RHA clinics selectively in towns where physicians are already established in private practice.

The purpose of this distortion of the program are manyfold. The following are a few of them:

I. Destroying the private practice by claiming freedom of choice to the people.

II. To recruit people for themselves, instead of co-operating with the already established doctors, by discouraging the practicing private physician in this area, substituting them by nurses and medics, short circuit TV, two way radio, in order to secure shorter working hours and huge reward. There is no 24 hour, 7 days a week coverage of a physician as it is offered by the residing physician.

III. Instead of accepting honest competition (which is the basic requirement of the American Democratic system) with the other hard working, dedicated private doctors on equal terms, they are trying to destroy them with their own tax money, pretending that there is a crisis in medical care in those areas, for which they are so concerned to help low income people.

I attended several meetings in many towns in West Central Maine. I had the opportunity to observe with my own eyes, to hear, during the discussions of the RHA program the people demonstrated repeatedly that they are not thirsty at all for this kind of promise of the so called "elixir of life and good health" as it is offered by the director of the RHA.

Repeatedly and unanimously the people decided to reject the RHA program because they see clearly behind this false benevolent promise, the real motivation is the existence of personal interests.

Thank you for your interest of peoples problems.

Senator MUSKIE. Mr. Palmer, you may proceed.

STATEMENT OF GEORGE PALMER, PHILLIPS, MAINE

Mr. PALMER. Senator Muskie and ladies and gentlemen, I can only without going into it too much, to correct some of the statements that Mr. Conant has made, one of them has to do with house calls.

If they do, it is not an act they originally told us.

They said there would be absolutely no house calls, and if a person had acute appendicitis, he would get to the clinic the best way he possibly could, and once they are there, he would get to the hospital the best way he could also.

They were not concerned with how the feelings of the area were, or in the manner in which they wanted things set up for themselves.

As a result of this, the feeling of one physician anyway was this, that he wanted the right to practice medicine as he saw fit.

If his feeling for a patient was such that he was concerned with their health, then he wanted to follow it through instead of leaving it to somebody else, it just could not exist in an area where the RHA was, and he moved from the area.

Another one was harassed out of the area until Franklin County was left with only one physician.

The next move was here to the Livermore Falls area, and then he was gone, and I imagine there will be more.

It seems more they are trying to set up a monopoly in the medical field rather than to care for the aged.

In deference to the facilities that would give the aged a better medical delivery, I might say that the Social Security benefits that are received by the aged now are far less than they should be in accordance to the OEO guideline levels of antipoverty, of the minimum wage, and when you compare this as some of the speakers this afternoon said, a person receiving Social Security at $100 a month, OK, the money that has already been expended and given to RHA, if placed in a trust fund, would produce enough money in interest each year to take care of more than any 3 years would have produced so far in health care to the needy, the senior citizens, and others.

The feeling is if this money is given to RHA, if it is given to organizations that are more concerned with pocketing money themselves rather than with the care to the senior citizens, then it is wasted.

Certainly the senior citizens of the country have the capability of thinking for themselves, then I am sure this money could be used a great deal wiser, far more so than the setups they have today, and I have one more person that I wish you would allow to speak.

Please come on up.

Senator MUSKIE. You may proceed.

STATEMENT OF ROSWALD DYAR, FARMINGTON, MAINE

Mr. DYAR. I am Roswald Dyar, and I am chairman of the health citizens committee.

In my district, we had three physicians in the area plus an osteopath, and at the present time we have one doctor left.

In my position, I am receiving complaints from people complaining of the medical care there, it is not as good as the medical care they were getting in the past.

Our basic assumption is that RHA will provide more services to the people of the country, but the observations through the complaints I have received is it leaves a lot to be desired.

I think for the free enterprise system, that we have expended Federal revenues in the county, and utilized the funds well, and that the

people are working to bring in doctors into a free society, and that we can accomplish more in that way.

Now, the elderly are being helped to the extent that they are being looked at through screenings, but whether or not this is a RHA function, I would not know.

There are so many people that need the services of this type of thing, that are being overlooked that the far reaches of west upper Maine, it would be an almost overwhelming job to get all of these people in, but in a nutshell, the people that need these services are the people being overlooked.

Senator MUSKIE. Thank you very much, gentlemen.

Our next witness on the panel, Dr. Richard Chamberlin, member of the executive board of the Maine Medical Association.

STATEMENT OF DR. RICHARD CHAMBERLIN, MEMBER OF THE EXECUTIVE BOARD, MAINE MEDICAL ASSOCIATION, WATERVILLE, MAINE

Dr. CHAMBERLIN. Mr. Chairman, members of the committee, and guests. I am Richard T. Chamberlain, M.D., FACP, director of continuing medical education, and also director of continuing care, at Thayer Hospital in Waterville, Maine.

I am also currently the chairman of the committee on continuing medical education and of the peer review committee of the Maine Medical Association.

I address this committee as a representative of the Maine Medical Association, but I must add that my comments are not necessarily endorsed by every member of our association.

You have heard or will have heard about many barriers to health care for older Americans. Many of these are barriers that are shared by all Americans regardless of age; that is, lack of finances, fragmentation of services, lack of primary care or access to care, et cetera.

Using a fairly traditional physician's approach, I should like to try along with you to make a diagnosis.

Faced with the problem of barriers to health care for older Americans, one must ask why do these exist. To put it another way, why do the barriers or lack of access to care, lack of finances to pay for care, et cetera, exist in the first place? Is there a common denominator?

I feel these defects exist for a very basic and broadly stated reason; that is, lack of basic knowledge and understanding of the health needs of older Americans. You may tend to disagree with this statement because there is certainly a large body of knowledge about the problems of all Americans.

There is some documentation such as disease incidence, mortality rates, et cetera. But I am speaking of a more basic issue which applies to much of medicine, not just that of the elderly; that is, lack of knowledge and/or understanding of the natural history of disease.

A corollary to this is lack of understanding as to how individuals adapt to their disease.

Even allowing for the fact that the problem of natural history of disease is a difficult one to solve, what else can we say in a more pragmatic way about care of the aged in terms of this lack of understanding?

LACK OF TRAINING

Lack of training of all health professionals. Traditionally in medicine, one is taught in terms of specific disease entities.

While the care of the elderly also requires knowledge of specific diagnoses, one is really more concerned about the loss of the person's function in the community than one is with the scientific diagnosis per se.

The elderly person cares little about the fact that he has heart trouble for which he has to take pills and see his doctor periodically.

He cares when his heart trouble causes him so much shortness of breath that he cannot get to his senior citizen group or to the market. He eventually knows and comes to accept that his illness is chronic and not curable, but he does still want to function as well as possible in society.

Our whole medical care system, from basic training on through reimbursement mechanisms, including those of the Government, is keyed on the basis of finite diagnoses, not on the functional needs of the patient. I add parenthetically, I think this is where a lot of our problems come in.

We are forced to write down the diagnosis. Patients have problems that do not necessarily fit into any scientific diagnostic categories.

An instance of this is contained in a study entitled "Demonstration of Rehabilitation Potential of Patients on Home Care or in Nursing Homes—1959 to 1963" (demonstration grant No. 447 of Vocational Rehabilitation Administration, Department of Health, Education, and Welfare). This is on file with the Department of Health, Education, and Welfare.

Among other things, this study revealed that elderly patients in nursing homes desired three things. One, to hear. Two, to see. Three, to be able to chew food.

Translated, this meant that regardless of the specific diagnosis for which the elderly patient was admitted to the nursing home, the individual would have been happy if he could chew his food and enjoy it, thus being well nourished; see well enough to read, do sewing, or watch TV, thus being in touch with society; or hear what others were saying so that he could communicate.

Yet so many of our public assistance programs have not covered denture work, eyeglasses, and hearing aids.

You have heard some of the testimony today of how outreach workers and others have had to use all of their wills and ways to get around these barriers to helping people's needs.

The study also showed that a lot of people were in nursing homes only because there were not sufficient resources in the community to care for these patients at home.

I emphasize this study ended in 1963, and a lot of these things are now more readily available. Such resources as homemaker programs, and geriatric "baby sitters" are examples.

I believe these services would be available if we had been trained to understand the needs of the patients and the nature of the problem. I speak now of the medical profession.

It is difficult to prove, but it is entirely possible that many elderly patients that are now admitted to acute care facilities with symptoms

and signs of some obscure chronic disease, are in truth suffering from an element of depression due to the compromise of their functional ability rather than to their specific diagnoses.

This whole area of study is being covered better in some medical schools, and I call to your attention a book entitled "Continuing Care in a Community Hospital," written by Harold N. Willard, M.D., who is now in the department of medicine at Yale University School of Medicine, teaching the discipline of continuing care to student physicians in such a way as it may be more lasting in their own practices.

Loss of Regional Medical Program

Again, I should like to add to my formal statement, one of the losses, in relation to medical education in the State of Maine, is the regional medical program. Many ideas in this medical school (the proposed medical school for Maine) would have been quite innovative in terms of this kind of teaching about patient needs.

Finally, I should like to put the need to understand this basic problem into the perspective of the future. The medical profession is now charged with the responsibility to improve professional review of medical practice under the professional standards review organization requirement of Public Law 92–603. A vital part of that process is the adoption of standards of care in various categories of disease.

It is much easier to adopt the standard that an EKG is required for the diagnosis of a myocardial infarction (heart attack) than to adopt a standard that following a stroke, an 85-year-old lady should be able to dress herself with no assistance, transfer from bed to chair and back, and/or walk with a walker. We must take care in adopting standards and applying them that the functional needs of patients in a community are not omitted.

In summary, many of the barriers to health care for the elderly are similar to those of any age group. However, the problems of the elderly are complicated by a lack of understanding of the needs of the elderly in the context of traditional medical diagnosis and treatment.

