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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(Home Health Care)

THURSDAY, JULY 12, 1973

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

The subcommittee met at 10:07 a.m., pursuant to recess, in room 1318, Dirksen Building, Hon. Edmund S. Muskie, chairman, presiding.

Present: Senators Muskie, Kennedy, Chiles, Fong, and Percy.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Elizabeth M. Heidbreder, professional staff member; John Guy Miller, minority staff director; Robert M. M. Seto, minority counsel; Patricia G. Oriol, chief clerk; Gerald D. Strickler, printing assistant; Betty Rose and Ann Todaro, assistant clerks.

Senator MUSKIE. The hearing will be in order.

This subcommittee took a great deal of testimony yesterday on problems confronting health care agencies. Some of that testimony was technical; some was brutally simple—what should be an important segment of our national health care system has been badly crippled by a combination of negative attitudes and shortsighted, sometimes contradictory, Federal policies.

We will continue to take expert testimony this morning on home health care, but we will begin this morning with three witnesses capable of telling us more about a basic issue which should remain close to the heart of these hearings.

I am referring to the idea, apparently shared by the general public and many medical practitioners, that somehow the so-called geriatric patient is a low-priority patient.

I am happy to welcome Ms. Maggie Kuhn, national leader of the Gray Panthers movement, Ms. Sharon Curtin, and Dr. Herbert J. Shulman.

It is a pleasure to welcome you to this committee this morning. And I gather, Ms. Kuhn, that you are the leadoff witness in this panel.

STATEMENT OF MARGARET KUHN, LEADER, GRAY PANTHERS, PHILADELPHIA, PA.

Ms. KUHN. Thank you, Senator Muskie. I am very honored to be here and to participate in this panel, and to bring to your attention some of the human factors involved in the work of this committee.

The Gray Panther network is a national coalition of young people and old people working together for social justice and social change. We are challenging and pressing for the elimination of all forms of agism, age discrimination against all kinds of people, particularly the young and the old who are particularly oppressed by age discrimination.

We are working to make our society more human and to really maximize the fact that this is the age of liberation and self-discrimination. Now in this age, old people are shut out from any kind of decisionmaking in the public policy arena, and in many of the private sectors. We have no place. So we are organizing to make a new place for ourselves.

We believe, many of us, that many aspects of our society are sick, and this committee, concerned about health, needs to be concerned about the basic sickness of our society.

One aspect of the sickness of our society is the way in which we have dealt with the powerless people in our society, the very young, the handicapped, the infirm, the sick, and the aged. These people are defenseless against institutions that have been set up purporting to serve us. And instead they have rendered us more powerless, more defenseless, and we are well on our way to becoming vegetables.

"Liberators of Society"

Now we propose and, indeed, we are demonstrating how this kind of tragic tide can be reversed, how young people and old people can work to make this age of liberation a reality. We represent a new generation of old people who have the numbers, the time, the experience, the wisdom to be the liberators of society and attempt to turn this society around.

We propose to and indeed we are demonstrating how to work for effective and efficient policy changes. I am going to read into your record and leave for your committee's record a basic policy change in the whole health care delivery system * that we support and press for.

We are social critics of this sick society. We are the ones who are most free to analyze its strengths and point to its weaknesses. Indeed, we have nothing to lose by initiating certain basic changes. Here is a case in point. On June 23, 1973, in New York City, we sponsored a health conference that was a counterconference or an alternative conference to the national convention of the American Medical Association opening in New York City at the same time.** I have two people right here with me this morning, Dr. Herbert Shulman and Ms. Sharon Curtin, who were participant leaders in our conference. We are making some very radical corrections in the face of the AMA's policy.

It is some of the critical matters that were brought up in our conference that we want to bring to you today. I would like to emphasize a few points from the statement that I have given to your committee for your record. Our statement indicates that we have been aware of the health crisis for a long time. Many people are talking about it. We have been chiefly educated by this talk. We got our degree, you

* See app. 1, item 1, p. 587.
** See app. 1, item 2, p. 594.

might say a Ph. D., a doctorate, in health and the politics of health, when Medicare was adopted.

It promised great things, but it has been very short in the delivery of those things. We have discovered in these lessons that Medicare has taught us that money isn't enough, that technology isn't enough. The basic problem with this new-found technology has been expressed in many ways. America is the best place in the world to go if you have a rare kidney disease, but you might just as well be in Guatemala when you have arthritis, as I have, if you have hypertension, or if you have any other prevalent chronic ailment that the elderly are predisposed to.

Health Care for all the People

Health care technology has to be controlled by the public as a whole if it is to serve the public interest. We have learned that health care is a political issue where old people are the pawns in the power struggle to preserve the economic power of the medical profession. Our uncoordinated, piecemeal system has become a two-class system: one for the rich and one for the poor and the near poor. Health care is a right for the entire society and we are working to help people to secure this right. To leave it up to the providers and the insurance companies to decide what health services should be available has created a crazy system, even under Medicare, in which hospitalization is financed, but preventive visits to the doctor are not.

We have learned that our country needs a comprehensive national health policy, planned and evaluated by the consumers of health services, with national financing and administration.

I could go on at long length about the institutional care that we devised to care for old people who are infirm. Much of it dehumanizes. We are very strongly persuaded that your subcommittee is on the right track by affirming health care programs to be delivered at home. It is necessary to take whatever measures are necessary, public and private, to maintain people in their own homes, free from the kind of oppression and suppression that even the best kind of institutionalization imposes.

We feel very strongly that the existing home health care services that have been pioneered in some places are so inadequate and so partial and so inequitably distributed across the country that a wholly new approach is necessary in order to make them available to everybody.

We see home health care, and indeed health maintenance in general, as essential parts of the new health system that we want, the national health service that we are proposing and that our statement, which I will leave with you, makes very clear.

I am also leaving with the committee the policy statement* which was prepared for our health conference by our health committee and was the working document for the Gray Panthers alternative conference held last month in New York. And the title of it is, "Toward a National Health Service."

The statement identified these characteristics essential to national health service: It should be of excellent quality, universal for all Amer-

* See app. 1, item 1, p. 587.

icans, regardless of age, sex, race, income, geography, et cetera. It should be comprehensive, including preventive, diagnostic, treatment and rehabilitative services, accessible to all who need care, and continuous from "the womb to the tomb." It is accountable to the people being served, with consumers having a participatory role in planning and policy decisions. It must be patient-oriented, not run for the convenience of the doctors and health institutions. Nothing short of the goal of a national health service will meet the health crisis and provide the quality care that American people need and want.

Thank you.

Senator MUSKIE. Thank you, Ms. Kuhn. Your complete statement will, of course, be included in the record.

[The prepared statement of Ms. Kuhn follows:]

PREPARED STATEMENT OF MARGARET KUHN, LEADER OF GRAY PANTHERS

I understand that these hearings have been called to talk about what has come to be known as the health care crisis, particularly as it is faced by older Americans.

However, I plan to talk about education.

Let me explain: People have been talking about improving the health care of older people for a long time now. There have been a number of programs and panaceas put forth that promised to deliver on all that talk. This periodic raising of expectation had its culmination in 1966 when, with the passage of Medicare, we were told that we were finally going to get good health care.

What we got instead was an education. All those programs and panaceas before Medicare were merely matriculation. We got our degree with Medicare (our Ph. D. degree: "politics of health, doctorate"). I'm going to forego giving the latest statistics documenting the health care crisis for older Americans.

I'm not even going to cite the grisliest incidents that have happened to older people of my acquaintance.

Instead, I'm going to talk about education beginning with six lessons the health system has taught old people during the past few decades.

LESSON NO. 1: MONEY ISN'T ENOUGH

I'm told that the American Medical Association waged the costliest lobbying effort in congressional history in its attempt to defeat Medicare. Though they lost the battle, they won the campaign. They show no sign of losing the war. You know what I am referring to: That phrase in the legislation about "normal and customary" fees, and the total absence of quality controls or accountability to either community or patients.

Between the unexpected dimension of the unmet health needs of old people on the one hand and the hastily boosted "usual and customary fees" of the providers on the other, Medicare was doomed to cutbacks, and the capstone was put on the inflationary spiral of health costs in the 1960's. Pouring more money into the present system without changing the priorities that govern spending, implementing cost controls, or changing the method of delivery, doomed Medicare from the start.

That was our first lesson in the educational program provided for us by the health industry.

LESSON NO. 2: TECHNOLOGY ISN'T ENOUGH

With Medicare we find ourselves able to get into fancy voluntary and teaching hospitals that were completely closed to us before (if we found a doctor who could admit us, of course). Technology that wasn't previously available was now at our disposal. In fact, we found ourselves subsidizing a lot of it out of $120 per day Medicare payments.

You can ask any researcher about how income from Medicare payments gets allocated within a hospital. One example turned up the fact that the majority of older patients were there not for medical reasons but waiting to be admitted to nursing homes.

The basic problem with all of this new-found health care hardware is expressed in a comparison we've heard many times now and in many different forms: "America is the best place in the world to treat your rare kidney disease, but if it's hypertension, arthritis, or some other prevalent, chronic ailment, you might just as well be in Guatemala."

Health care technology has to be controlled by the public as a whole if it is to serve the public interest and not just the research interests of the local Nobel aspirant.

These two lessons in our education are both what are called in the academic world "prerequisites" to the third lesson.

LESSON NO. 3: HEALTH CARE IS A POLITICAL ISSUE

The lobby against Medicare cited earlier isn't explainable simply as a fight to preserve the purity of American medicine from any Bolshevik taint, under the guise of preserving the sacred doctor-patient relationship. It becomes believable when seen as any attempt to defeat an attack on the economics of medicine and the unchallenged power of the doctor. Old people, the poor, and other vulnerable segments of the population become pawns in a power struggle, not people to be served.

LESSON NO. 4: IT DOESN'T WORK TO GUARANTEE GOOD HEALTH CARE FOR JUST ONE SEGMENT OF OUR POPULATION

To begin with, whatever means tests or cutoff points are used to define the population are bound to be unfair. Furthermore, such a mixed system inevitably leads to "two class" systems of health care. With health costs what they are, society simply won't tolerate taking over the health needs of just that segment. Thus the kind of cutbacks we've seen in the last few years are inevitable.

Health care has to be seen as a right for the entire society and serving the entire society with both cost and quality controlled by society, including the consumers of the service. The way to guarantee that the entire society will be served is for the public to be seated at the table where health care decisions are made.

LESSON NO. 5 (ALSO LEARNED THE HARD WAY): THE HEALTH CARE SYSTEM MUST OFFER ALL NECESSARY HEALTH SERVICES TO SOCIETY

The way in which health care is financed must make complete care a reality for all members of society. To leave it up to the providers and insurance companies to decide what health services should be available has resulted in the crazy system, even under Medicare, in which hospitalization is financed but preventive visits to the doctor are not. This is the case, even though we have known for years that going to the doctor for a checkup today will likely reduce the need for inpatient care tomorrow.

The tragedy is that there is little prospect of changing our financing of health care to take advantage of this fact.

Such a change would require a radical policy change in our health system.

LESSON NO. 6: THERE IS AT PRESENT NO EFFECTIVE WAY TO MAKE PUBLIC POLICY DECISIONS IN HEALTH CARE

Three years ago in an article in the Saturday Review, Senator Ribicoff reported that he had asked how the 24 departments and agencies of the Federal Government that spend the Government's $20 billion health budget contributed to the formulation of the national health policy. It was "with refreshing candor" that HEW replied saying: Up to and including the present there has never been a formulation of national health policy as such. In addition, no specific mechanism has been set up to carry out this function.

The result, of course, is that health services have become a political football. A President can attempt to cut off billions of dollars of services for political reasons, and it takes a Watergate to save them, perhaps for a year.

Ribicoff went on to draw the logical conclusion to what to him was "an intolerable situation."

> If there is no policy, there can be no goals. If there are no goals, there can be no strategies. This is what we have today, and the result is that medical

care instead of being a public responsibility is a private business. It is operated more for the convenience of the practitioners than according to the needs of the sick.

I could cite many more examples of the education old people have received about health care. In such areas as the stereotyping of older people by doctors, their gross neglect of us when we are patients in nursing homes, the effects of our two-class system of care, and the need for consumer participation in planning and evaluating the service. However, the more important question at this point is: How are we going to change the health system in such a way as to benefit from the lesson we have so painfully learned?

Most people know what they want in the health system. Our own policy statement, for example, from our Alternate Health Conference, elaborates on what we have identified as "the 12 indispensable characteristics of a quality health care system," which should be available universally.

We know what we want. There is considerably less agreement on the reasons for the failure of the present system. We older people have been educated about the reasons for the failure of the present system. The most difficult thing is to put together a health plan that really profits from lessons our health system has taught us.

One of the few public officials to have the courage to act on the basis of these lessons is Pennsylvania's insurance commissioner, Herbert Dennenberg. He put his finger squarely on the point I am making in a recent speech in which he said:

> The keys to making a health delivery system work are consumers' control, cost control, and quality control. None of the proposed health insurance plans is strong enough in terms of these key controls because none requires basic changes in our overall health delivery system. The proposals backed by AMA and the Health Insurance Association of America are just bad jokes.

What kind of health plan would both promise what everybody wants in a health system and make the basic changes in that system that will allow it to deliver what it promises?

In our view, the only model for a national health system is a *national health service.*

Such a structure would provide the national financing, administration and policy setting that are essential if the plan is to work. It would provide for a single progressive system of financing to replace the hundreds of insurance and governmental sources of funds. This would insure a dependable income to the system so that financing is not subject to frequent political changes, yearly legislative appropriations or executive whims.