Support of research into the natural history of disease and in the realm of continuing care at the medical school level is urgently needed.

Senator Muskie. Thank you, Dr. Chamberlin. It is practical and human commonsense to the problems we have been addressing.

Rehabilitation Potential

I have two questions, and I think our next witness and next group is getting a little restless about the drive home, so I will just ask a couple of questions, if I may. What more can be done in nursing homes in the way of restored medicine?

Dr. Chamberlin. This study I referred to revealed a lot of the patients evaluated did have a rehabilitation potential.

What can be done is the matter of going to the nursing homes, re-evaluating the patients, using some of the objective's functional scales which depict the losses, and then planning a sensible program to meet these losses, which then, of course, can be evaluated in an objective way.

This can be done; the study team that did this particular study simply formed itself into teams that visited nursing homes and re-

evaluated patients, making recommendations to whoever the primary care physician might be.

I think we would find in doing so, a lot of assistance in relieving the nursing home bed shortage, patients that are there, that do not need to be there.

Excess Hospital Beds

Senator Muskie. Do you have an excess of hospital beds in Waterville?

Dr. Chamberlin. It all depends on how you define them. I think we have an excess of acute care beds in Waterville.

I do not know if we have an excess of beds for people who need beds for various levels of care. Again, it is a matter of redefining the levels of care, and I forgot the point, but it is the right patient for the right bed at the right time. That is really our problem.

Senator Muskie. In Waterville, it is, of course, a medical center. Are you gaining the concepts of what you are doing there?

Dr. Chamberlin. I think they are making strides. There is now a Waterville Council of Hospitals, consisting of representatives of the three hospitals, and I think they are looking at the problems in a more realistic way than they have in the past.

I think that, for instance, one hospital gave up its obstetrical service and consolidated this; and, as I understand it, just recently an osteopathic physician has applied for and received privileges in obstetrics at one hospital where obstetrics is, so I think we are moving that way to allocate beds on a regional level. We have a long ways to go.

Senator Muskie. What is the Old Sisters Hospital being utilized for?

Dr. Chamberlin. This is now the Mount St. Joseph's Nursing Home. It is divided into two levels of care, intermediate care on one floor and boardinghome care on another floor.

I think they have a very active program there—for instance, in-house physical therapy and so forth—and I recall Dr. Brinkman's statement that nursing homes in many people's minds still denounce the end of the road; and places like Mount St. Joseph's, this is not true.

It is another step along the way toward recovery. I recently had several patients that went from our continuing care unit there to Mount St. Joseph's and then on to home, and we hope it is an appropriate time in the course of this problem.

Senator Muskie. So it is possible to turn that around?

Dr. Chamberlin. It is possible.

Medical Care Review

Senator Muskie. On the PSRO's that you have already mentioned, has the establishment of such organizations helped you meet the goals of yourselves as you have set for Maine?

Dr. Chamberlin. That is a difficult question, I believe. In my way of thinking, the review of medical care has to be done as close to the local level as possible, the hospital itself.

I do believe there has probably got to be a regional body above this to tie all of the hospital reviews together, and I hasten to add that traditional utilization review committees, although they have worked,

are not meeting the needs of what I understand the PSRO requirement would be, but using them as a basis and assisting them in improving their in-house review along some guidelines that can be developed in our State, that we might do this as a designated State area of PSRO's.

We have not heard the guidelines on that yet, but we hope that this will help; and in our case, the medical association has gone on record as being in favor of being that supervisory body rather than to turning this job over to somebody else.

Senator MUSKIE. How long have you been practicing in Waterville?

Dr. CHAMBERLIN. I have been practicing for 5 years, from 1962 to 1967, and then I worked at the hospital as a salaried physician with many responsibilities, the only clinical responsibility being in the field of what we call continuing care, and it is better known by many people as medical rehabilitation.

Senator MUSKIE. Is my impression accurate, that there are some refreshing winds of change blowing through the Maine Medical Association?

Dr. CHAMBERLIN. Very definitely. I think the association looks at itself very carefully; it did this a few years ago, changed its bylaws, elections are held in a more democratic fashion.

A lot of things that used to be the criticism of traditional organized medicine, that they just did not do anything and was against everything, that, I believe, we are getting away from this now.

Particularly in Maine, I think to a certain extent on the national level, the AMA has done some of these moves.

Senator MUSKIE. Can you do something effective about providing medical care in the sparsely settled areas?

Dr. CHAMBERLIN. This is again one of those difficult things. I believe a program such as the Rural Health Associates is one of the answers.

I also believe there is no single answer to all of these problems, and that one that is right for one area geographically, is not necessarily going to work for somebody else.

On the other hand, the kind of program I visited, the Rural Health Associates program, I believe they could do this kind of thing.

I would like to add in relation to the review of quality care, that for the first time, we have in the medical profession an opportunity to really measure objectively, quality care under a program such as this HMO type of program. The fact that you can define the population treated and do some really good statistical analysis, I know will allow for good quality measurements to be made.

In this area of trying to improve, the taxpayer's money has been well spent on a product that has some kind of measurement, some kind of quality control, it is something that we just have got to do, and have not done up to now, and this kind of a program must be done.

That makes that jump a little easier, and this again is what the PSRO requirements are, the basic philosophy, which I could not disagree with at all.

Senator MUSKIE. Thank you both very much.

Dr. CHAMBERLIN. Thank you.

Senator MUSKIE. Our last panel is the State Council of Older Persons, headed by Mr. Jack Libby.

STATEMENT OF JACK LIBBY, STATE COUNCIL OF OLDER PERSONS, BREWER, MAINE

Mr. LIBBY. I must say you have a lot of stamina, Senator, and so do these great folks right out here.

If it were not for these folks here, I would suggest we leave our testimony with you and depart for home, but I know this would not be fair.

Up to now you have heard from people who are agency people, people who work for these services for the elderly for a living.

Now you are looking at some of us who are retired and doing it from a different viewpoint, I guess, you might say.

We have become involved and just cannot find a way to get out of it.

I do have a prepared statement here that I will try to get through quickly, and I know some of our other people here feel the same way.

Sometime, somewhere, somehow, someone will solve the problems we have today relative to the aging.

Some of these problems of course we have created ourselves. Forty and 50 years ago we did not have hundreds and thousands of people working toward the goal which seems to be what we have set to meet.

Those of us who are old enough to be considered senior citizens know that when we no longer were the responsibility of our parents, our parents soon became our responsibility.

This was standard and despite the fact that today this would be considered a hardship on the young family, we knew no other way and lived accordingly.

Then in 1937 laws had been passed and put into effect which gave many retired people an income. If it wasn't much, it was something.

Industry, business, and labor began setting up pension funds and soon some old people were in better shape than they had ever dreamed of.

But at present, this group is very much in the minority. Let us hope their numbers grow as time goes on.

Thousands of senior citizens in our State are just not living as wholesome a life as our parents did when we took care of them.

Some say that now they are independent. But many of them are sick and hungry and would be much better off if they were dependent with full stomachs.

Our theory is fine. For some people everything is lovely. We two old Libbys never had it so good. We live in one of the oldest houses in the city which has been ours for many years, we drive a car and have a colored television which was a gift.

"ROADBLOCK TO HAPPINESS"

I say we never had it so good but this could change so suddenly. We have never yet had to buy medicine. If or when we ever do, we will be like so many people I know very personally, because of this program.

This buying medicine or prescription drugs is the roadblock to happiness for too many people. Their income, although adequate to keep them afloat while they are well and able to live without drugs, seems to evaporate so quickly when they start doing business with a pharmacist.

Recently a bill was to come up for hearing in a committee of our State legislature relative to advertising the price of prescriptions.

A friend of mine who is proprietor of our locally owned pharmacy called me to tell me that he was very much opposed to it and wanted to know if I would be attending the hearing and how did I stand.

Of course my answer was that I stood for whatever was best for the consumer and if the passing of this bill would help, then I was for it.

But getting down to commonsense, how can a layman like myself know any of these answers. It has to be trial and error. We have no qualifications that might help us in our endeavor to help make life better for our needy elderly.

Someone asked us to join the crusade and we became involved. And how we became involved. We have had difficulty taking care of ourselves and our families all our life and suddenly we find ourselves up to our neck in other people's affairs.

But how about a politician? He becomes a candidate for public office without having any qualification for the job, only that he wants to serve and the voters elected him.

He learns while serving and sometimes that is difficult and costly. This is happening in our program. It has been proved, I am sure, that the cost of implementing and operating some of our programs has gone way overboard.

In December, when the bridge went out and some people suddenly realized that funds were no longer available, I got many calls, because of my office as president of the State council, telling me that so many people were to lose their jobs and wasn't there something that I could suggest in an effort to save these jobs.

Not once did someone call to tell me that some old person would be going without because of the cutbacks. Strange, isn't it?

Several weeks ago when I visited for a short while with Mr. Oriol, as we talked about health care, I mentioned that we have in our area a commodity food program. Why not a commodity drug or medicine program?

Preposterous? Maybe, but I will go for anything because we are in this and the cause is so real that we cannot get out without a solution.

It is not my problem, it is not your problem. It is our problem. Local, State or Federal, what difference does it make to the recipient of the assistance.

When we were in school we were given assignments that we were sure just did not make sense, but always whether or not we came up with the proper answer, there was an answer.

The same goes for what we are faced with today.

There has to be a proper answer and for the sake of every citizen now and in the future, we have to come up with it because the minute we are born we start to age.

President Johnson used the phrase, let us reason together.

Or, if we could only try a little harder in our State house and in our Congress to do this, our load would be lighter, our road would be straighter and the hopes and dreams of those in need might come true.

Many services, of course, are related to health, and some of my colleagues are here with me to tell you of our problems with these services.