Control and ownership of the health system would be in the public sector rather than in the hands of private enterprise. Greatly increased local consumer participation would prevent national health service from becoming just another topheavy bureaucracy.

A cabinet-level national health agency would provide the direction and leverage to make the changes that need to be made on a national scale if our health system is to serve everyone.

No *piecemeal* solution is acceptable. The existing patchwork quilt of health programs—one for older people, one for the poor, one for children, etc., only serves to cut us off from each other.

Half-way steps like national health insurance are no better. Paying the bills on a national scale for an unfair and inefficient health system would be a giant step backward in our view.

Innovations like HMO's, greater use of physicians' assistants, etc., for all their merits cannot be passed off as solution to the overall health care crisis.

Nor is *better regulation* of a system controlled by the providers an answer. The people as a whole must own and through their representatives control the health system if it is to serve all of us.

What is needed is a national health service forged out of a basic restructuring of our health care system—its financing, delivery, and regulation. It is our hope that the members of this committee will have the courage and foresight to push for a national health service as the only adequate solution to the health needs of our country.

Senator MUSKIE. I wonder if I might just take up three or four questions to emphasize the points that you make. You have already touched on your first point; that is, Medicare has demonstrated that

money isn't enough. And by that you mean that unless the money is utilized and focused wisely and more precisely it isn't going to do the job. And your complaint is that the really enormous sums of money made available by Medicare haven't been focused upon the needs where they truly exist. Is that your point?

Fee System Out of Balance

Ms. Kuhn. That is my point. And also a very critical escalating of "the normal and customary fees" of the providers of services that they have maintained. The fee system is just clear out of balance.

Senator Muskie. The effect, then, has been that the money made available generally by Medicare has imposed an upward push on the freeze, costs, and on prices generally.

Ms. Kuhn. Without any quality control. I see none of this really being exercised by the medical profession, nor accountability to the patients and to the public for the services that are rendered.

Senator Muskie. Now your second point, it being that technology isn't enough, is intended to emphasize the fact that bricks and mortar are not enough to deal with the health problems of many people, and especially those who suffer from chronic illnesses and health problems apart from the acute illnesses which are those principally served by hospitals and institutions of that kind.

Ms. Kuhn. Indeed, the medical profession is pretty well oriented to deal with critical illnesses, to deal with an acute symptomology. They get bored and are turned off when we can't get well in a hurry. And we don't get well in a hurry, medically-wise.

I think that Dr. Shulman is going to elaborate this out of his experience, that this retooling and reeducation of the medical profession and its goals need to be achieved in order to get us out of the crisis bag.

Senator Muskie. Your third point, that health care is a political issue, I think speaks for itself. We don't need to elaborate on that.

But your fourth point I think especially needs emphasizing. That is that it doesn't work to guarantee good health care for just one segment of our population. That has been the effect, in your view, of Medicare and many other Government programs that have been developed. It has taken a piece of the problem, dealing with a piece of the population, and it hasn't produced an overall system that works for all members of our society.

Ms. Kuhn. Indeed, there are two responses that I would make. Not only is it piecemeal and a patchwork, but a good many of the patches are missing. So it really doesn't cover. We see no coherent mechanism or no coherent policy developed on the national basis that makes it possible for our country to have an overall health policy as it is presently set up.

We also see the segmentizing of our population for a particular kind of service that Medicare provides, for example, leading inevitably to a two-class system of health service, which is dehumanizing and anti-American really.

Health care we see as a right for everybody. Quality, excellent health care for everybody, not simply the rich who can afford very specialized care, but for all.

Senator MUSKIE. Now your fifth and sixth points logically follow what you have just said, that the health care system is necessary health services to society. At the present time there is no effective way to make public policy decisions in health care. That leads you to your conclusion that what we need is not national health insurance, it is not simply a patchwork of worthwhile innovation like HMO's, but what is needed is a national health service.

I wonder if you would expand on your concept of what a national health service should consist of and should provide.

NATIONAL HEALTH SERVICE NEEDED

Ms. KUHN. Well, for one thing, it is national. We see it as heading up at the Cabinet level with a new national health agency that would pull together all of the separate parts that are now administered in a dozen different places. We see it as based in different consumer-oriented mechanisms providing for continuing evaluation and input from advisory councils, local and regional groups of consumers working with health professionals. Now the consumers are left completely out, the health professionals thinking quite accurately that they know the technical answers. They do indeed. But without input from the consumers and without some really responsible planning and exercise of control and critique on the part of the people who are at the receiving end, it seems to me that no health care system can long endure or really continue to serve.

Now we feel that your committee should press towards this kind of national health service. There is a good deal of thinking in this country that if we got health insurance we would be in better shape. If we just had more money coming into the system, this is all we need.

But I am not willing, and my peers are not willing, to have the insurance underwriters and their lawyers determine what I need and why. Only I as a health consumer and only my peers as health consumers can responsibly respond to that question of what I need.

Senator MUSKIE. I can't resist one final question. Why did you choose the name Gray Panthers for your movement, your organization?

Ms. KUHN. Well, we like the name Gray Panthers. The media gave it to us. Our square name is really square. "The Consultation of Old and Young People Working for Social Change." By that name we might not have gotten here today.

To the people who are turned off by the title Gray Panthers, we say: "We are very sorry, obviously you are not ready for the kind of militancy that tackling the problems of our society requires. And if the name disenchants you, you are probably not going to be our colleagues in the kind of critical analysis of society and the kind of sustained responsible action for social change that we are into." We are demonstrating what old people and young people can do together.

Senator MUSKIE. Well, I must say that having had the opportunity now of reading this, the Gray Panthers suits you very well.

Ms. KUHN. Thank you. That is a lovely comment for you to make about us. I will remember that.

Senator MUSKIE. Senator Chiles?

Senator CHILES. No questions.

Senator MUSKIE. Senator Kennedy?

Senator KENNEDY. I just want to apologize for being late for the hearing. I will look forward to reading your testimony. I want to welcome you here.

Senator MUSKIE. Dr. Shulman?

STATEMENT OF HERMAN SHULMAN, M.D., CHAIRMAN, NATIONAL TASK FORCE ON AGING, MEDICAL COMMITTEE FOR HUMAN RIGHTS, AND DIRECTOR, GERIATRICS CLINIC, LINCOLN HOSPITAL, NEW YORK, N.Y.

Mr. SHULMAN. My name is Herbert J. Shulman, M.D. I am chairman of the national task force on aging of the Medical Committee for Human Rights, director of the geriatric clinic, Lincoln Hospital, and assistant professor of medicine, Albert Einstein College of Medicine, Bronx, N.Y.

I am here today to talk about agism and how it affects health care. The end result of the agism within our society is discrimination against older people in all walks of life. The negative attitude toward aging affects people of all ages so that many fairly young people feel they are already old. A youth culture has flourished which excludes most people in the country.

Agism affects health services in much the same manner as the rest of the society. With a health system which is not organized to deliver quality care to most people, the elderly because of their greater need for health services suffer more than others.

I will make a brief tour of areas of the health system to point out how agism influences health care.

In the acute public hospital—usually a city or county institution—many older people are admitted there because they have nowhere else to go. They are called "disposition cases" and are eventually transferred to nursing homes or extended care facilities.

"DISPOSITION CASES"

These "disposition cases" are frequently frowned upon by the medical staff because they are not acutely ill, though they occupy a bed in an acute hospital. Because of the disinterest in these patients, it is not uncommon for their medical care to be neglected while in the hospital.

The patients frequently spend many months in the hospital awaiting transfer; during this time they usually have no organized recreation programs or in fact any activities to keep them from sinking into deep isolation. At Lincoln Hospital, an acute public hospital in New York City, we have begun geriatric rounds where each week a so-called "disposition case" is discussed in depth by a team. The latter consists of doctors, nurses, dieticians, social workers, and physical and occupational therapists.

The conference tries to focus on many aspects of that person's problems so that a coordinated therapeutic approach can be planned. It should be noted that we cover only a fraction of those cases, since funding is not available to organize a large-scale approach.

Outpatient care is not emphasized in general within the present health system, but it is the elderly who frequently suffer the most. For

example, a patient in a typical hospital outpatient department may have to travel to different areas for an X-ray, electrocardiogram, blood test, dietary counseling, social service assistance, public health nurse counseling, psychiatric consultation, or general physical examination.

While this is inconvenient for any patient, it is more difficult for an older person to transcend these barriers. It is not surprising that many older people don't return for their next clinic appointment choosing no health care instead.

In a very few hospitals, a geriatric clinic has been established to provide more convenient, comprehensive services to the elderly. In the geriatric clinic at Lincoln Hospital, for example, we have the dietician, social workers, public health nurse, and psychiatrist all available in the same area as the patient's primary physician.

When patients go to other areas, they are escorted by senior aides who also act as patient advocates. It should be noted that clinics such as ours rarely serve more than a fraction of the older people coming to that institution. Our clinic illustrates what could be done, but funding for expansion and even for maintenance of existing services is not available.

There is a preferential availability of funds for maternal, infant, or child care projects as opposed to those for the elderly.

Outreach programs screen populations for abnormalities which might require medical care. These are well known though insufficient programs which screen for lead poisoning in children or tuberculosis. Comprehensive outreach programs for older people are rare; by this I mean a program which periodically tests and examines an older person for most common medical problems such as hypertension, heart disease, arthritis, glaucoma, or bone disease.

A very few programs do exist to screen patients in a senior recreation center. We have tried to start this in areas of the South Bronx adjacent to Lincoln Hospital, but getting any funds for this sort of program has been extremely difficult.

Funded Through Model Cities

I would just say that the senior aides in our clinic and the help for this attempted recreation center has been funded through model cities, and this program is being cut off in the near future.

Home care programs largely care for older patients. A well-run home care program can maintain a patient reasonably well in a familiar home environment, avoiding the institutionalization of the patient in a nursing home or chronic disease hospital. Unfortunately, large areas of the country have no home care programs, and those which do, such as New York City, have an increasing difficulty in recruiting physicians.

I have worked in areas of home care and I found it a very gratifying experience, but many physicians do not feel that way.

The practice of medicine has shifted over the years to a much larger population of patients with chronic diseases, many of whom are elderly. Chronic disease hospitals house a large number of older patients. They are usually staffed by dedicated physicians who work in isolation from the mainstream of medicine which is the acute care hospitals, in particular the university teaching hospitals.

In nursing homes which house a million elderly patients who are chronically ill, medical care arrangements are even further removed from the mainstream. Frequently the availability of a doctor to nursing home patients is erratic, while the number of patients who receive high quality long-term care from the same physician is quite small.

One of the greatest influences on the nature of the mainstream of medicine are the medical schools with their large network of teaching hospitals. Few, if any, American medical schools have departments or professorships in geriatrics, and many have no courses at all in this area.

It is a rare medical student, or even intern or resident, who has spent any time in a nursing home; most have never even visited a chronic disease hospital. Very few have participated in home care programs, if available, or geriatric clinic or outreach programs, if they exist. It is not surprising that large numbers of graduating physicians have developed neither experience nor interest in dealing with health problems of older people; only a very few plan to devote much of their career to geriatrics.

The mental health of older people is greatly influenced by the negative attitudes toward aging directed at them by others and by themselves. Some older people have actual organic brain diseases, such as senile dementia, for which there is no treatment, and which may sometimes require institutional care. Because of the rarity of trained geriatric psychiatrists, some patients who have treatable psychiatric problems are erroneously labeled senile and committed to a mental hospital where they may remain undiagnosed and untreated. The availability of psychiatric care in nursing homes is virtually nil, though large numbers of patients have psychiatric problems.

Osteoarthritis—Little-Known Disease

In the area of biomedical research there is increasing recognition of the importance of study of the aging process. Nonetheless, there are areas such as arthritis where research funds are declining. Osteoarthritis, the commonest form of arthritis, which affects mainly older people, is the subject of very little research despite the fact that 10 million Americans suffer from it. Medical students have told me they didn't know osteoarthritis was a disease though many of their grandparents would testify to its reality. Arthritis, as a group of diseases which cause chronic suffering more than death, has not been deemed a priority for research funds.

The failure of the present health system to meet the health needs of the general population, but in particular of older people, should mandate its complete overhaul. It should be apparent that the solution to the problems I have outlined requires more than mere health insurance, since older people have had that since 1966 without any solution to those problems.

A complete overhaul of the health system to direct it at meeting the health needs of the population at large, and the elderly in particular, would likely result in a nonprofit health system with a decentralized locally controlled administration including consumers in policymaking. The Medical Committee for Human Rights, a national organiza-

tion of people concerned with changing the health care system, is in favor of such a system.

Some actions by the Congress would help the elderly in the immediate future. Funds should be appropriated for the establishment of geriatric clinics in hospital outpatient departments and nonhospital ambulatory care facilities. A nationwide outreach program which sets up health screening sessions in every senior recreation center in the country should be started. Medical schools should receive funds to establish departments of geriatrics which would promote training and interest in this field to students and faculty.

Medical schools and hospitals should be funded to establish integrated systems of health care for all nursing homes and other chronic facilities in their areas. Funds should be appropriated for training and service programs in geriatric psychiatry. Funds for neglected areas of chronic disease research such as arthritis, and in particular osteoarthritis, should be increased. Greatly expanded home care programs should be funded as an alternative to the institutionalization of patients.

And, finally, I would suggest an expansion of the senior aides programs to include senior aides working in the health field.

Thank you.

[The preliminary position paper on national health care of the Medical Committee for Human Rights appears in appendix 1, item 3, p. 595.]

Nonprofit Public Health System Concept

Senator Muskie. Thank you, Dr. Shulman.

I wonder if you would expand a little more on your concept of a nonprofit public health system. Would that embrace every hospital, every doctor, every health facility and resource? Just what would it be?

Dr. Shulman. Well, I think that it is clear that a new type of health system is needed. And I think it is obviously a very complex endeavor to design such a system. Many of the countries have designed systems which perhaps would be more suitable for their country than such a system is for our country.

I think it is fairly clear that the American public itself will have to design a system that is appropriate for this country. It seems that in any comparative analysis the amount of money spent on health care of the United States is either first or second, so that the problem cannot merely be funds. And, therefore, it requires a revamping of where that money goes.

I know that that analysis of the health care system would show that a large share of that money goes to profits disproportionate to the amount of service rendered.

Senator Muskie. Do you have in mind a Government-operated system? In all respects?

Dr. Shulman. I think that in theory a Government-operated system would be preferable if that system were administered locally. In other words, it would not be an advantage to have an increased bureaucracy which would make it more difficult to change things or to have the flexibility necessary to perform in a given area.

But I think that with appropriate local and controlled administration that public reorganization of the health system would be of definite advantage.

Senator MUSKIE. Would this eliminate the doctors, the private doctors for private patients?

Dr. SHULMAN. I think that in some countries public health systems leave the doctor with the option for private practice. Other countries did not allow that option. I think that this country would have to go at its own rate to find a way to deal with it. I personally prefer, as do thousands of other doctors, to work on a salary arrangement.

Senator MUSKIE. In your statement you refer to the disposition of cases. I wonder if you would expand on the reasons why such a patient spends so many months in the acute care hospital when they are not in need of that type of care?

NEW YORK CITY SHORT OF NURSING HOME BEDS

Dr. SHULMAN. I think that this is primarily due to the shortage of nursing home beds, really, in New York City, particularly in the South Bronx. In the South Bronx the last nursing home was recently closed. The nursing homes are many miles away. On some occasions the patient of South Bronx has been sent to a nursing home in Connecticut, which makes it virtually an impossibility for a poor family to visit that patient very often.

Second, because of this shortage of beds the nursing homes are able to pick and choose the patients. In other words, a patient who requires less care is a less costly patient for the nursing home, and the proprietor of that nursing home can make a choice to pick such a patient who requires very little care as to one who would require a great deal of attention from the staff.

Senator MUSKIE. Then I wonder if you would tell us more about the Medical Committee for Human Rights. Has it developed concepts with respect to a national health service?

Dr. SHULMAN. Yes; the Medical Committee for Human Rights was formed in 1964 during the civil rights movement. It was formed primarily to send doctors and nurses to the civil rights marches in the South for medical care which they had difficulty receiving locally.

Since that time, the Medical Committee for Human Rights has became primarily an organization of people who work in the health field, such as doctors, nurses, social workers, technicians, and consumers, who are interested in working for change within the health system and also general social change within the society.

There is a national health plan which was drafted by a very talented member of the Medical Committee for Human Rights, which was an idealized health system which is available and which I could submit to this committee to put in the record.

I think that there is an interesting aspect to that. In reviewing this national health plan, as my consciousness about older people has risen, I think that it needs to be revised. Even that idealized plan has to be revised further to allow for the special needs of older people.

Senator MUSKIE. On this question of a national service or a national health system, one final question. Then I will yield.

It seems obvious that you and Ms. Kuhn emphasize this point because you are concerned that putting more and more money into the present system will not produce better care for people who need care. But I am still interested in knowing to what extent it would require an enlarged Government role in establishing programs, facilities, policy direction, and so on, and would require enlarged Government role in distributing the resources available for health care.

It would require, also, some provisions for financing health care for those who cannot pay out of their own resources. In terms of the financing, are you thinking in terms of national health insurance? Are you thinking in terms of a system that is financed as a Government agency, or department, or appropriations providing, say, free care to those who cannot provide it? Or exactly what do you have in mind with respect to that aspect of your concept?

Dr. SHULMAN. First of all let me just say one thing in response to the beginning of your statement. Pouring more money in the present system I can't say is of no avail. It may not be the best way to spend money. It is clear that one can outline programs which would immediately benefit many people in the country.

CONCEPTS FOR FUNDING

But it seems that that clearly is not the final answer. So to your question of how to fund such a system, I think that there should be certain principles and I think that one could derive the answer from that.

I personally believe that health care should be essentially without charge at the time of service. That is, cost should not be a consideration in getting health service. I think that national health insurance could meet the financial needs of such a system if it were written in such a way that it were graduated, which differs then from the present Social Security taxes. If the graduated income tax were used, the deductibles and other special clauses should be eliminated so that health care is truly available without cost at time of service.

Now, whether it makes more sense to have national health insurance as a separate tax on top of the graduated income tax or whether to fund that as a part of the general budget, I would leave to people far more knowledgeable than I.

Senator MUSKIE. Thank you, doctor.

Senator Fong?

Senator FONG. Dr. Shulman, you seem to think there is a failure of the present health system to meet the health needs of the general public and especially the older people. You said there is in the medical schools a lack of departments on geriatrics. And you talk about the mainstream of medicine. Now how would you go about delivering the health services in a more efficient manner?

Dr. SHULMAN. To the elderly?

Senator FONG. Yes.

Dr. SHULMAN. Well, I think I have concentrated a bit on the so-called mainstream because I, myself, have spent, as many people have, quite a good deal of time in so-called academic medicine which I think has become a very dominating force in the direction of medicine in this country.

As I said, within that complex of medical schools and teaching hospitals, there is very little interest shown or actual programs in the area of geriatrics. I would think that one way to stimulate interest would be to provide funds to set up either centers or divisions of geriatrics or to propose innovative health care programs for older people which would work out of that institution, such as providing health care to a local nursing home which usually doesn't have such a system.

Now I think that also expanding home care and trying to encourage these universities and hospitals to start home care programs is necessary. I think that very few hospitals in the country have home care programs. There happens to be a fair number in New York City.

I think that funds for appropriate purposes tend to encourage people to experiment with things which they might not do otherwise. I think that another problem I alluded to would be the thing that this committee wants to expand, that is, home care. One, you have to interest physicians in this sort of thing.

I think we realize there is a shortage of physicians. That means that these physicians have a multiplicity of jobs to choose from. The choice depends on that person's interest and the remuneration, but mostly on interest.

I think one has to make geriatrics, such as home care, attractive to people so that they will want to work in that area. Otherwise, even with funding the programs one may have some difficulty in recruiting competent, qualified people.

Senator FONG. You start with the premise that there is a lack of doctors?

Dr. SHULMAN. I think there is a lack of doctors, yes, sir.

Senator FONG. So the first thing to do is get more doctors?

Dr. SHULMAN. I think there is a need for more doctors, but I am also trying to say that there is a need for a change in the orientation of those physicians. Now it is clear that the newer medical students are more interested primarily in primary care than perhaps their classmates 10 years ago who were more interested in being specialists.

But nonetheless, I think that interest in geriatrics could be stimulated among these students. If the student is innovative he might take an elective in home care. For a majority of students the exposure is not there. To get people interested in geriatrics would make a tremendous difference in being able to structure these programs.

Senator FONG. So the idea would be to include efforts to encourage the medical student to go into geriatrics?

MEDICAL SCHOOLS IN FINANCIAL QUANDRY

Dr. SHULMAN. I think the medical schools, in my knowledge, are in financial quandary. It seems that many of them have difficulty making decisions as to what their future direction is. The Carnegie report has showed that medical schools should be more for community health, with smaller emphasis on basic research.

Nonetheless, the funding for that has not become available so that even where the desire to make that move exists—and I shouldn't say that this desire is so widespread because so many like it the way it is—even if that desire is there, without funding to provide geriatric programs, they just don't happen.

Senator FONG. You believe that funding should come from the Federal Government?

Dr. SHULMAN. It seems to me that that would be the most appropriate source.

Senator FONG. You stated in your statement here that it is difficult to recruit physicians for home care programs. Now how would you get them interested in home care programs?

Dr. SHULMAN. As I stated, I think that interesting them in geriatrics, in chronic care in general through their training by developing the type of programs that I mentioned would make many more physicians interested in this type of practice as opposed to more traditional practices of medicine.

Senator FONG. Thank you.

Senator MUSKIE. Senator Chiles?

Senator CHILES. You talk about a possibility that chronic disease hospitals house a lot of older people and there are dedicated physicians working there. Are there sufficient physicians in those hospitals?

Dr. SHULMAN. I don't think I am qualified to answer that question.

Senator CHILES. You then talk about the difference between these physicians and the mainstream that are in acute hospitals. Isn't that always going to happen where you have a sort of specialization?

Dr. SHULMAN. Well, I don't think so. I think that the reason is that, as Ms. Kuhn has pointed out, doctors have a traditional interest in acute care. In other words, most of the hospitals that we all hear about are acute care hospitals. If you go in for something you usually don't stay for more than a few weeks. The only reason you might stay longer is the delay in getting things done or waiting because people stay there waiting to go to chronic disease hospitals or nursing homes.

CHRONIC DISEASE HOSPITALS

But in every city throughout the country there are one or more chronic disease hospitals where patients are expected to go for a period of months. Most are expected to spend the rest of their lives in those institutions.

These are patients who have heart trouble or strokes or other kinds of trouble which require more medical attention than they could get in a nursing home but not acute enough to stay in an acute hospital.

Senator CHILES. That is a fairly new institution?

Dr. SHULMAN. No, sir. It has been around, to my knowledge, for many years. I don't know what the local one is, but I am sure there is one.

Senator CHILES. But you can't tell us whether there are sufficient physicians in those hospitals?

Dr. SHULMAN. I don't have that type of data. I didn't come prepared with that. I think the main point I was trying to make, if I can be even more blunt, geriatrics and chronic diseases do not have the kind of sex appeal that attracts people.

Senator CHILES. It is not being taught in the medical schools?

Dr. SHULMAN. It is not emphasized and sometimes not taught at all.

Senator CHILES. That is all.

Senator MUSKIE. Thank you very much.

Before we have the next witness to testify, I think the best introduction that we could give is to include in the record the review of her book which appears in the New York Times' book section of February 4 of this year. The book is entitled "Nobody Ever Died of Old Age." That is somewhat reassuring to some of us.

So, without objection, that review * will be included in the record and we would like Ms. Curtin to testify at this point.

STATEMENT OF SHARON CURTIN, R.N., LOVETTSVILLE, VA.

Ms. CURTIN. Thank you, Senator.

Some years ago when I was a recent graduate of nursing school, I had a job as head nurse to the geriatric ward. It was in a general hospital in California. I found myself working the midnight-to-8 shift by myself because we couldn't get help on the ward and I had to cover.

For a number of weeks I worked nights taking care of 30 geriatric patients. Many of them were chronically ill. Most of them were unable to get out of bed. I worked this for 2 solid weeks, 14 days, without a day off.

During that time we never could get anybody to come in, so I was just stuck, because it was my responsibility as the head nurse. And every night for 14 days I could not take care of these people because I didn't have the time to do the things I had to do. I barely had time to change the soiled sheets and hand out the medication and do the paperwork.

I felt haunted because the corridors seemed to be filled with the whispers of these patients; they just needed a little time and comfort and a little care and I couldn't give it to them. I also found myself, because the work was hard and difficult, being much rougher with these patients than I would have been ordinarily. I was tired.

After that, I quit working in the hospital because it was just too hard. I couldn't be the kind of nurse that I wanted to be. I am still haunted by those people who died with their heads turned to the wall, alone.

It seems like I have been on some kind of a search for the responsible elders of my tribe. I have worked in a national mental hospital. I was at a nursing home. I have worked in emergency rooms, doctors' offices, and as a visiting nurse.

"RIDICULOUS, SCANDALOUS * * * FRAGMENTED"

I found that the health care that is available for the aged in this country is ridiculous, scandalous. It is fragmented. People have a tendency not to listen to the elder patient. I think that both for the person who is old and ill, and, and for the person who tries to deliver that care, it is a frustrating, alienating experience because of the way the system is set up.

I had a friend who was 96 and was in a nursing home for a while. I saw her disintegrate while she was in there. She was never called by her name. They called her "Honey" or "Dearie." She lost all sense of privacy about her own body. Showers were in an assembly fashion.

*See app. 1, item 4, p. 600.

This was a very fancy nursing home, built after the passage of Medicare. The average fee was about $1,000 a month. In all those visible ways it had improved over other places I had seen including the "old folks home" that I remember from when I was a kid in Wyoming. One could call it a good nursing home. It had clean linen and the food wasn't bad. They did try to take care of the patients. Yet the staff was untrained and they didn't really care about the old people. They found it somehow alienating to work around them.

It was sometimes impossible for my friend to really hang on to herself. In fact, if she hadn't been so mean and so ornery and hadn't been very independent all of her life, I don't think she could have survived that experience.

I think the staff of that nursing home, and of other places I have worked, was not callous. I think that they are underpaid. I think that they are poorly trained. They usually received their training by working with another aide. Even the professional staff doesn't understand the special problems of the elderly.

Certainly in my training I was taught nothing about geriatrics. I was just lucky that I grew up with grandparents and great-grandparents and great-aunts. I have been around old people all of my life. That was one reason it has been easier for me to work with them.

All of the programs I know about or have worked under are frustrating for the person trying to work with them. If you work in the Golden Age Club, for instance—I did home health care out of a senior citizens center—and found that pretty soon the list of people you have to see is so long you don't have time to give proper care.