First, I am going to call on one of our board of directors, the Reverend Arthur Durbin of Waterville, who has been with us ever since we formed our group 3 years ago.

Mr. DURBIN. Senator, I am a minister, and I hate to have a short text, but it is going to be.

A few years ago, after studying the program in Waterville, we established luncheon programs, which you know about, and we are going to talk for just a few minutes, as chairman of the Waterville Housing Authority, we looked around after having been given an assignment of what greater service we could render.

HOUSING UNITS WITHIN SENIOR CENTER

We went to the hospitals and asked if we would suggest a program, if they would support it, and this is the program we came up with before applying for another hundred units for only housing in the Waterville area.

We felt that the hospitals were overcrowded, and there were people in the hospitals who could be relieved from the hospital, and that we could make room for those who were sick.

The hospitals told us there were persons in there who could go home if they had a home to go to.

They could not go home and stay alone, and many of them were in homes where they were living alone, so this is the proposition we came up with, if they, if we should apply to HUD, and we have applied to HUD for another hundred units of housing for elderly in the Waterville area, the first floor would be used for senior center activities that have been talked about here which we carry on now, the nutrition program, and also Meals-on-Wheels program, which would cover the whole area.

The second floor would be assigned to patients from the hospital who could be discharged from the hospital, but were not ready to go home.

Either they were not permitted to go home, or there was no home to take care of them, and so we would develop a program for rehabilitation on the second floor, probably a dozen or more apartments would be equipped, so they would take care of themselves, and for a limited period, probably 2 or 3 months, if necessary, and then the social workers or their families would make arrangements for them to go home, and then the rest of the building would be used for the regular elderly housing units that we have now.

With the cooperation of the city of Waterville, we have fine cooperation between the city government and the housing authority at the present time.

We did not always do it, but we have at the present time, and also the hospital council, they are 100 percent behind it, you make the application, we will do the cooperation, and we will get this thing on the road.

We went to Manchester the 2d or 3d of January, they approved the program, although it has never been done, there is no reason why it cannot be done in Maine.

We feel things can be done in Maine that cannot be done any place else, so we made the application.

It was approved, and then a few days later, the housing was frozen, but at the present time we have the approval of HUD, our plans are all in, and although it is a new plan, they are willing to go along with it and try it out.

We feel this is a good program, and we in the Waterville area will be benefited, also the people of the State might have an example of this kind of cooperation between the hospital, the housing authority, and the city itself.

Thank you very much.

Senator MUSKIE. Thank you very much.

Mr. LIBBY. Now, I would like to have you hear from our secretary and treasurer, who is a retired school teacher, and she is just about to travel in Europe next week, so we are pleased to have been associated with her for the past 3 years, Mrs. June Perkins, of Springdale.

STATEMENT OF JUNE PERKINS, SPRINGDALE, MAINE

Mrs. PERKINS. I am going to be very brief and submit two ideas which I do not think have been touched upon in today's hearing.

One of them is an idea which I suggested at the housing conference in November, which was the training of live-in help.

We touched on the very low income, we have touched on the poverty level, we still have a group of elderly who are above both those levels, who have the same reluctance to being institutionalized, who could stay in their own homes, and could afford to pay somebody to come in and stay with them if we could find the people to do it.

I am a full-time volunteer working with the elderly, so I get many, many calls, "Can you find somebody to stay with my aged mother, or my aged father?"

Children living in another part of the country, their parents want to stay in the family home. They range in age perhaps from 75 to 90. They are mobile, they are very active mentally, but they just cannot cope with the physical exertion of getting meals, for instance.

I have very close contact with an 80-year-old woman who could get her own dinner, but then was too tired to eat it, so as a result, they go to tea and toast and preserves, and the first thing we know they are malnourished, and they are in a hospital or nursing home.

I think we would be able to recruit people for this sort of service if we could put it onto a real status level.

I would like to suggest perhaps a short training course of 2 months or 3 months in which they would be given some elementary psychology, of the aging, to prepare them to live with a person, who would have some training in elementary nutrition, who would have enough training in health so she would recognize when it was time to call on a physician for the person that they were living with, and I had even gone so far as to talk with the local concentrated employment program in Sanford to see if we could set up such a training course.

They were very receptive, and then the funds were frozen, so I am still working on the idea.

I think it has a great deal of merit, and is something for all to consider for this special segment of the elderly that we often forget.

This would work in the same way as preventive medicine. I know that we are running into difficulties on the doctors, on the system of clinics, and we know that we have decided it is much more favorable to have the health screening clinics, and we know that these centers could be established in a good many of the rural areas in Maine, and that one of the goals is to reach people in the rural areas, and we are hopeful that we might have a project for health screening within our organization, and that we can help people.

In Sanford we have an immunization program where they are given booster shots and initial shots.

Health Screening Clinics

We have held five clinics, and of these 75 percent have been referred to the Northeast Hearing Clinic in Portland for further help.

Senator, this is a cooperative effort between Community Health Associates and the Trafton Senior Center.

Small fees are charged, for example, of $1.50 for blood pressure, and $1.75 for flu shots.

The local doctors are cooperating with us, some receiving only $10 for services.

The blood pressure clinics are conducted by two of the nurses of the Community Health Association, and we do have referrals to the Sanford physicians.

There is a need for just a small amount of funds to buy small pieces of equipment, that is, a cot for glaucoma examination.

Some of the clinics do not pay their way, and the tab has been picked up by Community Health.

However, this association operates on a very restricted budget and cannot indefinitely pick up these deficits.

The approximate figures on attendance at the Well-Aging Clinic are as follows:

The flu immunization program serves 100.

The blood pressure clinic, once a month, 50.

The hearing clinic 6 to 8 at each of 5 clinics for a total of 40.

The blood sugar test reaches 65.

The glaucoma clinic reaches 65.

The heart program reaches 120, and the Pap clinic for cancer reaches 125.

Of the referrals, 33 percent examined for blood pressure were referred to personal physicians.

Seventy-five percent of the hearing examinations were referred to the North East Hearing Clinic.

Ten percent examined for blood sugar, two diabetics were discovered.

Four suspected cases were found for glaucoma, and on further examination, two were negative, one borderline and one actual.

We would like to include a SSMA 12, blood test.

What we have is a grassroots organization, and it will go on no matter what happens to the Federal funds.

Senator Muskie. Thank you. That is reassuring.

Mr. LIBBY. Sitting besides me is Harold Collins who was up here once before, and I blame him somewhat for us being so late.

He told me that we would be out of here by 4 or 4:30.

Sitting right down here in the front row are a couple of our directors, and I have just asked the young lady here to take a picture, and I am sure she has.

Now, to show you that we are not old people, we have younger people working with us, and serving on our board. I would like to introduce the chairman of our business committee, Rev. Gerald Kinney, director of the Methodist Home for the Aged in Rockville.

STATEMENT OF REV. GERALD KINNEY, ROCKVILLE, MAINE

Reverend KINNEY. Senator Muskie, guests, I am not going to read what I had prepared. I do want to make two or three points that I think have been touched on in a number of presentations today, but I do not think they have been said quite in the way for me to make sense to talk about them.

AVERSION TO NURSING HOMES

We have heard it mentioned that people as they get older hesitate to allow their doctor or their family to suggest nursing homes.

The same reluctance is also present when you talk about homes for the aged, if the older person has a concept, and I suggest that the major reason we run into these kinds of problems is the lack of privacy, and the lack of self-determination, and the minute details, the decisions that make up one's lifestyle.

I suggest, and this comes out of our experience in housing for the elderly, that management does not have to control a person's life to the degree that is often the case, whether it be housing, boarding home, or even nursing home.

This is usually done at the expense of the individual's right to privacy, his right to self-determination, and I do not see the conflict here between good medical practice, and recognizing the person's individual rights, and I am suggesting that one area that might have to be explored more extensively than it has at this point in terms of the way in which we render services to people, whether this be institutionalized or home delivered, is from perspective of what we are saying to that person, are that we can identify a problem you have here, it is where day schedules are set, where you can have visitors at times, where you cannot have a private room, where you can say this is mine, I want this time for me.

I see it happening in far more subtle ways in a lot of housing where social services are provided, and in a lot of service agencies where the agency becomes involved in trying to justify its existence by how many people it has coming back, and so there is a creation of a dependence complex, and I suggest that while all of these things are necessary, which we have heard it today, and my paper touches on housing as a provider of ways to keep people out of boarding homes and nursing homes, that we need to look at management as an entity that has not yet been thoroughly examined, from the perspective of what is management's prime function, and is it their aim to keep the

organization going, or is it there to serve the people for whom the services are rendered.

I just raise this as a question that your committee might want to delineate a little further.

If I can help in any way in the future, I would be most happy.

Thank you.

Senator MUSKIE. Thank you very much.

Mr. LIBBY. All of us on the board of SCOOP are connected in some other way with the senior citizens program.

The gentleman on my right has been my traveling companion for 4 years, he lives just 8 miles above me in the town of Waterville.

He is a retired engineer, and is still a consultant engineer.

We six in a row here were delegates to the White House Conference on Aging, and previous to leaving for the conference, the delegates met and elected this gentleman on my right as Maine's outstanding senior citizen.

I was never so proud in my life, we went to Washington, we roomed together, and I am telling you, we are pretty close.

We do not always agree, in fact we disagree sometimes, but I hope we are always friends, and that we will be together and working on this program.

I would like to introduce to you now one of my best friends, the vice president of SCOOP, Mr. Floyd Scammon.

STATEMENT OF FLOYD SCAMMON, VICE PRESIDENT OF SCOOP, BREWER, MAINE

Mr. SCAMMON. Thank you, Jack.