If you can't give the care that is really needed by people, you begin to harden. You start closing your eyes to things. This happens to almost everybody that works with older people. They start not listening. They think it is "just" an old man or it is "just" an old lady. "I don't really have to pay any attention."

Callousness to Old People

We are encouraged in this attitude by the culture as a whole. We are being callous to old people and thinking of them as going to die. We don't think of them as having a future. We think of them as people who are boring and not very interesting to work with.

If you are over 65 and you are trying to find health care, you find out that the first barrier you meet is glazed eyes and careless hands, anxious to move on to somebody else. I don't think it is because the people who are doing the work are evil. They are ignorant and they are blind.

I think we forget that we are all terribly ignorant about our own body. We forget that we are aging every minute. More and more of us are getting older and older. We tend not to pay any attention to those things. I know as I get older I keep thinking of myself as young. I am used to being called one of "those kids that are demonstrating."

I was laughing the other day because they are still calling us those kids and we are all in our thirties now. It is another example of how we tend to put labels on things by age. I have seen it in psychiatrists' emergency rooms. It is very interesting to watch. You have two pa-

tients come in saying that they are depressed. One of them is 63 and the other is 30. They both look the same. Their heads are drooping and their shoulders are pulled forward. Their eyes are tired and dull, and they are obviously depressed.

Well, the 30-year-old patient will spend a lot of time with the doctor and be given an appointment as an outpatient. People will spend a lot of time trying to cheer 30-year-olds up. They are the right age for a good psychiatric prognosis.

The 63-year-old patient will be interviewed for 2 minutes and be labeled as having organic brain disease. He might get some medication and be sent out without any aid or comfort because the doctor or psychologist has been taught to think of anybody over 60 as having brain damage. Their heads are soft. It is not that they can get depressed like anybody else; it is just that their heads are soft.

Particularly, in a psychiatrist's terms, they are rejected. I have worked in psychiatric emergency rooms. And I can say that there were older people who were depressed that I could talk to and find out something about them. I felt very much that their symptoms and their complaints were very much like somebody who is younger. But I could never get it through any of the doctor's heads or professionals that I worked with that they ought to listen more carefully. Usually the response when I started agitating was that an older person should have shock treatments, which is kind of a saddening thing for older, depressed patients. I didn't like that either and I didn't agitate too much.

National Institutional Bias

I think the second barrier to the older person might be the fact that as a society, when faced with a problem area, we decide to build an institution to take care of it. It is like we are a whole Nation of social architects. This, I think, is a ridiculous thing.

Recent studies have shown that only 4 percent of those over 65 are in institutions now, and probably half of those are inappropriately placed. They could manage at home or in a group situation with other people if they just had a little bit of help. They don't belong in the institution. This is a deposition problem and a lot of them end up in the back wards of State hospitals or in nursing homes, particularly if they have money. They don't belong there. They belong at home.

They belong at home except for two facts. One is that they don't get the little bit of home health care they might need, simple aids like scrubbing the floors once a week or doing the grocery shopping. They might need someone to come in and take care of medication properly. Second, they may need company, and have no one.

It is horrifying if you talk to people who have been institutionalized and you discover the sequence of events that led to their being put in what is essentially a prison. I remember one family I worked with who were evicted for nonpayment of their rent. The reason they hadn't paid their rent was their checks were stolen from the mailbox. They were paranoid because they lived in a rotten neighborhood. They ended up locked in the State mental hospital. He didn't need psychiatric care. She eventually was given shock treatments because

she did get pretty weird in the State hospital. But they are still there and they don't belong there. They belong in some kind of community. I couldn't get them out.

I had no power. The doctor felt they should be there. The social worker couldn't think of any place else to put them. There was only a brother in the family and I think he was the one that belonged in the mental hospital.

So these are the sort of things that happen to people. It is by accident, almost, that they suddenly got called to the attention of some part of the social system, some welfare worker, or doctor, who suddenly start interfering with their lives. They end up institutionalized when they might have ended up at home if somebody had tried harder.

The sad thing is that care for elderly is a big business. And certainly Medicare has been mentioned before, where the prices on everything went up amazingly high. Two of the nursing homes I worked in had a really interesting sort of a kickback. The pharmacist would kick back a percentage of his bill to the nursing home in order to have the privilege of providing medication for patients. The patient paid for it separately. This made their medical bill much higher, of course.

I think that leaving the health care system tied to the profit system is asking for trouble. You are providing a service that is not a service like buying a car or painting your house. It is a life service, and if the motives for delivering the care are the same as painting your house, it makes me a little suspicious about the quality of care.

I think that most people who are medical people or paraprofessionals are sincerely interested in their jobs. But as it is now, they are encouraged to think of it as a job and as a business and not as a real service that they want to give to the people because they are part of their community, part of their family. I think maybe the only way to get really good medical care is to be a child, or wife, or husband of a doctor. They are the only people that never have to pay for care either.

Large Family Assumes Burden

Recently my grandmother fell and broke her hip. I am from Wyoming originally, so medical service is sometimes sparse. She is in a hospital 50 miles from home. She has been lying in bed for a week waiting for a doctor to come and operate on her hip. There is only one doctor in the whole State that will operate on someone that old. And she is lucky because she has a family. She had 10 kids and her kids had 10 kids so there is a lot of family around her. Also, the family takes on the financial burden for her. She is lucky; she didn't get health care, but she does have love and care and comfort.

I worry about myself. I don't have any kids. Who is going to take care of me after I am 65? I don't want to be as powerless and victimized as I see most old people are in our society.

Thank you.

Senator Muskie. Thank you very much, Miss Curtin.

We put in the record earlier this New York Times review* of your book, and I would like to read something from that, because I think that what you have said in your testimony this morning perhaps gives us the spirit of what is required and our purpose.

*See app. 1, item 4, p. 600.

These are the two quotations that I like:

I sometimes have a dreadful fear that mine will be the last generation to know old people as friends, to have a sense of what growing old means, to respect and understand man's mortality, and his courage in the face of death. Mine may be the last to have a sense of living history, of stories passed from generation to generation. My identity is established by family history.

I don't know if there is any way that this committee can supply that ingredient of human life. I suspect there isn't. Yet your testimony is valuable because I think this is the essential ingredient to providing a decent care for each other. And it is well to bear that in mind as we think of the programs, the institutions, and policies we might create or construct in order to provide a system of health care.

None of it would work without this. It may be that the growing depersonalization of our age is irreversible. That is really what you are saying. But you do emphasize the importance of insuring that older people are made to feel a part of a continuing community. And since the subject of these 2 days of hearings is specially focused on home health care, I think your testimony is particularly welcome.

Now I wonder if you might expand from your own experience a little further on what you see as the essential services and techniques that are important in any worthwhile home health care programs.

Health Care System Utilization of Elderly

Ms. Curtin. First of all, I think that the health care system ought to be controlled and run by the people who utilize the services. They are interested in what can be improved and giving good care. For one thing older people ought to be used, utilized. There are a lot of volunteer programs that I think older Americans get into. There is the Foster Grandparent program where they work with retarded children.

But I think it would be important for them to work with older people also. Because nobody can understand better than somebody who has been through it.

I am not a real believer in Federal Government programs. I think that it takes people standing up and demanding something and going out and doing something about it to really utilize anything. I don't like anybody getting kicked by the Federal Government, getting the program pulled out from under them. They have the program for a year and then they depend on it and then it disappears. All of those things could be removed if the people who run the program are older people who keep the community moving, have an interest, who see what has to be done. These are jobs and controls at a community level.

Senator Muskie. Thank you very much.

Senator Fong?

Senator Fong. Miss Curtin, I have read your statement and I have listened to you. It seems that you are really talking about a thing which this committee has very little power over. You are really talking about man's inhumanity to man. You talk about being at the ward where you have 40 beds and you were the only one working there and you couldn't get another person to work. Why was that?

Ms. Curtin. Well, hospitals generally have trouble getting help. Nobody wants to work on the geriatric ward either because it is the hardest work in the hospital.

Senator FONG. How do you get people to work?

Ms. CURTIN. I think, too, if people would not find older people disgusting to be around. I think there has to be a total change of attitude in how we view age.

Senator FONG. The attitude?

Ms. CURTIN. The attitude, yours, mine, and everyone that works with them.

Senator FONG. Your statement seemed to deal more with the attitudes of physicians, attitudes of nursing homes. Here is a woman that went to a nursing home and she pays $1,000 a month. Yet she doesn't get the things she is supposed to get, the comfort and people to listen to and to talk to. How do you get that?

Ms. CURTIN. Well, I think that we need a different sort of a society, one where it would never occur to anybody to neglect other people simply because they were old and infirm.

Senator FONG. Actually you are saying we should reform our thinking, reform society.

Ms. CURTIN. Yes.

Senator FONG. I was appalled last night to see a picture in the Evening Star where a family was evicted. There were four or five people just pilfering the possessions of this person. How do we reform these people? In public they are stealing, they are committing a felony. How do we reform these people?

Ms. CURTIN. I don't know.

Senator FONG. Is it difficult?

Ms. CURTIN. It is difficult, but I think you don't start by saying it is impossible. You start by saying it is difficult.

Senator FONG. No, I don't say it is impossible. Our attitude has been too calloused. We don't think about the other man's problems. We are too inhuman about his problems. We don't relate ourselves to him and his suffering. Isn't this the whole gist of what you are saying, to change the attitude? There should be more humanity toward our fellow human being, that we should try to solace them, comfort them, and do everything possible to help them?

Ms. CURTIN. Yes. I just think you can't always be looking out for yourself. I don't know that that is a real common thing. I don't know that very many people are totally calluous.

MUGGINGS COMMON IN NEW YORK

Older people are designated as targets. In New York City over half of the older people get mugged every year because everybody thinks of them as people who are weak and unable to take care of themselves. All our culture, the things we have in our heads about them, makes them a target.

Senator FONG. You hear of those people confined at home and for whom the Government provides warm meals, and then the people who are taking those warm meals to those houses get mugged. How do you really reform that? How do you get away from that? Isn't that the real problem, that there are so many people who are so committed to these crimes of violence?

Ms. CURTIN. I think it is very difficult to say. This is a society that for 10 years destroyed another country on the other side of the world.

We are raising a whole generation now that has grown up in believing that this society can move anyplace they want to, just bomb the hell out of it, destroy the whole culture and get away with it. I think that is really hard to separate the kind of things you see every day on the street from how we act as a Nation.

Senator FONG. It is a questionable thing, isn't it. The question of whether we just intentionally went out to destroy the culture.

Now getting back to this care of the elderly. You talk about the physician who takes care of the younger man and lets the older man go, and the nursing home is there just for profit. How do we get away from it? Even if we pour all the money we can into nursing homes, do we make it any better?

Ms. CURTIN. I don't think that I would even start pouring money, unless you are talking about national health care or socialized medicine.

Senator FONG. I think that is what you are talking about, that every illness of a person should be cared for?

Ms. CURTIN. Absolutely.

Senator FONG. How would you go about that? Through insurance or through Federal appropriations?

Ms. CURTIN. I think probably it would be through Federal appropriations. It seems the logical thing to be funded nationally.

Senator FONG. How do you get away from the nursing home in which they give no comfort to the aged?

Ms. CURTIN. I think that one way you get away from that is that the older people have to build their own caring network. A couple things we tried is a commune of older people where people would move from one of the mental hospitals in New York, into an apartment, four or five together. What one couldn't do the other one usually could manage. It does work.

I think programs like that should certainly be encouraged in nursing homes. We think that institutions are always the answer. We think of that as the only solution. When we are looking at old age I think we have to look in another direction.

Senator FONG. Do you know of any group that have communed together, the aged, that each contributes some type of work toward the whole group so they can get along?

Ms. CURTIN. Yes.

Senator FONG. That is being conducted somewhere?

HELPING OTHERS IS TRADITIONAL

Ms. CURTIN. I think it is being tried informally in a lot of areas. It is kind of a tradition in this country. If Grandma Sue is sick, then Aunt Mary, who is not really a relative, comes in, and then Cousin Jenny comes in. This is in a small town a lot of the time.

You see two or three or four of them in a large commune. This should be about the size of a family so they are able to live in a family house. Not a large group, because if it is too large a group, somebody is going to play social worker instead of just being equal.

Senator FONG. Thank you.

Senator MUSKIE. Senator Chiles?

Senator CHILES. It is interesting, that in your book, the thesis is everything is geared to the young. I think that is so true. Where do you

think now people tend to make the transition from being young to the crossover line?

Ms. CURTIN. As I told you, as I get older that line seems to get further and further away.

Senator CHILES. I find the same thing.

Ms. CURTIN. I don't think it always comes from the outside in. I think it begins when somebody else thinks you are old. I think suddenly you have to realize that you are older.

Senator MUSKIE. You are the only one in your class that stayed young.

Ms. CURTIN. Something like that, right.

Senator CHILES. How is it that you go about that attitude, or how about making that change, or what change can be made?

Ms. CURTIN. I think groups like the Gray Panthers are one of the most important things. They are a visible, articulate group of people who are out there in front. People can look at the Gray Panthers and people who are members, and they can say, "Isn't that sweet." Sooner or later they are going to find out that Maggie is going to hit them over the head if they continue to treat them in a condescending fashion.

I think old people are the ones that have to change that. They have to demand things just as women had to demand not to be condescended, too. I think old people have to do that by gathering together and getting strength from each other.

OLDER PEOPLE CATEGORIZED

Senator CHILES. More and more as we get into this a little better we realize that we tend to just place some curtain over the older people and then, one, they are categorized, and once the curtain falls and as you say that doctor treats them differently, all treatment is completely different. I think that is done very much without anybody realizing it at all, that that is happening.

That is something that has grown up over the last 50 years or so. But I only became aware of it just very recently and now began to see the different ways it has happened. How do you attack that?

Ms. CURTIN. There are ways. One way is that people ought to be more educated about their bodies so that they will understand the aging process and what it is all about. So then it is not as much of a shock. They also understand what kind of care they can demand and expect to receive. I don't know how you change the whole attitude of the whole country.

Senator CHILES. I am not sure the Government can do that.

Ms. CURTIN. You could set an example, you know, by always taking your grandparents to lunch. That is an important thing to do, to keep older people a part of your life, an integral part of your life. You can show them this side for everybody. That is where you start. That is where anybody starts, just a few people trying to do something.

In China five guys went into the mountains for a while and they had a revolution. That is the sort of thing we have to do now. Start with whatever we have and go on.

Senator CHILES. Thank you.

Senator MUSKIE. Thank you all very much for your excellent testimony. We are delighted to have had you here this morning.

Our next witness is Dr. Charles C. Edwards, Assistant Secretary for Health, accompanied by Dr. John Zapp, Deputy Assistant Secretary for Health, and Claire Ryder, Chief, Ambulatory and Home Health Services Section.

Dr. Edwards, when it has quieted down a little identify yourself and others in your group for purposes of the record.

STATEMENT OF CHARLES C. EDWARDS, M.D., ASSISTANT SECRETARY FOR HEALTH, ACCOMPANIED BY JOHN S. ZAPP, D.D.S., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION; JOSEPH MANES, DIRECTOR OF LONG-TERM CARE, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE; THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION; MARIE CALLENDER, PH. D., SPECIAL ASSISTANT FOR NURSING HOME AFFAIRS; AND CLAIRE F. RYDER, M.D.M.P.H., CHIEF, AMBULATORY AND HOME HEALTH SERVICES SECTION, HEALTH RESOURCES ADMINISTRATION; DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. EDWARDS. Thank you, Mr. Chairman. I recognize there are quite a number of us here, but there are quite a number of us in the Department of Health, Education, and Welfare that are involved and interested in this.

I would like to introduce, if I could, my colleagues. On my immediate left is Dr. Claire F. Ryder, Chief, Ambulatory and Home Health Services Section. To her left is Mr. Thomas Tierney, Director, Bureau of Health Insurance. On the far left is Joseph Manes, Director of Long-Term Care, Medical Services Administration. On my right is Dr. John S. Zapp, Deputy Assistant Secretary for Legislation. Next to him is Marie Callender, Special Assistant for Nursing Home Affairs.

Mr. Chairman, do you want me to go ahead?

Senator MUSKIE. You may proceed.

Dr. EDWARDS. I would like to read portions of my statement, but with your permission we would like to submit the entire statement for the record.

Senator MUSKIE. It will all be included in the record and you may present it in any way you wish.*

Dr. EDWARDS. Thank you very kindly.

Mr. Chairman and members of the committee, you have asked the Department to present goals for home health services and to discuss the effects of the recent reorganization of the Department on the realization of these goals.

GOALS FOR HOME HEALTH SERVICES

Our goals for home health services or for these services are for them to become an effective resource for health services delivery in our pluralistic health care delivery system. Our principal objective is to

*The prepared statement of Dr. Edwards appears on p. 575.

develop a full range of alternatives to the often inappropriate institutional care to enable people to maximize their independence and participation in community life while maintaining their health.

It has been only in the past two decades that home health services have been recognized and widely acknowledged as one of the promising approaches for responding to the pressures upon the delivery of health care that can more positively assure health care for the American people.

Home health care programs have demonstrated an ability to expand the capacity of our delivery system by providing needed care while conserving scarce and costly resources, both institutional and professional. Home health care service systems may also exert some restraining influence on overall medical care costs.

The Department of HEW encourages the development of and access to home health services through the efforts of several agencies. The health service and resource agencies have attempted to be catalysts for community development of effective home health care mechanisms. The health financing agencies have sought to provide financial access to Federal beneficiaries in need of the service of home health agencies. The human resource and service agencies have encouraged the integration of home health services with other service needs of the elderly, the poor, and ill or disabled persons.

One of the earliest evidences of HEW interest in home care was a Public Health Service survey of selected programs conducted in 1954 with the Commission on Chronic Illness. That study revealed very few programs in existence. Two surveys conducted in the following 10 years showed slow but steady growth in such programs. The 1964 Public Health Service survey of coordinated home care programs identified 70 operational programs. At that time it was estimated that there were probably 100 additional programs which, with some modifications, could be considered as coordinated home care programs.

Between 1960 and 1967 many collaborative activities were carried out between PHS and national private organizations interested in furthering home health care resources. Such organizations as the American Medical Association, the American Hospital Association, the National League for Nursing, Blue Cross Association of America, National Association of Blue Shield Plans, American Public Health Association, and the American Public Welfare Association joined with the Public Health Service to conduct national and regional meetings, prepare materials such as the "Guide for Development and Administration of Coordinated Home Care Programs," and to assist with needed data collection.

Personnel Training Centers

During this time, the Public Health Service also supported the development of training centers for home care personnel in various parts of the country. Just prior to the enactment of Medicare, there were seven of these centers, training over 2,000 persons per year.

I would like to move on in my testimony, Mr. Chairman, to discuss very briefly the Medicare program.

Home health services for the aged and disabled are an important component of the coverage provided under the Medicare program,

which is administered by the Social Security Administration. Under Medicare, home health benefits were designed primarily to meet specific medically related home care needs of the patient who does not require the continuous intensive care that is provided in hospitals and skilled nursing facilities, but who nevertheless suffers from a condition of such severity that he is confined to his home under the care of a physician and is in need of either skilled nursing care on an intermittent basis, or physical therapy or speech pathology.

Such coverage is intended to support the use of this alternative to continued inpatient care by aged and disabled patients who might otherwise be forced to obtain services in hospital or skilled nursing facilities. Home health services are covered under both parts of the Medicare program. Payment of the full reasonable cost is available for up to 100 visits under the hospital insurance stay, and for up to 100 visits per calendar year under the supplementary medical insurance program (part B), without regard to whether the patient has had a prior hospital stay.

Senator FONG. That means that the patient can have 200 visits?

Mr. EDWARDS. That is correct.

I would like to now, Mr. Chairman, very briefly summarize the role of Medicaid.

Title XIX, known as Medicaid, is administered by the Medical Services Administration of the Social and Rehabilitation Service. It provides Federal matching payments for State expenditures for health care for the poor.

In fiscal year 1972, 52 States and jurisdictions were participating in Medicaid. All States participating in the program must provide medical assistance to recipients of cash assistance—poor persons aged 65 and over, low-income blind and disabled individuals, and AFDC families.

In addition, States may extend their programs to cover the medically needy—those persons who would be eligible for cash assistance except that the level of their income and resources is sufficient for their maintenance needs but not to pay for necessary medical care.

Every State with a Medicaid program is required to provide home health care services for all individuals who are eligible for skilled nursing home care. The services provided to Medicaid eligible under home health care are intermittent or part-time nursing care, services of a home health aide, and medical supplies and equipment.

Under current regulations, an agency providing home health services must be certified as a Medicare vendor or be eligible to become one. In areas where there are no title XVIII (Medicare) agencies, an independent registered nurse or licensed practical nurse under a physician's direction may provide services to patients in their place of residence.

HUMAN RESOURCE AGENCIES

Then moving on in my prepared statement, the human resource agencies, I would like to very briefly summarize their role.

The Administration on Aging administers or assists in several programs related to home health services for the aging, authorized by the Older Americans Act.

Title III of that act authorizes projects to increase the capability of the elderly to maintain independent living. Many of the projects con-

tain explicit home health components and many others have health-related aspects. Besides visiting nurses and home health aid services for the home-bound elderly, services include homemaker, immunization, screening programs, health education, accident prevention techniques, home repairs, and delivered meals.

Some title III projects also train geriatric aides to provide services for and monitoring of the home-bound ill. Title III also supports model projects "to develop and test innovative approaches to change those conditions that prevent or limit opportunities for older people to live independently and participate meaningfully in community life." Of the 21 model projects funded last year, 18 had homemaker and/or home health aide components. In 12 of these, home health components were established because of the model project, while in the other 6 situations, the projects served to link existing home health resources with other project resources.

Under title IV of the Older Americans Act, research and demonstration projects have been conducted to test alternatives to institutionalization for the elderly. The Medical Services Administration and the Health Services and Mental Health Administration have assisted in the funding of these grants. These seek to develop models by which the Department's goal of providing alternate living and service arrangements for older Americans who would require hospitalization without such services.

Regarding the effects of our recent reorganization, Mr. Chairman, presently the major health and social service agencies of HEW have each exercised a responsibility for some aspect of furthering development of and access to home health services under Federal programs. There have been cooperative grants for projects. There have been cooperative regulations. There has been extensive involvement with professions and communities.

Linkages to Financing

It is my hope and intention to provide leadership in the development and carrying out of the Department's health policy to this end. I have strengthened the capacity of my immediate office, directed a study of and helped to effectuate a realinement of the health agencies, and established direct linkages to the health financing programs that will, I believe, permit more effective policy and program development and consistent application of policy.

The recent reorganization of the Health Services and Mental Health Administration and the incorporation and consolidation of all long-term care concerns in the Health Resources Administration will offer greater opportunity for the pooling of existing interests and expertise, the crystalization of proper Federal, State, and community public roles, and the implementation of a more comprehensive and effective national programing and evaluation effort, with respect to home health services projects and activities.

We hope to be able to better understand why providers have often been reluctant to utilize home health services to provide their patients needs, how resistance by providers, patients, and community elements can be overcome, how to assure better linkages between inpatient health

care institutions, and home health services, as well as with other health care services and centers which communities need to provide comprehensive health services.

In 1970, President Nixon announced his health care strategy for the 1970's. Preservation or expansion of what is good in our present system is the hallmark of that strategy. Home health services are one of the good parts of the system. It is my pleasure to have a significant role in coordinating the Department's programs to further improve and expand our home health services efforts.

Mr. Chairman, this concludes my statement. My colleagues and I would be pleased to answer any questions. As I mentioned earlier, we have the expertise of the experts of the Department here with us to try to answer questions.

Senator MUSKIE. There is a vote underway on the floor, so I will recess for a period long enough to get there, vote, and come back. We should be back within 10 or 15 minutes.

AFTER RECESS

Senator MUSKIE. We always have too little time to probe the questions raised by the testimony against conflicting testimony and to form the basis for some judgment.

So I would like to get at the heart of some of the questions, ways, and issues formed in the last 2 days. As I read your statement last evening, I found it difficult to distinguish between what it said and what was said by some of our witnesses yesterday. All seem to be a wholehearted, comprehensive endorsement of home health care as an option that should be available in our system. And yet there are entirely different conclusions as to where we now stand with respect to official policy, programs, and practices.

So I would like to ask, if I may, two or three questions which go to the heart of what creates the issue of the conflict of you and the administration as you represent it and the witnesses yesterday. It is obvious they are very unhappy. You will see this if you read the testimony of yesterday or the report on it. They are very unhappy about the impact of our present Federal policies upon the prospects for making home health care a viable home health resource in the country.

One issue in that controversy is the provision of household services to the home-bound patient, such as changing beds and bringing food. Medicare regulations, and Medicare is not your particular responsibility, but nevertheless I would hope I could get your comment, allow payments for home health aides for these services only—and I quote: "If these household services are incidental and do not substantially increase the time spent by the home health aide, the cost of the entire visit would be reimbursable."

But yesterday we heard testimony by Hadley Hall, executive director of the San Francisco Home Health Service, and I quote: "Can any reasonable person assume that doing necessary cleaning, shopping, cooking, and laundry because of health will be only incidental in terms of the time of any person?"

The reason home health aide services were included in the original Medicare legislation was so that our ill population could remain in

their home rather than be institutionalized. This cannot happen if maintenance services are not covered.

Using the Home Health Care Option

In other words, the point made by Mr. Hall and other witnesses yesterday was that the home health care option will not grow or be developed unless these incidentals or maintenance services are made available in the same way they are made available in hospitals, or in a similar way.

Would you give me your reaction to that in terms of your own concept of care, and second, in terms of your current policy and practices?

Dr. Edwards. Yes, Mr. Chairman. First let me just say that I certainly don't consider myself an expert in home health services. However, I have been interested in health for a number of years, since I have been involved in the health care delivery system. I would certainly agree with you that we are a long way from where we want to be in terms of home health services. It is a long way from where I would like to see it.

I do think that we made some strides in the right direction in the last few years and particularly in the last year or so. I think there are two very real elements to this and your very articulate witnesses, just like ourselves, expressed some of the intangibles that are very difficult for Government agencies to get hold of.

I think the attitude of medical professionals has not helped this movement a great deal. I don't think the average doctor tries to find a role for home health care services or tries to make home health care services a very meaningful part of the health care delivery system. That is a problem of education and understanding.

I would tend to agree with you that you cannot look at just the delivery of professional health services as the total program of home care. Maintenance services have to be considered in developing the overall strategy and program concept in specifically identifying what Medicare will provide.

I would like to have Mr. Tierney speak to that particular issue, if you don't mind. He is better acquainted with it.

Mr. Tierney. Senator, it strikes a very basic provision of the Medicare law. I am afraid some people think we are engaging in semantics, but if you go back and read through the law in the committee reports it is quite obvious that the Congress had in mind providing a health service, and it provided that the whole cornerstone of the benefit was based on the necessity of providing a health service in the home.