Senator Muskie, I wrote this little piece last night after I found out that I was going to be picked to say a few words, and I know these good people out here, that their minds can absorb only so much, so I will be brief.

I will speak on the greatest needs of older people.

First is transportation, particularly in the rural areas.

Whatever other services are provided they are worthless unless the people who need them can get to them.

The problem is there whether the old person who lives in the rural areas has money enough to live on or not.

Many older people, particularly widows, have never driven a car and many more have lost their right to drive because of age or infirmity.

And, as I said at the first Blaine House conference, if the State has the right to take away a person's right to drive a car, and it has, then the State should assume a responsibility to that person for their transportation needs for essential services.

Transportation should be provided, as needed, for essential services and those able to pay a reasonable fare should be allowed to do so.

In the urban areas a transportation system to supply the needs of the old and the feeble should be established using the present taxi service, where available, by some form of coupon or credit card system which would allow those selected by a careful survey to have free or subsidized transportation on a limited scale.

It is said that solitary confinement is the most vicious form of punishment. Too many of our older people are victims of solitary confinement in their own homes.

High Cost of Drugs

Second, some solution to the problem of the high cost of necessary and unnecessary medicines and drugs.

Many older people, who have less than enough income on which to exist at the lowest possible level, are paying a large percentage of their income for the drugs which they believe are necessary to keep them alive.

Here we need two things. First, clinics which will help them to better health with fewer drugs, and, second, help for those who must have expensive medicines by local, State or Federal supplemnt to their meager income.

Third, whatever is necessary to allow them to stay in their own homes as long as possible.

Four things come to mind:

First, enough homemakers to supply the needs of all those who must have a little help because of illness, handicaps, or recent hospitalization.

Enough is being done now to furnish all the information necessary for the expansion of the homemaker program.

Second, a property tax relief program which will prevent any old person from having to sell, give up or abandon their home, against their will, because of property taxes.

Third, some program which will assist an old person to make necessary repairs to the place where they live in order that they may be able to stay there as long as they wish and are able, with the other help outlined above.

Fourth, provide some recreation and fellowship with friends.

Because we believe strongly that we should try to improve the quality of living of all our senior citizens, and because we are sure that loneliness seriously lowers the quality of living of any one affected, regardless of income, home or health, we urge the formation of senior citizens clubs in every area where a few can be assembled.

The experience which we have had in eastern Maine shows that such clubs may expect to receive help from local governments, and if a small amount of money is available to subsidize a few bus trips and/or rallys and picnics, much can be done at a very small cost per person.

The Senior Citizens Council of Greater Bangor is now servicing 52 such clubs in a five-county area and more are being sponsored all the time.

This involves information, referral and outreach, with which the council is much involved.

In summary, I guess what I am saying is that we need a multiservice project in every area.

I would like to quote just a word from William A. Nolan, M.D., a noted surgeon and author of a best seller, when he said why in the world does the public spend $5.2 billion a year on prescription drugs and another $2.2 billion a year on nonprescription drugs when they do not need half or two-thirds of what they are buying?

For every patient who spends $110 for an antibiotic that is necessary for a cure, two patients spend $20 for antibiotics to cure infections which they have not got.

He asks, why do so many of us throw away so much money?

That is sort of a summary of this meeting, Senator. I thank you very much.

Mr. LIBBY. Are there any questions, Senator?

Senator MUSKIE. Well, I do not think you leave me many questions.

I think you have covered the ground. With all respect to the rest of you, I think Mr. Scammon really wound up with my closing statement.

Mr. LIBBY. That is right.

Now, I would like to close this program by telling something to the audience relative to Senator Muskie.

Nineteen years ago I met Senator Muskie for the first and only time. He was then as you remember, in 1954, a candidate for Governor, and and Everett Mittle, whom you know real well, brought him to my office at the mill, and said, "Jack, I want you to meet Ed Muskie, who is a candidate for Governor," and I said, "For Governor?"

Well, he said, "Mr. Libby, don't you think I have any chance?"

I said, "About as much chance as the snowball on a hot stove. We reelect our Governors."

Now, of course there were a lot of things happening in Augusta that I knew nothing about at that time, or I never would have made that statement, but you see what has happened in the interim.

He was elected Governor, from there to the U.S. Senate, and today, I think we are very lucky to be sitting here and chatting with him as we are in our State.

[Applause.]

This I have said to you, because I have never forgotten it.

Of course, he would not remember such a thing as that; however, again, on behalf of SCOOP, thank you very much.

Senator MUSKIE. Thank you very much, Jack.

You know, the reporter really is the fellow who has been working hard all afternoon, because he has had to take down every word that we have been saying. I do not think we have used any excess words as far as I am concerned. I was amazed that 4 hours had passed. I have enjoyed this afternoon, I have been enlightened by it, and more than that, I feel at home, so it has been a good afternoon, and I want to thank all of you who have been here, and especially those of you who managed to stay until the end.

Thank you very much.

[Whereupon, the hearing was adjourned at 5:45 p.m.]

APPENDIXES

Appendix 1

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM MAINE'S REGIONAL MEDICAL PROGRAM, AUGUSTA, MAINE, TO SENATOR MUSKIE, APRIL 18, 1973

DEAR SENATOR: Enclosed is the limited information which we have been able to assemble in response to your letter of April 11. I am sorry that we do not have more detailed statistics about problems of the aged but our approach has been to determine health problems and seek health service delivery solutions for the entire population as opposed to age specific solutions.

"1. What RMP studies indicate about age distribution in rural areas of the State and consequent health care needs. Do certain areas of the State have high proportions of elderly residents, and what consequences does this have in terms of medical resource utilization?"

A. Maine has a very high percentage of elderly people, 11.3 percent of the population being over 65 years old, as compared to 9.4 percent nationally. Over 50 percent of them live in rural areas. The elderly frequently are also poor; more than one-half have annual incomes of less than $3,000. The rural poor are faced with three major problems in obtaining health care:

(a) Few available doctors (the physician/population ratio in Waldo County is 1/1,944).
(b) Lack of transportation.
(c) Inability to pay for services.

Surveys also show that low-income people have proportionately higher rates of illness and lower rates of hospital and physician visits than people in a higher socio-economic bracket. A higher than normal incidence of heart disease is reported as well.

Some Maine statistics:

Deaths from "diseases of the heart" (1967):
United States, 364.5 per 100,000 population.
Maine, 472.5 per 100,000 population.
Washington County, 594.2 per 100,000 population.

Deaths among people over 65, most common causes:
Heart disease, 47.8 percent (of all deaths, 1969).
Cancer 14.6 percent.
Cerebrovascular disease, 11.7 percent.
Respiratory disease, 6.0 percent.

The medical resources avaailable to those in rural areas consist primarily of individual physicians and small community hospitals. Several home health and public health nursing agencies provide home care for the elderly. Several physicians have indicated poor nutrition and chronically disabling conditions are prevalent health problems among the rural aged.

"2. What do your studies indicate about transportation inadequacies in regard to health needs of the elderly?"

A. Because they live in primarily nonurban areas, the elderly must frequently travel a long way to see a doctor. Thirty-nine percent of the people surveyed in the Hancock-Washington County coastal region had to travel more than 15 miles to get to a doctor, and 87 percent of Jackman residents reported they must go over 35 miles to see a dentist. Consequently, transportation is a big factor in seeking health care in rural areas. In a survey done among surplus food recipients in the Cumberland-Sagadahoc County region, 48 percent of the people

said that they had problems seeing a physician, and 75 percent of these quoted "lack of transportation" as the reason. "Inability to pay" affected only 39 percent of the respondents. This particular area has an over-65 population which comprises 22 percent of the total population.

"3. *Does your family practice residency program have special importance to the elderly?*"

A. The aim of the family practice residency program is to prepare young doctors for and encourage them to practice in the rural areas of the State. Improving the availability of physician care in these areas will upgrade the level of care that the elderly are receiving, since lack of adequate physician manpower is one of the features of the rural community that contributes to crowded schedules and infrequent physician visits. Redistribution of physicians will shorten the distance rural people must travel to see a physician. In connection with the residency program, a model practice clinic will be established in Augusta. Residents will be trained to use new types of allied health personnel and new technologies. (Family nurse associates are not being trained to assist physicians in the care of adults. For example, FNA's work in Rangeley, Rumford, and in the island community of Stonington where an FNA-run clinic is connected to Blue Hill Memorial Hospital by closed circuit TV. An FNA also works in the Park-Danforth home for the elderly in Portland. FNA's have special training in care of elderly patients and are geared toward mobilizing and integrating other health resources in behalf of their patients. Learning to utilize FNA's and other assistants will be an integral part of the resident's training.)

"*4. What do your studies indicate about the adequacy of information among elderly in regard to health programs meant to serve them?*"

A. We have very little information about the adequacy of information the elderly have about health resources. Fifty to fifty-six percent of all the people we have surveyed felt that general health services in their area were either not available or were inadequate to meet their needs. People were questioned specifically about facilities for the treatment of heart disease, cancer, and stroke; approximately 50 percent felt that resources for these conditions were inadequate. In Jackman, only one-third of those surveyed knew where to find nursing home facilities that could handle problems in these three conditions. Forty percent of Jackman residents are over 55. Eighty-seven percent of the Indian population indicated that they would like to help to find out how their families could receive additional health services.

The following reports of our surveys and other statistical references were used in framing these answers to your questions:

Bolaria, Bhopinder, Health Care, Health and Illness Behavior: Study of a Rural Community (Jackman), July 1971.

Bolaria, Bhopinder. Health Care, Health and Illness Behavior of American Indians in the State of Maine, February 1971.

Bolaria Bhopinder, Health Care, Health and Illness Behavior of Low-Income Families in the State of Maine, January 1971.