Now if that health service is required and if the skilled services of a nurse are required in order to provide professional care, then these other things come into being. A home health aide is provided because there aren't enough nurses to do all these things. But a health aide, with emphasis again on health, would also be allowed to do nonskilled things and nontherapeutic things like cleaning the house, going out and buying the groceries, doing the cooking, and that sort of thing.

It seems again a semantics distinction but that is the very distinction that limits the Medicare program. That is the end of it.

Senator MUSKIE. Are you saying that the Medicare program permits the home health aides to do these incidental things?

ASCERTAINING CONGRESSIONAL INTENT

Mr. TIERNEY. Yes, sir. But I think people tend to think in terms of homemaker service, somebody who will really come in and take care of the person who doesn't maybe have a health problem or doesn't need professional service or doesn't need an intermittent skilled nurses aide, but has a need for assistance in living, just the basic activities of life. But the Congress very clearly say no—that we cannot include as a benefit. It has to be related to the skilled care. It has to be related to the need of professional nursing. And it can carry with it the services of a home health aide who will be allowed, in addition to laying on of hands, if you will, to do these other things around the house.

Senator MUSKIE. Let me read the law:

The terms home health service means the following items of service furnished to an individual under the care of a physician by a home health agency or by others under arrangements with them made by such agency; under a plan for furnishing such items and services to such individual established and periodically reviewed by a physician, which items and services are provided under visiting the patient in a place of residence used in some individual's home.

Item four is the one that relates to home health aides—"To the extent permitted in regulations, part-time or intermittent services of a home health aide"—now that language by itself would seem to give the administrator considerable leeway——

Mr. TIERNEY [interrupting]. Yes.

Senator MUSKIE [continuing]. "In permitting the reimbursement for incidental services." These are the kind which you seem to be referring to. The thrust of the testimony yesterday was that that administrative discretion has become increasingly restrictive over recent years in interpreting this language. I wonder if you would comment on that.

Mr. TIERNEY. Yes, Senator. Of course, we know the best interpretation that any agency can give in trying to assemble regulations under a directive of that sort is the committee report of the legislative committee. And I think if you go through that, particularly the Senate committee report, it is quite a bit more restrictive than that.

For example, it points out that it is the intent of the committee that the person be home-bound. You don't really find that in the legislation. And it goes on to say that it is the intent of the committee that what I was talking about before, there be a basic health necessity that triggers the whole benefit.

The basic health necessity is the need for skilled intermittent nursing services. When that exists, then a home health aide can be employed and we have then interpreted that to mean and established that to mean they can conduct these obviously nonprofessional services.

Senator MUSKIE. I think it would be helpful, and I will ask the staff to include the current language on the committee report so that we will have it to refer to as we study this program.

[The information referred to follows:]

1. Report of the Committee on Finance on the original Medicare legislation (H.R. 6675), page 33.

"Covered services.—The proposed posthospital home health payments would meet the cost of part-time or intermittent nursing services, physical, occupational, and speech therapy, and other related home health services furnished by visiting nurse agencies, hospital-based home health programs and similar agencies. More or less full-time nursing care would not be paid for under the home health benefits provision. Payments could be made for services furnished by other parties under arrangements with such agencies—the services of an independent physical therapist and interns and residents in training of an affiliated hospital, for example.

"To the extent permitted in regulations, the part-time or intermittent services of a home health aide would also be covered. The duties of the home health aide which would be covered are comparable to those of a nurse's aide in the hospital who would have had training and experience that is not ordinarily possessed by lay people—for example, training and experience in giving bed baths to ill and bedfast patients. Often, the home health aide services are essential if the patient is to be cared for outside a hospital or nursing facility. *Food service arrangements, such as those of meals-on-wheels programs, or the services of housekeepers would not be paid for under the home health provisions.*

"While the home health patient would have to be homebound to be eligible for benefits, provision is made for the payment for services furnished at a hospital or extended care facility or rehabilitation center which requires the use of equipment that cannot ordinarily be taken to the patient in his home. In some cases special transportation arrangements may have to be made to bring the homebound patient to the institution providing these special services. The transportation itself would not be paid for. If he is furnished other services at the hospital or facility at the same time, these too could be paid for, even though they are of a kind that could be furnished in the patient's home. But such services would be covered only if they are furnished under arrangements which provide for billing through the home health agency. For example, if it is necessary, because of the size of the equipment involved, to take the patient to a hospital to give him physical therapy and while at the hospital he receives speech therapy, benefits could be paid for both services, but only if the home health agency takes responsibility for arranging and billing for all the services."

2. The report of the staff to the Committee on Finance in the United States Senate on "Medicare and Medicaid, Problems, Issues, and Alternatives," dated February 9, 1970, page 37, said:

"HOME HEALTH SERVICES UTILIZATION MUCH HIGHER THAN ANTICIPATED

"In the absence of adequate information, the actuarial estimates in both 1965 and 1967 assumed a first-year cost of about 50 cents per eligible person for posthospital home health services under the hospital insurance program. This represented a $10 million cost in 1967. It was assumed that home health services would result in some hospitalization cost savings.

"Actual costs in 1967 were about 2½ times that figure, and the 1969 revised actuarial estimates start with a base cost figure of $1.30 per enrollee for 1967. Both per capita costs and utilization rates are assumed to increase by the same percentages as extended care facility utilization and daily costs are projected to rise. At these rates of increase, the per capita cost of home health service will jump from $1.30 in 1967 to $1.83 in 1970, and to $2.39 by 1975."

3. On page 111 of the report, it is stated:

"Homemaker benefit as alternative to institutional care:

"Institutional utilization review, ideally, relates the patient's need for continued institutional care in the context of available alternative services. Many physicians and a number of health insurers have pointed out the pressure for continued hospitalization of a patient for several days more than medically necessary because of the lack of someone to assist the patient at home with food preparation, routine cleaning, etc., during the first week or two following discharge from the hospital. During that period, the patient gradually recovers capacity for independent living and ability to meet his routine living needs. In the absence of assistance at home during that recuperative period, physicians are understandably reluctant to discharge patients and patients are reluctant to go home. The present alternative to continued hospitalization is to discharge the patient to an extended care facility or skilled nursing home, which, while less costly than hospital care, is still quite expensive and often encompasses more care than those patients need.

"The staff recommends that *consideration be given to authorization of homemaker services to a medicare beneficiary* where his physician certifies that in the

absence of such services continued institutionalization of the patient would be required. While the benefit would be charged against the home health coverage in medicare, a homemaker agency, distinct from the present "home health agency" employed in Title 18, might be an adequate and less costly alternative to use of a "home health agency."

"To avoid abuse and to gain appropriate experience with a homemaker benefit, provision of this coverage might be made available initially on a demonstration project basis. That would enable comparative experience to be measured and costs assessed. Further, at the beginning, and perhaps permanently, such coverage should be limited to the number of days specified by the physician not to exceed a period of 2 weeks."

4. The Report of the Committee on Ways and Means on H.R. 17550 (the predecessor of H.R. 1) dated May 14, 1970, however, contains the following language:

"Homemakers' services under medicare.—Your committee gave consideration to coverage of the services of home maintenance workers (homemakers) as part of home health services under both the hospital and medical insurance programs. *Under the present law, the home health benefit is designed for those beneficiaries whose conditions do not require the continuous medical and paramedical care provided in hospitals and extended care facilities, but nevertheless, are of such severity that the individuals are under the care of a physician, confined to their homes, and in need of active health requiring skilled services.* Care that is primarily custodial in nature, whether the care is provided in a nursing home or provided by a health aide in a private home is not covered under the medicare program. Nor is the care covered when the patient needs only personal care or nonskilled health care.

"Although home maintenance services as such are not covered under the home health benefit the covered services of a home health aide may include certain home maintenance services which are performed by the aide under professional supervision. *These services* may include keeping a safe environment in areas of the home used by the patient, such as changing the bed, light cleaning, laundering essential to the comfort and cleanliness of the patient and include seeing to it that the patient's nutritional needs are met, which may include purchase of food and assistance in preparation of meals. *These services may be covered when they are only incidentally provided while the home health aide is fulfilling her primary function of providing health services.*

"Your committee believes that while financial assistance in maintaining one's home may be necessary and desirable for the well-being of an older person, *it is not the purpose of the medicare program to cover all services an older person may need or use, particularly those which are not clearly a part of the person's health care.* In view of these priorities, your committee is requesting the 1969 Advisory Council on Social Security to make a study of the unmet need of medicare beneficiaries for homemaker services."

5. Recent expression of Congressional intent is contained in P.L. 92-603. In Section 222(b)(1)(E), the Congress extended the experimental rights of the Secretary established under Section 402(a) of the Social Security Amendments of 1967. The amendment provides that in order to determine whether coverage of homemaker services would provide suitable alternatives to the posthospital benefits presently provided under Title 18, *the Secretary may experiment with covering the services of homemakers for a maximum of 21 days if institutional services are not* medically necessary. (Italics supplied.)

Restrictive Interpretation of Law

Senator Muskie. Is it true that the witnesses yesterday were in error when they said that the interpretation of this language has become increasingly restrictive since it first became law?

Mr. Tierney. No, I don't think increasingly restrictive at the present time, Senator.

Senator Muskie. I think they are speaking not of just the last year or two, but over the entire period.

Mr. Tierney. Yes, it has.

Senator Muskie. It has become more restrictive?

Mr. TIERNEY. Yes. In application and in practice it has, Senator. I think the record will show and certainly the record of the Finance Committee hearings in 1969, that nobody had a lot of experience with home health care as a third-party benefit. I think one of the greatest breakthroughs Medicare made was that it was the first program of any size that ever really recognized a home health service as a covered benefit.

And quite honestly, when it started it was a very small portion of the whole program. It was never designed or estimated to be more than 1½ percent the total of part A expenditures. We had a lot of programs with Medicare program processes, and I think it is quite true, Senator, that home health bills just got paid and there really wasn't much of an analysis of them.

Until we finally got to a place where we could stand back and look at how things were going and the Senate Finance Committee put a very heavy spotlight on the entire benefit administration, it was quite apparent that bills were being paid that shouldn't have been paid at all.

So from that point on when we began to be more responsive, if you will, in the administration of the acts' provisions, there were bills turned down.

Now even to date, Senator, the number of bills turned down is only about 2 percent of the bills submitted. And I say that only to get a perspective and not to tell you that there isn't a problem, because there is a real problem.

Ninety-eight percent of the bills are paid, but the 2 percent which aren't are still a real problem, and some bills, I think this is another point, just don't get sent in.

Senator MUSKIE. That is the point I was going to make. There was quite convincing testimony yesterday indicating that there has been a chilling effect which has inhibited people from submitting these bills. Let me just ask that with respect to the Senate report to which you refer, there has to be, according to the language you used, some real health triggering to eligibility for reimbursement. Could that be, under the law, the imminence of hospitalization?

Mr. TIERNEY. No, not really, Senator. As you heard this morning, and I am sure you did yesterday, there are two separate provisions. There is part A, where you have to be in the hospital 3 days and all the rest of that. Part B is the other. In each part of the program, 100 units are available.

In both cases, the laying out of a medical care plan and the physician's determination of the medical necessity of this care triggers the benefits.

Once that is established, then the benefits are available. But those are the things that start it.

Senator MUSKIE. So that really home health care under these restrictions is closely tied to hospitalization?

Mr. TIERNEY. Not under part B. There is really no tie, Senator. They don't have to have been previously hospitalized. Nor is there any requirement that there be an imminence of hospitalization. Under part A there does have to be prior hospitalization.

Senator MUSKIE. What is the limit to reimbursement of the kind of services or otherwise with respect to part B?

Mr. TIERNEY. Well, first of all, agencies must be certified in order to participate at all. They are allowed under current legislation to be reimbursed the lesser of their charges or their costs under a cost formula. That is the way they are paid because like a hospital or a nursing home, they are providers and they are reimbursed the same way.

Senator MUSKIE. I wish you would review some of the testimony yesterday which indicates this. We put the specific questions to you. The view that you get this morning of the impact of the current policy practice is different from the view we got yesterday, and these were responsible people who testified yesterday. They didn't make careless or unfound complaints, I don't think, about the program. They posed a rather disconcerting picture of the program that is not moving, that is slowing down, that is being chilled, and is being inhibited and restrained because of the restrictive interpretation of the law made by the agencies. You don't give that picture at all.

Mr. TIERNEY. I don't minimize the validity of what those people were saying nor of what the young lady was saying this morning. I think the frustration arises, Senator, out of a great recognition of a real need and a wish that if we can fill that need and take care of an old person and keep her out of the hospital by taking care of her at home, that is a desirable thing to do. I totally agree.

But the frustration comes from finding out that we won't pay for that because there really isn't any basic certified health need and that—what they are doing is coming in and feeding her and changing her bed and taking care of her, the living problem. That is a very bad situation. I don't quarrel with that. But the law, Senator, says that we will pay for health care.

Senator MUSKIE. Apart from the law, the health problem includes the kinds of services we should be providing or reimbursing.

Mr. TIERNEY. I don't know that I am qualified to speak of that. My job is to try to administer what has been done. I personally think that an expansion would be desirable or at least we could get away from the idea of covering only health needs. This problem isn't all health but the only thing that is available at the moment is a health insurance program.

Senator MUSKIE. What is health? Miss Curtin this morning described the deterioration of someone, of an elderly person in a nursing home who was charged $1,000 a month. She was getting presumably the skilled health care that would qualify for reimbursement under that law. But her health was deteriorating. Why? Because of the absence of "nonhealth" legislation.

But the problems they are describing here are the nonhealth elements in the quality of life in that nursing home. There could be a deterioration of health in the home, not for the lack of technically skilled nursing care but because of lack of other kinds of care.

Now, what should the dividing line be? This is what I am trying to get from you people who are experts.

Dr. EDWARDS. Could I ask Dr. Ryder to address herself to that?

Dr. RYDER. Senator, I find myself unable to separate social needs, environmental needs, and health needs. I believe they are irretrievably

intertwined. I would like to say, however, that the problem of paying for all of these services is what we are addressing.

To learn more about what should be paid for, section 222 of Public Law 92–603 provides an opportunity to test out a clearly defined homemaker service as a possible alternative to the present benefits under Medicare part A. It will allow us to establish some demonstrations and experiments designed to test out what kinds of patients would benefit from this particular service, the length of the service that they would need, and the costs and impact of such service.

Clear Definition of Service Needed

One of the concerns that I see addressed in these projects as a part of this whole area of homemaker-home health aides—and I hyphenate the terms rather than separate them because one person, the homemaker-home health aide, provide both elements of this kind service—how this service can expedite or even make possible the delivery of professional health services. There are times when a responsible caretaker is not available. The patient lives alone or the caretaker is a frail, 80-year-old man who can't give the care needed. We then have to find someone to give that care. The homemaker-home health aide then becomes a provider of a combination of health and social services. This kind of supportive service must be more carefully defined and the benefits worked out carefully through these kinds of demonstrations.

Right now the cost of such a service is an unknown factor, in a sense. We therefore need some time to develop the parameters of such a service.

Senator Muskie. Is it your position that at the present time we should operate within the present limitations until we learn more through the demonstration projects that have been authorized under the law? And how long will it take us before we learn enough to expand the concept?

Dr. Ryder. The plan for setting this program in motion is now under consideration. As soon as the approval is given to move forward and funds are found, these projects could begin to provide us with some information within a year. We will not have all the definitive answers by then, but some answers will be available if the projects can be started within a reasonable period of time.

Senator Muskie. Have you seen the definition of home health care which has been developed by four national organizations to which reference was made yesterday?

Dr. Ryder. Yes, I have, sir.

Senator Muskie. How far from the present policies is that definition? Is it consistent with it? Is it broader than the present policy?

Dr. Ryder. From an administrative point of view I think it lacks certain elements, but from a service or a philosophical point of view it is certainly consistent with the overall desires of the administration to provide home health services as a benefit under Medicare.

Senator Muskie. The administration is not prepared to accept it as a basis for reimbursement under Medicare?

Dr. Ryder. I think there needs to be additional factors considered. For example, reimbursement of home health services under Medicare

requires the involvement and direction of the attending physician. These roles of the physician are omitted in that definition. The definition does not preclude them, but it does not state them either.

Senator MUSKIE. That is the only important missing element.

Dr. RYDER. I believe so—to the best of my understanding.

Senator MUSKIE. Now I would like to put to you another criticism raised yesterday. I am not going to put them all to you, but this one, I think, ought to be discussed by you since it was raised by a group yesterday.

It is the requirement of skilled nursing care eligibility. You have already discussed this somewhat. As I understand it, to be eligible for home health care reimbursement a patient should be eligible for skilled nursing care. Is that correct?

Dr. RYDER. Or physical therapy or speech therapy.

Senator MUSKIE. Those three. With respect to the first, one of yesterday's witnesses representing the National League for Nursing described, in her words, how this requirement and the regulations implementing it had become a major barrier to the delivery of care to the aged. She concluded, and I quote, "Greatly needed care has been withheld: patients, families, nurses and SSA/BHI personnel have suffered immeasurable pain, frustration, expense and wasted effort at horrendous cost without return to the taxpayers."

How would you react to that?

"SKILLED NURSING SERVICE"

Dr. RYDER. I think that the term "skilled nursing service" refers to the fact that a skilled nurse, that is a registered nurse or licensed practical nurse, provides a service. I think at one time, however, it was felt that that service had to also be a "skilled" service, regardless of the fact it was a professional person delivering it.

Senator MUSKIE. A skilled health service.

Dr. RYDER. Yes; it had to be a skilled health service. The recent redefinition by the Social Security Administration of "skilled nursing" allows the patient's condition to be considered. Thus, if an individual needs a service that could perhaps be provided by a nonskilled person, but his condition is such that he requires a nurse to perform that service, this could be counted as a skilled nursing visit. I think the redefinition and clarification has eased the situation considerably.

Senator MUSKIE. I would like to interrupt my questioning and your answers a moment, if I may.

Mr. Wilbur Cohen, who was Secretary of HEW not so long ago, is in a position to give us some testimony on the history of this situation. I would appreciate it very much if you are willing to do that, if you could stay a few minutes for that.

Senator Kennedy?

Senator KENNEDY. I had the good opportunity to listen to Dr. Edwards on our Education Committee on the whole community school programs. And, of course, he has such a range of experience and interest, especially in the health area problem of the elderly.

I wonder if I could ask some questions. I just have some brief questions, if I could go on. Then I will look forward to reading Mr. Cohen's testimony.

Senator MUSKIE. Go ahead.

RESTRICTIVE GUIDELINES

Senator KENNEDY. I want to extend a welcome to all of you who are here. Basically the problem with the more restrictive guidelines is that when these programs were developed there was a liberal interpretation of them and then there began to become some kind of recognition of the tremendous increase in the cost of these programs. It was really, at least it is my impression, that as the increased cost became more apparent, there was a direct relationship to the more restrictive aspects of the guidelines themselves. At least this has been my impression and conclusion.

I don't know whether you want to make any kind of comment whether it is a reasonable inference to draw or not. But that is certainly one that I have drawn over the period of time. Do you want to make any comment on that, Dr. Edwards?

Dr. EDWARDS. I don't, Senator. Perhaps Mr. Tierney would.

Mr. TIERNEY. Senator, the only thing I would say is that I am not sure that it is total costs because the costs of home health care have never really been a significant part of the Medicare program. Certainly it was made apparent in the Senate Finance's examination of the administration of Medicare programs that intermediaries were apparently paying for a lot of bills that shouldn't have been paid for. They stopped that, so it is a combination of the cost plus simply not continuing to pay for services that should not have continued to be paid.

Senator KENNEDY. You certainly should consider the cost of the custodian's care, nursing home care. They have been going up very significantly over a period of recent time.

Dr. Edwards, in your testimony you talk about a comprehensive coordinated approach to the organization, financing, and assessment of health care. Do you have your testimony in front of you on that paragraph?

We need a comprehensive coordinated approach to the organization, financing, and assessment of health-related care. Most importantly we need a smooth continuum of care, right from the hospital to the nursing home, to day care, home care and other services. Thus, home care is seen as an important aspect of an integrated package of services available to the individual as needed. Development of any aspect of the service continuum would likely result in an imbalance of services, costs, and patient well-being.

I think that says it. I agree with that commentary 100 percent. Now to go one step further, it would seem to me if we are going to achieve that, this coordinated approach ought to be included in the health insurance package if we are going to eliminate a piecemeal approach and coordinate a more comprehensive approach in terms of day care, nursing home, and other services.

It would seem to me it should be included in the health insurance package. Let me say that the Health Security Act, which you are familiar with, does not include the kind of programs which I think you have outlined as being essential and necessary here. Their exclusion was primarily because of the cost factor, which you may be familiar with. Those that developed the financing of the Health Security Act estimated those costs to be about $8 billion, which is enormously expensive. It was difficult to relate the expenditures for these services to the kinds of savings which I think we would have in other areas of health services under the Health Security Act.

Can you indicate now whether this kind of coordinated approach would be included in the administration health insurance program, or will it be a piecemeal approach?

Dr. EDWARDS. I can't, obviously, through a point in time give you what the administration's program is going to be specifically, but I think without it we are not going to solve the kinds of problems we are so familiar with. I think this was one of the problems we didn't think about when Medicare and Medicaid came about. I think we didn't really think about how we were going to meet the demand, how are we going to develop some kind of comprehensive strategy to take care of this problem.

I don't think we can come up with a financing program without looking at all the issues, and namely, how do you coordinate these things and bring them into the total program.

Senator KENNEDY. Well, I wish we could be somewhat more precise on that. Have you developed a cost figure on the custodial care, nursing home care, other kinds of services?

Dr. EDWARDS. We have some figures. I don't have them with me now, but we have some figures that I could discuss with you. But I don't have them now.

Senator KENNEDY. Could you submit them for the record, Mr. Chairman, the figures that they have?

Senator MUSKIE. Yes.

Senator KENNEDY. I am referring to the administration's system with respect to the cost for custodial care, nursing home care, the other day care and other care services. I think it is very sizable.

Dr. EDWARDS. It is sizable.

[The following reply was received:]

We have reviewed our departmental records and are unable to provide definite national cost figures for the existing amount of custodial care, home care and nursing home care because such data has not been collected on an aggregate or national basis.

In answer to the second part of your question, the administration's national health insurance proposal is presently under development and when completed, we will be able to discuss with you the administration's approach to insure that health care services supported under the proposal is delivered as a continuum, including home care, nursing home care, and associated services. At that time appropriate cost data will be available.

Senator KENNEDY. We ought to, I think, really lay out what these costs are, and what really needs to be done if we are talking about that $8 billion.

The American people, I think, if you are really serious about doing the kinds of things you are hoping to do, ought to recognize that this is going to be costly.

COORDINATED ADMINISTRATIVE APPROACH

My understanding is that we have several programs around the country that are trying to zero in a little bit on each of the elements of the total cost.

But you are unprepared now or unwilling to indicate whether this will be a part of the administration's overall package on health insur-

ance? I am talking now of the kind of program that you have identified as the best approach, the coordinated administrative approach.

Dr. EDWARDS. Well, I am very hopeful. Obviously I can't be any more specific than that. But I am very hopeful that it will. I can't believe that we could really give you a plan without including the coordination. I will say that.

Senator KENNEDY. Could you give any indication when that program will come up, your health insurance, anything further on that?

Dr. EDWARDS. The Secretary indicated, I think it was yesterday or the day before, that by late September—well, he made a commitment for late September. We are heavily involved in it right now trying to look at the basics and seeing what kind of basics we can put together for these issues.

Senator KENNEDY. I don't know if you are familiar with Dr. Lionel Cosin's program. I would be glad to refer it to you for your health report. I would be glad to send you a note on it.

What we saw there, the kind of integrated approach which they have developed and he has developed is absolutely superb and a really outstanding example of other countries and other programs perhaps. The amount of time that it saved compared to people being in the hospital on more expensive kinds of programs was enormously impressive.

He also testified before our committee and I would be glad to send you a copy of that testimony as well. I think he has been one person with an extraordinarily successful program.

I want to thank you, Mr. Chairman.

Senator MUSKIE. Thank you, Senator Kennedy.

Before I call on Mr. Cohen, I would like to ask just one final reaction from you, if I may. My time is running out and we have another witness in addition to Secretary Cohen.

Your statement contains a note of optimism, with respect to the future of the Medicare program, that was a reverse of that which we received yesterday.

DECLINE OF HOME HEALTH AGENCIES

The report prepared for our subcommittee which was released yesterday gives us the following figures. It may or may not be in variance of the figures that are contained in your statement, but they show a different trend. It showed the number of certified home health agencies actually declined for the past 2 years in a row. In 1970 the number was 2,350. In 1971 it was 2,256. At the end of last year it was 2,221.

Your statement referred to the last figure but not the first two. Don Trautman who represents the National Association of Home Health Agencies told us that. He said the home health agencies are facing a financial crisis. They are being forced to curtail services, or in some cases, terminate services.

If a substantial portion of home health agencies are forced to discontinue operation, there will be no recourse but to keep patients in the institutions. Research reveals that the cost of health care in such a setting as that is 2½ times the expense of the same service in the home.

Dr. Edwards your own testimony showed that last year's Medicare reimbursement for home health care also went down to $69 million in 1972.

So the whole picture presented to us yesterday and the report prepared for us that was released yesterday is a deteriorating one rather than a growing one, a healthy one, as your testimony suggests this morning. Would you want to comment on that apparent difference in perspective?

Dr. EDWARDS. I would just say a word, Mr. Chairman, and ask Dr. Ryder if she would care to comment.

I don't know if your use of the word deterioration is quite the right word. I recognize the total dollar difference; however, the reduction in the number of home health care agencies has in part been caused by a consolidation in the number of home health care programs over the Nation. At least as I understand it, the consolidation has brought about the establishment of a number of agencies that are providing more comprehensive services than existed with the larger number of agencies that were in existence several years ago.

I think in addition to that, it isn't just a matter of dollars. It is a growing awareness and appreciation on the part of other members of the health care system what the real role of home health services can and should be. I think one of the reasons that I am, to a limited degree, an optimist, is because of a growing awareness of this. There is a growing awareness that is a fact which can not only provide better care, but hold the lid on overall health care costs. From that point of view I think there is reasonable optimism.

Senator MUSKIE. I think I would say that it is fine to have a general overall appreciation of home health agencies and their programs, but that in the meantime they face three specific problems that aren't being recognized and utilized in current policies.

RESTRICTIVE REIMBURSEMENT POLICIES

One is the Cost of Living Council, and I refer you to the testimony yesterday to get the details on that problem. Secondly, the restrictive reimbursement policies to which we have already made reference and which were really belabored yesterday. And finally is this whole question of the basis for reimbursement, being cost versus charge, whichever is the lesser, which really seems unconscionable in the application.