Bolaria, Bhopinder, Social Correlates of the Utilization of Selected Health-Care Services: A Study of Fifteen Communities, August 1970.

Bolaria, Bhopinder, Availability, Accessibility, and Utilization of Selected Medical Services: A Study of Fifteen Rural Communities in Maine (Some Preliminary Findings), January 1970.

Pocket Data Book, An Economic Analysis of Maine; Department of Economic Development, 1970.

Maine Vital Statistics, 1969, State of Maine, Department of Health and Welfare, Office of Vital Statistics.

I hope this information is helpful to you at your hearing.

Very truly yours,

MANU CHATTERJEE,
Program Coordinator.

ITEM 2. LETTER FROM RURAL HEALTH ASSOCIATES, FARMINGTON, MAINE, TO SENATOR MUSKIE, MAY 15, 1973

DEAR SENATOR MUSKIE: Thank you for the advanced copy of the hearing testimony given at Livermore Falls. I made a few changes which I would appreciate being included in the final draft.

The following may more clearly express our concerns for changes in legislation affecting health care. We at Rural Health Associates feel very strongly that

HMO's offer an opportunity to stabilize the cost of medical services. By purchasing services on a prepaid plan the incentives of keeping a patient well shifts to the providers. Today's fee-for-service approach only rewards them for giving services to the patient. The experience of existing HMO's point out many advantages such as savings on hospitalization and emphasis on preventive practices and education.

If HMO's are to be developed and function properly in rural areas, at least three things have to happen at the federal level:

(1) Permitting legislation which allows for their development and overrides State insurance regulations that prohibit their establishment.

(2) Some funds to provide for planning and startup costs need to be provided. This is a major undertaking and cannot be funded locally in rural areas.

(3) A reinsurance or catastrophe illness plan needs to be established so that all HMO's who wish can join to pool their risks. Rural plans have a hard time developing enrollment enough to accept all of the risks. This should not be expensive on a national scale.

If the above legislation could pass, then the costs of health care to Medicare and Medicaid could be stabilized. A fee-for-service approach such as Medicare encourages over-utilization on the part of some patients and providers. It does not stimulate the development of preventive programs to keep the elderly well or out of hospitals. Medicare's review mechanisms will not accomplish this and only places hardships on the patient and hospitals when they refuse to pay for over-utilization of services.

A more uniform Medicaid program would assist us in Maine. There are many elderly who should be receiving more support for health care than they do now. The near poor are not included and they have to accept Old Age Assistance in order to qualify for Medicaid. This could be changed by a more uniform program, nationwide, that provides for more than categorical assistance recipients.

This may not be adequate but tries to express some of the need for programs to assist the elderly in our area.

Thank you for your interest and if I can be of further assistance, please feel free to contact me.

Sincerely,

CLINTON A. CONANT,
Executive Director.

ITEM 3. LETTER AND ENCLOSURE FROM ANDROSCOGGIN HOME HEALTH SERVICES, INC., AUBURN, MAINE, TO SENATOR MUSKIE, MAY 15, 1973*

DEAR SENATOR MUSKIE: Following the hearings of your subcommittee held at Livermore Falls on April 23, our staff did a analysis of Medicare-eligible patients in our home care program between November 1, 1972, and March 31, 1973. This study, a copy of which is attached, was accomplished under the direction of our staff nurse educator, Mary M. Kennedy.

The data in this report clearly shows that Medicare denies reimbursement for a significant portion of services delivered by this agency. We do not question the necessity for the exercise of reasonable controls by the Social Security Administration and its designated fiscal intermediary. We do question the extent to which payment limitations and complete disallowances have been made in cases in which we and the attending physician have defined a need for skilled nursing care.

In your May 4 letter to me you requested comments relative to present financial pressures on home health agencies, and suggestions as to how Federal legislation might encourage greater use of home health resources.

With respect to the first issue, I think it goes without saying that financial pressures on home health agencies are presently at an unprecedented level. This has resulted from a variety of factors including the continuation of tough wage/price controls on the health care industry, the provision in Public Law 92–603 whereby home health agencies will now be paid the lesser of charges or costs, the restrictive reimbursement practices of title XVIII, and the overall damaging effects of rampant inflation.

I'm certain that all of us in the home health care field share an interest in containing costs. However, we must compete in the open marketplace for necessary supplies, equipment, and, to an extent, personnel. A recent survey

*See statement, p. 220.

done, I believe, by the National Association of Home Health Agencies indicates that unless controls are eased, many home health agencies in the United States will be forced to cease operations. While this agency does not face an immediate threat of annihilation, continued excessive controls plus any further restrictive measures by Medicare and/or Medicaid would certainly place us in jeopardy. The National League for Nursing and other national organizations have presented the dimensions of the crisis and suggested remedies to our congressional leaders. We can only hope that the phase III guidelines, soon to be promulgated by the Cost of Living Council upon the advice of the Health Industry Wage and Salary Committee, will be as reasonable as possible.

How could Federal legislation serve to encourage greater use of home health resources? Perhaps the greatest boon to home health services would be implementation of a national health policy which puts a premium on home health care. It is well known that the home health services provision was more or less an eleventh-hour inclusion in the Medicare package. For years health insurance in this country has been crisis oriented, rewarding people for being sick rather than well, and encouraging, rather than discouraging, hospitalization. Medicare is no exception.

The original intent of Medicare was to foster the progressive health care concept. Today Medicare resources are disproportionately directed toward hospitals; extended care and home care have realized declining rather than increasing emphasis.

Development of the HMO concept can improve the lot of home health services provided that inherent in it is a requirement for comprehensive home care programs. Most likely this requirement will have to be legislatively mandated.

Inclusion of homemaker services as a Medicare would be a constructive measure. Not infrequently the provision of a few hours per week of homemaker service can enable an old person or couple to stay out of a nursing or boarding home.

Reinstatement of manpower training funds for both professional and paraprofessionals would strengthen home care, particularly in rural areas where trained manpower is in short supply. Professionals, physicians in particular, need to be taught to use allied programs, and conversely, these programs must be widely available to physicians once in the field.

New legislation of various types can foster the development of home health services, but much can be done in the meantime. For example, concerted and coordinated efforts by third party payors, public and private, could further reduce unnecessary stays in hospitals and nursing homes. More appropriate use of these components of the system, plus better insurance coverage of drugs and out-patient services will result in more appropriate utilization of home health services.

Speaking of manpower training and the overall development of home health resources, I think it is germane to mention a project we are presently involved with. Under a three-way contract between Maine's RMP, the Veteran's Administration facility at Togus and ourselves, we have implemented an educational effort entitled the "team nursing project." The broad goal is to develop comprehensive home care services in this three-county region through the medium of staff reorganization into five semiautonomous, multidisciplinary teams. The key person is a nursing educator, employed by the VA and assigned to this agency.

While the project has only been underway since last November, it has already had a positive impact in a number of identifiable ways: (1) Agency staff, many of whom have come to us with no training and/or experience in community health service, are participating in well organized and regular training sessions; (2) there has been an increased use of paraprofessional staff with more additions contemplated for the near future; (3) close ties with the VA hospital at Togus are being cemented and VA staff are demonstrating increased interest in, and commitment to the expanded use of community health services in behalf of veterans; and (4) the presence of a well qualified nursing leader has facilitated an upswing in our coordinative and cooperative relationships with other area health providers.

We believe this project, unique in terms of VA participation, represents a means through which two distinctly different service systems and a medical development program can join forces to meet the institutional needs of the VA and the education and manpower needs of a community health services agency.

Thank you for this opportunity to share information and express some not-so-original thoughts on the subject of home care. I know that all of us laboring in the vineyards look to the leadership which the special committee can, and I'm confident will provide in helping to shape national health policy.

Sincerely yours,

RICHARD H. HOOPER,
Executive Director.

[Enclosure]

THE ANDROSCOGGIN HOME HEALTH SERVICES' EXPERIENCE WITH MEDICARE, NOVEMBER 1, 1972–MARCH 31, 1973, BY MARY M. KENNEDY, R.N., M.S.

The majority of our elderly are of the mistaken opinion that when they become enrolled in Medicare and pay the deductible, they are eligible for services prescribed by their physicians. A review of 231 patients 65 and over who received services from this agency between November 1, 1972 and March 31, 1973 clearly demonstrates the fallacy of this assumption. While this constitutes a limited sampling of our total care rendered during this period, it portrays the extent to which Medicare fails to pay for necessary services.

As shown in figure 1, our basic problem has not been outright disallowances, but the high incidence of limited coverage. For example, diabetics are typically allowed six paid visits to teach testing of the urine, sterilizaton of equipment, measurement and injection of insulin, and preparation of a diet. In some instances six visits are adequate to accomplish these teachings. In other cases it is not.

FIGURE 1.—NUMBER OF MEDICARE BENEFICIARIES, THE PERCENT AND THE NUMBER OF HOME VISITS MADE ON ACTIVE CASES COVERED AND NOT COVERED BY MEDICARE FROM NOVEMBER 1, 1972 THROUGH MARCH 31, 1973, AT THE ANDROSCOGGIN HOME HEALTH SERVICES, INC.

	Number of patients	Percent of patients	Home visits paid by Medicare	Home visits not paid by Medicare
Paid in full	94	41	1,885	
Disallowed	25	11		173
Partial payments	109	48	2,899	3,249
Total	228	100	4,784	3,422

The 3,422 home visits made for nursing services and not covered by Medicare represents 42 percent of services provided to Medicare beneficiaries. These were financed as follows:

FIGURE 2.—PAYMENT MECHANISM FOR HOME VISITS MADE AND NOT PAID BY MEDICARE

Financial mechanism	Percent	Number of visits
Project independence	58	1,981
Medicaid	38	1,298
Other	4	143
Total	100	3,422

Needless to say, without Project Independence and Medicaid, the Androscoggin Home Health Services would be unable to provide services to a large portion of its clientele.

We believe that Medicare and other third parties should not indiscriminately pay for services, that some denials are inevitable and justifiable. With this as a basic premise, we reviewed all cases in the sample grouping which experienced either limitations or flat denials. From the review we selected two cases which we believe to be fairly representative of those which received partial support.

CASE NO. 1

A 71-year-old man with metastatic cancer (gall bladder) living with his 74-year-old wife (retired teacher) was being maintained at home with the nurse vis-

iting three times a week. The nursing short and long range goals were: Increase physical comfort and support patient and wife through trying time—help them adjust and accept impending death. The nursing actions were as follows:

1. Assess physical deterioration and report to M.D.
2. Take vital signs T.P.R. B/P and interpret finding and variations.
3. Assess gastric involvement and advise diet.
4. Maintain bowel function as indicated.
5. Irrigate urinary catheter 3X week.
6. Assess severity of pain, maintain medication above pain threshold as ordered by M.D.
7. Maintain fluid intake—prevent dehydration.
8. Maintain oral hygiene—teeth and mouth care.
9. Skin care—teach wife to care for broken skin area (decubiti) by turning, getting out of bed, keeping clean and dry. Apply maalox and sheepskin.
10. Teach use of walker, support and transfer techniques, prevent patient falling.
11. Maintain range-of-motion exercise.
12. Prepare for death—patient not told his diagnosis. With doctor and family permission allow patient to express his feelings—patient becoming aware of severity of his condition.

Nineteen nursing visits were made. Two home health aide visits were made. Six visits were paid by Medicare; fifteen were paid by Project Independence. Service started January 12, 1973. Service discontinued March 30, 1973. Patient admitted to hospital. Patient died April 8, 1973.

CASE NO. 2

Following a hip nailing for a fractured hip, a 67-year-old man was transferred from a hospital to an extended care facility and then to his home. Living alone with his 67-year-old wife who suffers from emphysema, this patient had a history of CVA's, the first of which occurred at age 42. The right elbow is frozen at a 90-degree angle, the right knee extremely stiff, and there is bowel and bladder incontinence. This couple lives in a country home and is assisted by grandchildren who help with errands, and children who help with care when their own family responsibilities permit.

The short and long term nursing goals are to assist the patient to reach his optimal level of functioning and maintain the couple in their home as long as possible.

The nursing actions have been as follows:

1. Develop a plan of care for the patient and his wife.
2. Initiate bowel-bladder training.
3. Initiate and maintain an exercise program based on the physical therapist's evaluation and periodic re-evaluations.
4. Dress ulcerated areas on heels and feet and report progress to M.D.
5. Check vital signs and report significant changes to M.D.
6. Teach wife range-of-motion exercises and correct positioning to avoid further contractures.
7. Teach wife skin care, and otherwise include her in all aspects of the patient's care.
8. Teach safe transfer activities as progress permits.
9. Re-teach patient how to dress and feed himself.

A total of 160 visits have been made to this patient since October 1971. Medicare covered the first 34 visits; Project Independence has covered the last 126 through March 31, 1973. Presently the patient receives two home health aide visits per week and a nursing visit every two weeks.

It is apparent from the above two examples, plus numerous other cases reviewed, that Medicare currently defines skilled nursing care as the performance of a specific procedure which is geared to the restoration of bodily function. As illustrated above, particularly in case No. 2, personal care, supportive care, observation, judgment, supervision and health maintenance activities are apparently considered outside the definition of skilled nursing care and generally are nonreimburseable.

Should this agency elect or be forced to discharge its relatively large number of cases which fall into the general category of case No. 2, many would very shortly be cared for in an acute or sub-acute institution, and the irony is that Medicare and/or Medicaid would be paying a large share of the bills. In recent

years we have heard a great deal of lip service being given to health maintenance, described by some as the keystone of progressive care. Unfortunately, Medicare—as we have experienced it—does not recognize the value of maintenance.

ITEM 4. LETTER FROM MAINE BLUE CROSS AND BLUE SHIELD, PORTLAND, MAINE, TO SENATOR MUSKIE, APRIL 30, 1973

DEAR SENATOR MUSKIE: Maine Blue Cross and Blue Shield covers over 66,000 senior citizens, or better than half of the over 65 population in Maine. As their representatives in the health care field, we hope that it was merely an oversight that we were not among those invited to testify at your April 23 hearing in Livermore Falls.

Certainly, we are efficient bill payers for Maine's elderly, both through companion plan, our Medicare supplement, and as Medicare Part A intermediary. In 1972, we provided over $3 million in benefits for 130,336 companion plan claims, and we were able to operate on just 7.6 percent of our income. But we also realize a strong commitment to our 444,000 members on whose behalf we contract with doctors and hospitals for services to help contain the spiraling costs of health care. We have done this through developing new benefit programs to utilize outpatient facilities and most recently have established coordinated home health care, a better way of preserving quality and reducing costs.

To promote better utilization of health care facilities, Maine Blue Cross and Blue Shield has also given active support to the State and areawide comprehensive health planning agencies which were established under Public Law 89–749. Our participating agreement with hospitals requires that any proposed renovation, construction or expansion of health care services or facilities must meet with the approval of the designated comprehensive health planning agency (B agency) or, in the absence of such an agency, the State comprehensive health planning agency (A agency).

We have also made great strides in the development of programs to suit the ever changing needs of the community. The health care planning and research department was established to meet our expanding needs in the study and development of new programs. The department is responsible for examining existing benefit programs to assure their effectiveness and, in cooperation with health care providers and comprehensive health planning agencies, finding new ways to provide benefits which would effect better utilization of health care facilities.

One area of consideration is in alternative ways to deliver health care. Maine Blue Cross and Blue Shield is developing a prototype health maintenance program which would provide preventive and traditional health services to enrolled members on a prepaid basis.

We have just agreed to assume financial management of regional blood banks, a very necessary service originally funded by regional medical program. The program has been experiencing severe financial difficulty and its bankruptcy would leave some of our State without an adequate blood supply.

In order to ensure that all of our various programs are meeting the needs of the Maine community, we established four regional consumer advisory councils composed of 15 consumers each. In 1972, representatives of the four councils were invited to visit our home office and study and comment on our entire operation. We have placed great credence in the advice of the council members, and as a result, they have helped us to be as responsive to consumer needs as possible.

It is our firm conviction that if the health needs of this Nation are to be adequately met under national health insurance, it can best be accomplished through legislation that will merge the resources of the public sector with those in the private sector that have demonstrated records of achievement in the provision and financing of consumer oriented health services. We respectfully request that this letter be entered into the record of the April 25, 1973 testimony taken at Livermore Falls.

Sincerely,

STEPHEN W. WOODBERRY,
Vice President, Community Services.

ITEM 5. LETTER FROM DR. HARRY BRINKMAN, FARMINGTON, MAINE, TO SENATOR MUSKIE, APRIL 24, 1973

DEAR SENATOR: First of all let me thank you for your interest in and your efforts on behalf of the senior citizens. I deeply appreciate the way you conducted the meeting which was so well attended and for making everyone feel at ease and feel free to express our opinions and views so frankly. I hope something was accomplished through this meeting.

As so often happens, we often fail to say what we should and at times say things better left unsaid.

Having myself now gone well past the traditional three score and seven years I hope that I can perhaps more understandingly speak for a group which time has forced me to join. I feel that so many policies relating to the older age group are made by people who have not as yet reached the age necessary to approach these problems from the proper perspective. I find that with the passing of years my sense of certain of life's values has changed and I am now convinced that longevity is much less important than the quality of life that still remains for us. There are many conditions in life which are worse than death, and also that man does not live by science alone or by the material things of life. As was mentioned yesterday, many of our older citizens are carried off to elaborate nursing homes with pine paneling and plush wall to wall carpeting with the thought that we are doing them a great favor, whereas, in truth, they are taken for their last ride to an environment totally strange to their accumstomed way of life. This is particularly true in this rural area with which you and I are so familiar. It is therefore my feeling that services such as home nursing, home makers, transportation, et cetera, which permit patients to remain at home should be stressed and supported. I am in complete agreement with Albert Schweitzer that, especially older people, should not be transplanted too drastically from the level of living to which they have become accustomed through the years.

Another of my criticisms of nursing homes is their lack of segregation, not racial, but the oriented from the disoriented. To place a well oriented old person constantly in close proximity to one or more disoriented persons, as is so often seen, is cruel and almost intolerable. I am not sure how this can best be dealt with but it cannot be accomplished by simply placing them in plush surroundings. We must respect their feelings as well as provide for the necessities of life.

Again let me thank you for coming here; it was a pleasure to have this first contact with you. If I can be of any service, please let me know.

Very truly yours,

HARRY BRINKMAN.

ITEM 6. LETTER AND ENCLOSURES FROM DEPARTMENT OF HEALTH AND WELFARE, AUGUSTA, MAINE, TO SENATOR MUSKIE, MAY 3, 1973

DEAR SENATOR MUSKIE: It was a real pleasure seeing you again last Monday and having the opportunity to testify before your U.S. Senate Special Committee on Aging, Subcommittee on Health of the Elderly.

The older people who attended and testified were greatly pleased that you could take the time to listen to them and their concerns.

As you requested at the hearing, I have compiled a summary of Federal impoundments, proposed budget reductions and terminations that would affect the elderly of Maine.

I have taken these figures from an impact study done in the office of the governor, March 7, 1973. I have attempted to include only the programs that would relate most directly to services for older people.

I am also enclosing for the hearing record an "overview of Project Independence" which will give you the background of the development of the project in the western Maine area.

I wish you the very best in your continuing efforts to improve the lives of our older people.

Very sincerely,

RICHARD W. MICHAUD,
Director, Community Services.

[Enclosures]

STATE OF MAINE

IMPACT OF FEDERAL IMPOUNDMENTS, PROPOSED BUDGET REDUCTIONS AND TERMINATIONS

Program affected	Anticipated funding level fiscal year 1973	Estimated dollar loss		Action date	Who/what is affected?
		Fiscal year 1973	Fiscal year 1974		
New England Regional Commission:					
Elderly health program	40,900	40,900	40,900		Health related services such as transportation and health screening for the elderly will be terminated in eastern Maine.
Transportation program	70,000	70,000			This would eventually have developed into transportation systems mostly utilized by the elderly since they are the group with the major need for this service.
Maine medical school	40,000	40,000			To develop a medical school in Maine which would train professionals and paraprofessionals for the Maine health care system.
Regional medical program	2,000,000	1,200,000	[1] 2,000,000		33 activities contribute to the financial support of: 100 allied health personnel. 109 nurses. 109 physicians. Improvement in health care delivery—1972: 2,316 health providers received training to improve their skills affecting 592,000 Maine residents. 596 new types of health personnel have been trained affecting 342,000 Maine residents. 900 nurses and 350 physicians have been trained in coronary care affecting 48 Maine hospitals.
Department of health and welfare health facilities construction program (Hill-Burton hospital construction).	5,000,000		5,000,000	[2]	Approximately 25 percent of population currently served by outmoded or poorly distributed hospital beds—primarily rural areas.
Emergency medical services program	200,000		165,000	[2]	Moneys may be in another part of Federal budget but, if so, no one (including Washington) knows where. If our training programs for about 5,000 emergency health service personnel will be curtailed.
City of Portland, community development, Model Cities	1,800,000	None	1,200,000	June 30, 1973[4]	13,000 people in Portland benefit directly or indirectly from services delivered to inner-city section where bulk of low-income residents live. 450 persons are employed to operate about 35 services. The Model Cities grant generates additional $3,800,000 in matching funds or private donations to these programs for total annual impact of $5,600,000 spent for people needs. $1,700,000 of the generated money comes from private sources that have become ineligible under new HEW FR guidelines published Feb. 16, 1973.

STATE OF MAINE—Continued

IMPACT OF FEDERAL IMPOUNDMENTS, PROPOSED BUDGET REDUCTIONS AND TERMINATIONS—Continued

Program affected	Anticipated funding level fiscal year 1973	Estimated dollar loss		Action date	Who/what is affected?
		Fiscal year 1973	Fiscal year 1974		
City of Lewiston, community development, Model Cities	2,000,000	None	1,400,000	June 30, 1973	14,000 people live in Lewiston and benefit directly or indirectly from services to lowest income neighborhoods. 300 people are employed to operate 28 services. The Model Cities grant generated an additional $1,300,000 in matching funds or private donations to these programs for total annual impact of $3,300,000 spent on people needs. There is no special breakdown on private contributions. (The Model Cities program ends 12 mo. sooner than Federal Government had promised. Thus, city loses $2,000,000 it had planned for fiscal year 1975.) Note: Services include: 1. Child care. 2. Food and services to elderly. 3. Recreation programs and facilities. 4. Education for special students and new facilities. 5. Law enforcement aides. 6. Housing services.
Federal security IV-A, 16 and Related Services. Day care, and other social services to aged, blind, disabled and AFDC (past, potential, present).	12,000,000	[1] 1,800,000	[1] 3,800,000	March 1, 1973	Services will be terminated or reduced to 39,000 people in the last quarter of fiscal year 1973 and an additional 34,000 during fiscal year 1974. Reductions will be caused pursuant to new regulations which eliminate groups from eligibility who previously were eligible, and which prohibits use of private funds as "seed" dollars for Federal matching.

Office of Economic Opportunity, Community Action	2,334,000	[4] 2,334,000+	Community Action agencies are the major social service and delivery system serving rural Maine and Maine low-income people. Through Community Action agencies efforts, additional funds both Federal and non-OEO and State and local moneys have been mobilized. (Result in approximately $5,000,000 additional dollars.) This total program effort is dependent on the existence of Community Action agencies. If the agencies are eliminated then the following programs will be eliminated: 1. Community outreach—Provide information and referral services and crisis support to approximately 150,000 people. 2. Community health services—Provides various kinds of services including dental, immunization clinics for children, lead poisoning screenings, and transportation to clinics for approximately 8,500 people. 3. Economic development—Has created opportunities for supplementary income for Maine citizens particularly senior citizens and rural both serving approximately 1,900 people. 4. Housing services—Includes house outreach, location of emergency housing, housing construction, house counseling, and home rehabilitation programs. Serving approximately 3,000 families. 5. Job placement and job counseling services—Presently serving approximately 1,000 people. 6. Nutritional programs—Provides educational and administrative support for donated food programs. Affecting approximately 64,000 people. 7. Senior citizen programs—Provides such services as hot meals, recreation outreach, part-time employment affecting approximately 20,000 senior citizens.

Explanatory notes used:
[1] Impoundment.
[2] Program terminated as of June 30, 1973.
[3] Reduction, program continues.
[4] Program terminated June 30, 1973, and proposed for Special Revenue Sharing.

Overview of Project Independence, An Areawide Model Project Under the Older Americans Act

Project Independence is a comprehensive program of services to the aging operating in a three-county area (Androscoggin, Franklin and Oxford Counties), which is 4,347 square miles in area, or the size of the States of Connecticut and Rhode Island combined.

A survey of western Maine senior citizens by the Western Maine Task Force on Aging which was conducted during March and April of 1970 in conjunction with the Maine Committee on Aging report, "steps for Maine's elderly", brought forth some startling facts about the senior citizens who live in Androscoggin, Franklin, and Oxford Counties. It was upon this data that the initial impetus for the areawide model program called Project Independence for these three counties was begun.

This survey found that the median income of older people in these three counties was 5.8 percent below that for all older people in the State of Maine. Based on the lower (or minimum) budget standard developed by the Bureau of Labor Statistics of the U.S. Department of Labor, 29 percent of the older couples and 65 percent of the older individuals in the three-county area have incomes below the level necessary to maintain adequate health and well being.

In 1970, there were 805 persons per physician in Androscoggin County, 951 persons per physician in Franklin County, and 1,262 persons per physician in Oxford County as compared with 800 persons per physicians in the United States. The senior citizen survey found that 51.3 percent of the tri-county senior citizens felt their health to be fair, poor, or very poor, as compared with 44 percent of all older people in Maine. Because of their health, almost a quarter of the older people in the three counties needed help with grocery shopping, almost 30 percent need regular help with house cleaning, 24 percent need regular help with their laundry and 10 percent need regular help with cooking.

The people in the tri-county area also lacked mobility. A total of 41.3 percent of the older people said they need help with transportation. There were 37.0 percent of the tri-county senior citizens who ranked transportation as one of their most important problems. Almost 42 percent said their transportation problems were due to a lack of a vehicle, inability to drive, or lack of public transportation as compared with 36 percent of all senior citizens in Maine listing these reasons for lacking mobility. A significant number of older persons, 18.1 percent of the survey respondents in the three counties, said lack of companionship was one of their most important problems as opposed to 15.9 percent of all older people in Maine who said this was an important problem to them.

The 1970 senior citizen survey also found information, or the lack of it, to be a significant problem among the Androscoggin, Oxford, and Franklin senior citizens. For example, 20.4 percent of the survey respondents in the three counties ranked information as one of their most important problems while 16.6 percent of all Maine senior citizens said information was a major problem for them. In regard to particular programs, a third of the tri-county older people felt they do not have enough information on Social Security, 25.8 percent felt they do not have enough information on Medicaid, 33.5 percent felt they do not have enough information on Medicare, 27.2 percent felt they do not have enough information on tax relief for the elderly, while 16.6 percent felt they do not have enough information on food stamps or donated commodity programs. In addition, 19.5 percent of the tri-county interviewees ranked information about health care as a major problem (as compared with 14.3 percent on a statewide basis) and 30.4 percent ranked information on financial assistance programs as one of their major problems (as compared with 26.6 percent of all older people in Maine).

It was against this backdrop of low incomes, significant health care problems, large informational gaps, a high lack of mobility, and a lack of socialization and companionship that Project Independence was developed through the cooperative effort of senior citizen consumers, officials from major public and private agencies providing "health related services" in the tri-county area and technical assistance personnel. This cooperative effort was under the overall direction and guidance of an area aging planning group, the Western Maine Task Force on Aging.

In defining the primary objective, Project Independence became the vehicle through which older persons in western Maine would become more accessible to area health related services through: (1) Linking older persons with existing health services; and (2) creating, establishing and expanding effective and low cost services while avoiding expensive and often unnecessary institutionalization

such as nursing homes, hospitals, et cetera. Essentially, the program seeks to increase the independence of living for the older person, prolonging the period of time which the older person lives in his own home while providing a measure of quality in the older person's life.

Operationalizing the above goals and objectives led to the following services to be provided by Project Independence.

1. Information, referral and outreach services.
2. Minibus transportation services.
3. Health screening.
4. Homemaker-home health services.
5. Recreation/leisure time services.

These services are available to all older persons in the tri-county area.

Project Independence began actual operations during January of 1972. In a very short period of time, from January of 1972 to February of 1973, approximately 57,200 units of service have been given by Project Independence to older persons in the tri-county area. In addition, approximately 8,000 older persons have used one or more of the various services of Project Independence.

The following is a breakdown of the number of units of service given by the components of Project Independence during the year's period ending February 1973.

Components:	*Units of service (duplicated individuals)*
Information, referral and outreach	20,480
Minibus transportation	32,240
Homemaker-home health	3,580
Health screening	900
Total	57,200

The 57,200 units of service to 8,000 different older persons in western Maine means that *43 percent of the population 65 and over in the tri-county area have become more accessible to health related services in the tri-county area, thus overcoming some of the significant barriers to health care.* One can readily see that Project Independence is having a major impact on the lives of older persons in the tri-county area.

ITEM 7. STATEMENT OF JULES KREMS, PRESIDENT, MAINE FEDERATION OF LONG TERM CARE FACILITIES, PORTLAND, MAINE, APRIL 23, 1973

The Maine Federation of Long Term Care Facilities represents 18 nursing homes with a bed capacity of 1500. It was organized to achieve two purposes: (1) Improvement in the quality of nursing home care rendered our aged citizens, and (2) a cost related, as opposed to a flat rate method, of reimbursement.

There are two levels of nursing home care in Maine. The skilled nursing home facility, for whom payment is made at cost, is governed by rules and regulations which parallel those of title 18, Medicare Extended Care Facility. Professional nurses are required on a 24-hour basis. Rehabilitation, recreational and restorative services are required.

The Maine Federation supports the concept of the skilled nursing care facility for title 19 Medicaid patients and the cost method of reimbursement inherent in it. However, it would note that only a handful of the 5,000 or so nursing home patients in Maine are residing in or are classified as skilled nursing care patients. Upwards of 95 percent reside in or are classified as intermediate care facility patients.

The regulations governing the intermediate care facility are currently under revision both by the Federal Government and the Maine Department of Health and Welfare. In short, they differ from those regulations affecting the skilled nursing care facility in that they require licensed professional nurses to be on duty only during the 7–3 day shift, or during five shifts or 40 hours weekly. During the remaining 14–16 shifts, the aged and infirm need be under the care of only nonprofessional or nurse-aide personnel.

The Maine Federation would like to see intermediate care facility standards upgraded, particularly in the area of staffing. However, improvement in standards require funds and the flat rate method of reimbursement for intermediate

care facility patients is both inadequate, inequitable, and wasteful of tax payer funds.

Maine currently pays $440 per month for patients requiring intermediate care. This exceeds costs in some instances and is far below cost in others. On the one hand, it rewards the substandard nursing home operator while it penalizes the nursing home desirous of providing quality care. Its net effect is to promote substandard care by guaranteeing a level of payment regardless of services rendered. In that respect, the taxpayer is also placed in the position of paying for services that may not be offered.

The flat rate method of reimbursement has been deemed unjust by the Federal Government and by the Maine Governor's Committee on Aging. Public Law 92–603 mandates a cost related method of reimbursement by 1976. This date should be forwarded to correspond with the effective date of ICF regulations currently being considered by the Federal Government.

We would also call attention to the impact of Federal wage-price guidelines which essentially freeze prices and standards at their current levels. These create inequities as between those States which have cost-related programs and those, like Maine, which employ the flat-rate method of reimbursement. They promote substandard care and create a shortage of nursing home beds, thereby effectively denying access to nursing home care to the indigent aged and incurring increased costs to the taxpayers of Maine.

There is no stimulus to nursing home construction either by the nonprofit or proprietary sector, in a flat-rate method of reimbursement which bears no relationship to cost. The result is that the indigent aged are either being held in hospitals at per diem rates far in excess of those which would be paid to nursing homes, or are being denied nursing home care altogether. Nursing homes are being compelled to open their doors to those who can pay and to close their doors to the indigent aged.

The Maine Federation of Long Term Care Facilities urges the Federal Government to permit nursing homes to provide access to all American citizens, regardless of ability to pay.

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

If there had been time for everyone to speak at the hearing on "Barriers to Health Care for Older Americans," in Livermore Falls, Maine, on April 23, 1973, I would have said:

The following replies were received:

GEORGE SWAIN, FARMINGTON, MAINE

I do not think Medicare is adequate.

MRS. ERNA GOODSPEED, WEST FARMINGTON, MAINE

Why isn't something done about the high and higher costs of medications and prescriptions (for older people)?

IMELDA FILTEAU, LIVERMORE FALLS, MAINE

Doctors should be paid by Medicare for house calls. Medicare pays 80 percent of the calls made at the doctor's office. It is next to impossible for an elderly patient to go to the doctor's office.

Medicare is a blessing and I hope they expand it. I had the benefit of having Medicare and am thankful. Let's not abuse and destroy a good thing.

About nursing homes:

I want to stay in my home and be independent. Visit nursing homes and see the look of despair on these people's faces.

Their children dump them there and never visit them and take them out. In our homes we are free and happy. Visit nursing homes and see the cells the people are in. The rooms have been made into cells. Money. Money, greed, no charity. Visit the Marcolte Home in Lewiston.

OLIVE BONSEY, R.N., WELD, MAINE

I was at the meeting at Livermore Falls, but could not stay until the end.

I want to say that I hope that Project Independence will be continued. I ride on the buses and I know what it means to the oldsters. I have been with the driver when he backed in to the homes and helped the passengers. I hear their comments and know firsthand how much they need it.

I was public health nurse in South Franklin County for 20 years, then left to be a medical social consultant for Dr. Fisher under health and welfare. I still know a great deal about the "ins and outs" of Franklin County.

I do want to tell you about Harold Collins. He worked his way through B.U. and I think his degree is in psychology. He has always worked for the community and I do not know of any one person who has given of himself as he has. He is now working 60 and 70 hours a week for this project and he is

concerned for the senior citizens. I think the project should be taken away from community action and Mr. Collins have an office in Wilton. It needs someone with training and experience and this he has.

I do not believe that the public realizes how much money Project Independence is putting into community action and they should. The statements and insinuations I have heard in reading, and radio irritates. Credit should go where it belongs.

I believe the doctors at Rural Health Associates are doing well, but I do not like the administration, no more than I do community action.

I went for a blood sugar and paid $16 for that. I asked for a report and did not get it. I insisted and was told to come to RHA. I called the minibus and had to insist when I got there on a full report. I was charged $20 for that. That was outrageous. I am a senior citizen living on a pension and that should be given consideration. I left Weld at 7:30 a.m. without breakfast. I was picked up at 11:30 and driven all over the county arriving at Weld 3:50 p.m., still with nothing to eat. If I had had serious diabetes it would have been serious. Someone should have seen that I had at least a glass of milk. The administration has no professional knowledge or ethics. It is a business proposition. I resent it.

At this time I do not know what to do about medical supervision. Many Weld people are going to Rumford.

PATRICIA DEBRINNEY, LIVERMORE FALLS, MAINE

Let these committee people be brief and devote half the time to hearing directly from the senior citizens themselves. It is fine to hear from bus drivers, homemakers, etc., whose jobs depend on a good report on these hearings but if you really want to know about health care for older Americans then ask more:

(1) Older Americans.

(2) Physicians.

Seek out senior citizens groups for their unbiased advice or clergymen, social workers, etc., not associated directly with P.I. to see how health care is actually fairing.

NELLIE GILPATRIC, SOUTH PARIS, MAINE

That I think the talk on Welfare of the Elderly was great. I am on Welfare, and the benefits are fine. Also about the Mini-bus; since the Project Independence has been in effect. I have benefitted by it. I am a widow and if it wasn't for the Mini-bus, I wouldn't be able to go to the bank, shopping or get surplus food, or go to Senior Citizens meetings. I do miss not being able to go to Lewiston or Rumford, as the bus doesn't go anymore. We have taken a lot of trips and I sure hope we can keep the Mini-bus, because as I said before that is the only way I have to get anywhere, and I think it is a wonderful thing to have. Enjoyed the meeting today the 23rd. Hope we keep the Mini-bus, as it helps us that have no transportation.

PAULINE HAYES, FARMINGTON, MAINE

I heard a week ago on T.V.—"It was disgraceful in U.S. to eat horse meat" (which is the only animal, who has not the T.B.), but is it not more disgraceful to see the senior citizens fight for decent living and health? In the U.S.—Many countries abroad copy many things from U.S.—Why doesn't U.S. copy program of Sweden, France, Germany and so forth, in the health program? Hospitals, doctors, medicine, glasses, orthopedic apparel, etc. All are taken care of by their social security—why not adopt such program in U.S.? Also I am 71 years old, widow of a veteran and when I got the 20 percent raise of Social Security, I had a deduction on my widow pension of $20 a month, which means I did not get any raise at all—and this is for all of us in my position.

EDITH HEFFRON, DIXFIELD, MAINE

Why do doctors charge such exorbitant prices to Medicare when they submit their bills to them—and an individual like myself cannot get the doctors or any-

one in (St. Anthony's Hospital) St. Petersburg to sign any papers nor do I receive any reimbursement from Medicare. I was an outpatient from a bad fall. Thank you.

HAZEL P. TOWLE, MEXICO, MAINE

1. "Stay in your own homes" is the cry everyone said at the meeting at Livermore which I agree, *but* a widow owning her home usually has an older house, repairs to be made, etc. and yet in making out "Income Tax Reforms" cannot take out for repairs and pensions for us are stable. Neither can she be counted as "Head of the Household."

2. Why not. She lives alone which I'm doing. I do not wish to go elsewhere until I have to which I probably will someday as I had a very severe open heart surgery and osteoarthritis.

All of us widows over 70 are asking the same questions.

I have just finished a two year term of being President of the Oxford County Maine Retired Teachers Association.

That and those? Were asked me many times.

I enjoyed the panel and your preliminary speech before at Livermore. Knowing your family has been very pleasant. I didn't know exactly who to write to.

I am 76 and will be 77 in May. Have paid taxes all my life. My husband Carl died in 1942 and had my youngest son five years of age to bring up. Went back teaching then.

I think it is about time that Washington did something to help us on the previous questions.

Sorry to have bothered you with this and do hope they can help us.

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