These three problems have put agencies in a financial squeeze. That there is a financial crisis that forces agencies to curtail services and in some cases terminate operation.

So I think that while we focus on what is the healthiest long-term policy to develop, there should be some leadership within the administration to recognize these critical short-term problems which the witness described with an enormous sense of urgency yesterday and which I call to your attention.

Dr. EDWARDS. I think these are problems.

Dr. RYDER. I would like to address the fact of the declining number of home health agencies. I think one of the problems we are facing is that nearly 50 percent of home health agencies certified under Medicare have only one or two nurses on their staff. In addition, nearly 50 percent of certified home health agencies provide only nursing plus one additional service. Both of these facts mean we have limited service at the present time in nearly one-half of these agencies.

I would also like to say that our philosophy has been that every community needs home health services but not every community can

afford a home health agency. This brings me to the point of the decline in the number of agencies in recent years. We have growing evidence that communities are realizing that it is inefficient and ineffective to have two or three home health agencies in the same community battling with one another to get patients in their services. Many rural areas are trying to maintain a full-blown home health agency when they don't have the resources to do so.

Around the country, there is growing evidence of changes going on, sometimes with an increased population being covered in the long run with fewer agencies. As an example of this, there were five visiting nurse associations and health department agencies in Luzerne County in Pennsylvania. These five have consolidated their staffs as a single agency certified under Medicare. When they first came together, the five agencies could only pool their resources for taking care of 200 people at any one time. A little over a year later they are taking care of 900 people.

In Massachusetts and in Rhode Island, a similar type of regionalization of service has occurred so that a decreasing number of agencies has maintained or even made possible an increasing impact on the population served.

Senator MUSKIE. Could you supply us with the documentation of that?

Dr. RYDER. Yes, sir.

[The information follows:]

When Medicare benefits went into effect on July 1, 1967, there were 1,474 agencies certified to provide home health services. In 1970 this number increased to a peak of 2,350. Then a decline occurred which at first was due to the financial stresses of retroactive denials, particularly among the new or small agencies which were hastily developed, had poor administrative or management skills, or lacked sound community support. The latest information is that there are 2,210 certified home health agencies.

Recently, there is reason to believe that the decline is due to another factor—consolidation of resources. In many communities, several small home health agencies have been combined into a single larger organization, which then serves the same or even larger area of population.

Since Medicare, the Rhode Island Health Department has worked toward consolidating the small existing home health agencies into more comprehensive organizations. As a result the State has seen a reduction from 27 certified home health agencies in 1966 to 9 today, but the entire State remains covered by these agencies.

Massachusetts has embarked on a regionalization program for home health agencies. Efforts have been directed to consolidate small community agencies into a broader more comprehensive areawide home health agency.

The following chart reflects the regionalization which is occurring in Massachusetts home health agencies serving 351 cities and towns:

[In percent]

	1966	1972
Population coverage	97	99.4
Total number home health agencies	204	[2] 201
Number noncertified agencies	48	37
Towns without service	49	27
Number of single agencies [1]	173	149
Number of regional agencies [3]	31	52

[1] Includes 6 Blue Cross financed hospital based home care programs duplicating home health agencies already in the community.
[2] Serve 1 city or town.
[3] Serve 2 to 14 cities or towns.

Senator MUSKIE. I wonder if you would bear with us to allow Secretary Cohen to take 4 or 5 minutes at this point to give us his historical perspective of this problem.

[Dr. Edward's statement continues on p. 570.]

STATEMENT OF WILBUR COHEN, COCHAIRMAN, INSTITUTE OF GERONTOLOGY, UNIVERSITY OF MICHIGAN-WAYNE STATE UNIVERSITY; DEAN, SCHOOL OF EDUCATION, THE UNIVERSITY OF MICHIGAN; AND FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. COHEN. Senator, I would be glad to do this. The major public policy question we were faced with in the establishment of Medicare was how to undertake the biggest program in medical organization and financing in the history of this country. We were faced with the question of extending medical care to 20 million people on 1 day, 1 minute after midnight of the time that Congress put the law into effect.

I might say I, as well as my colleagues, were extremely concerned that our medical system in the United States was not equipped in planning to handle that. The opposition of the American Medical Association for 40 years previous to this led us to a position where we only had a minority of the physicians in the United States involved in the planning.

Therefore, in my own role at that time I took a very cautious role in implementing the program. And I will take the responsibility that most of the limitations and deductibles on insurance and restrictions in the law were put in with my concurrence in order that we could get the law started cautiously on the principle that Congress was always going to be here and could always reduce the deductibles or take out a limitation on expense.

In other words, I followed the policy contrary to what the Government did in OEO and contrary to what we did in other legislation I was involved in, which is "Don't try to do everything for everybody at once and then fail."

I was even more convinced of that since I left office that the administrative managerial aspects of new programs is extremely important to the American people and in their attitude about the ideological aspect of the program and how to finance it.

Prof. John R. Commons of the University of Wisconsin said: "If you have a choice between a good law that is going to be badly administered and a not-so-good law that is going to be well administered, take the latter." I have followed that in my own experience.

REASONS FOR '65 LIMITATIONS

Now the reason we put various limitations in the law on health services and on the skilled nursing home is because at that moment of time, in 1964–65, we didn't think we had the managerial experience to do everything. We felt that experience would show Congress how to make incremental change. I think it was the right philosophy.

I think we are now at the point with 7 or 8 years of experience where Congress can take out restrictions. I favor, for example, to

broaden the home health service at the present time to 200 days a year or even more. I don't think the cost element is that significant. I favor adding hearing aids and eyeglasses. I was opposed to them earlier but now I think we have a better idea on how to handle them. I now favor prescription drugs because we worked out a plan.

It is a very fine organization that Mr. Tierney produced in these years which I have great confidence in. I am sure Congress can build on that.

You cannot provide adequate home health services simply by providing reimbursement through the Medicare program. You must have a grant program that provides for the organization of home health services on an initial basic planning grant.

In other words, what I would favor is that you authorize either through a title of the Older Americans Act or a title of the Social Security Act or any appropriate place a 5-year categorical grant program. That is another case where categorical programs are justified and sound to provide the financing that would aid home health services to get initially organized. Once you get them organized you can get the current financing the same way as a child learns to walk. It has to crawl first and then walk, and so on.

Help the home health service get started and get the planning grant and maintenance grant started for 5 years and get them to go from adolescence to adult through the Medicare program. I am prepared to say that despite all the difficulties that occur, there is no question in my mind, Senator, of all the New Frontier legislation and of all the Great Society legislation, I am willing to say that the incremental approach that is used in Medicare is far more successful than that used in the OEO program or any of the education programs because it provides for managerial knowledge and skill upon which Congress can build.

Senator MUSKIE. Secretary Cohen, I appreciate that suggestion.

STATEMENT OF DR. CHARLES C. EDWARDS—Continued

Dr. Edwards, I know you have to leave. Senator Percy has one question he would like to put to you. And, Mr. Cohen I don't know if Senator Percy has a question for you too, but in any case I thought we could put these questions out to Dr. Edwards. Dr. Zapp has indicated his willingness to stay for questions. Then we can excuse you, Dr. Edwards.

Senator PERCY. My questions are very brief. I have two.

I understand the testimony yesterday, and again today, has indicated so far as the cost effectiveness is concerned, that home health care is highly effective and less costly than other types of institutional care. This certainly was brought out in hearings of this subcommittee that I conducted in Springfield, Ill.

MEALS-ON-WHEELS PROGRAM

Dr. Edwards, you are very familiar with the Meals-on-Wheels program. I won't go into areas you are familiar with. I delivered meals for a whole day some time ago, just to see what the conditions were and who was receiving these meals. And the cost was infinitesimal.

Most of the people, if they didn't have such an assist, would have to be institutionalized, and they didn't want to be. They were clinging to where they were staying, and they were pleased with the meals from the Meals-on-Wheels program which enabled them to stay in their own little home. This might be a little hole of an apartment on Wisconsin Avenue. They would rather stay there than be institutionalized.

Is it your finding that an expanded health care or home care would be a cost effective device? Should we be thinking of expanding it if we want to take care of the people in the way they want to be taken care of and if we want to do so at the least possible cost?

Dr. EDWARDS. There is no question about it, Senator Percy, that the closer we could move health care to the people the greater the effect it is going to have on the overall cost of health care. I think this is one of the real problems that we have to pay attention to in the Federal Government, that is to categorically look at each program while at the same time try to develop overall health care strategy. We must learn how to mold these categorical programs into a broad, comprehensive program.

I think there are a number of things we are going to have to do if we are going to contain the cost of health care within reasonable limits. One of the things is just exactly what you say. We have to encourage the service that will push health care away from the institution and closer to the home. I think this will have a tremendous impact this year or next year and ultimately on the overall cost of health care.

Senator PERCY. The second question: All of the other witnesses have one way or another said that access should be provided and an opportunity for such services expanded, all types of home health services. My question is where does the manpower come from? Do we have the delivery system if we expand such services? If not, what do we have to do to get it adequately delivered and adequate personnel to carry out the expanded service?

Dr. EDWARDS. Senator, if I could, I would like to ask Dr. Ryder to answer that. She is more familiar with the specific needs of that program.

Senator PERCY. I would be delighted. If you have to leave, you may slip right out.

Dr. RYDER. One of the things we have looked at is the usual challenge of having the professional person going out to individuals' homes, taking up more time perhaps than if these same individuals were located in an institution. However, home health services take advantage of several opportunities. One is that they offer an opportunity for part-time employment that institutional facilities would not find feasible. In addition, they provide an opportunity for inactive nursing personnel to come back into the field to take on a part-time job while still caring for young children.

NONPROFESSIONAL EMPLOYMENT OPPORTUNITIES

The second aspect of this question is that home health offers a very special opportunity for nonprofessional persons. The homemaker-home health aide is readily available. It does not take endless months to train these individuals. If agencies could be convinced that there would be adequate reimbursement for this service, there would be

adequate employment opportunities and it would not take too long to get ready for providing this service.

The third element of importance that we have not mentioned enough, is the resource of the family itself. Home health services make it possible to support the family, giving them the security of knowing that they have professional backup. I remember being very impressed by a family where the daughter was receiving renal dialysis in her own home. Her parents had full responsibility for her care. The father was a shoe salesman and the mother a housewife. With very little help and training, they were giving her superior care because of their great motivation to take care of their own daughter.

We are thus finding that home health can make possible an expansion of the manpower pool in several ways, that is, using part-time personnel, training semiskilled, or nonprofessional persons, and making full use of the patient and his family.

Senator PERCY. Just to comment on that. I am gratified to have your expression. One of the main principles of the administration has seemed to be volunteerism. The Government Operations Committee reorganized all of the volunteer programs under one head to economize and make them more efficient. I would suggest that within the executive branch you might point out the services that are going to be needed and get action to see whether or not they can't go out and recruit people for programs of this type.

The young man I delivered meals with was a conscientious objector who took years out of his life to devote himself to this activity rather than to military service. He had a warm personality. When he brought those meals to the older people he would just sit down and talk to them for a few minutes. He and they looked forward to it. It meant a lot to both. He thought that was one of the greatest experiences he had ever had.

I think a few months of training or a few weeks of training in a few cases would bring forth many, many people who would like to do this if we can indicate the need.

Thank you very much indeed.

Dr. RYDER. Such volunteer services are a necessary part of home health services. We need a telephone reassurance service or friendly visiting as well and volunteers are very capable of providing such services.

Senator PERCY. Mr. Chairman, I would simply like to say that we had a markup in some other committee that prevented my being here. But I commend the Chair on these hearings. I consider them extremely vital and necessary.

Senator MUSKIE. I hope you have taken care of my interests in some of those other committees.

Senator PERCY. We voted every proxy exactly in accordance with your instructions.

Senator MUSKIE. Mr. Secretary, thank you very much for helping with your testimony. Mr. Miller, minority counsel, does have a question on behalf of Senator Fong.

Mr. MILLER. Senator Fong had five questions regarding part B of Medicare that relate to home health care services, particularly as re-

lated to the individual. Perhaps the most efficient way to present them and to save time is for me to go ahead and read the five questions for the record.

The questions are:

(1) How does a person obtain home health services under part B of Medicare? We are talking about the patient now.

(2) Who determines eligibility of need for such benefits under part B?

(3) What review process is there once benefits begin?

(4) How fully have the home health services been used under part B of Medicare?

(5) Why has this program not been used more extensively?

Senator MUSKIE. Five excellent questions. Can you answer them, or do you want to supply the answers for the record?

Mr. ZAPP. Yes; we could supply the answers.

Senator MUSKIE. That is fine if you will prepare the answers, perhaps you could answer them more fully.

[The questions and answers follow:]

(1) How does a person obtain home health service benefits under part B of Medicare?

In order to qualify for home health benefits under part B of Medicare an individual must be entitled to Medicare benefits and enrolled in the medical insurance program (part B). In addition, the individual's physician must certify that he is homebound and requires skilled nursing services on an intermittent basis, physical therapy or speech therapy, and must establish and periodically review a plan of treatment for providing the required home health services. These services must be provided by a home health agency which is participating in the Medicare program. An individual who meets these requirements is eligible to have payment made on his behalf for the skilled nursing, physical therapy or speech therapy he needs, as well as for any of the other home health services specified in the law which are required for the treatment of his illness or injury. These services include occupational therapy, medical social services, the use of medical supplies and appliances and the part-time or intermittent services of a home health aide. The aide may provide such services as meal preparation and maintaining the cleanliness of the home but only to the extent these services are coincidental to the health care of the patient. Conversely, an individual who does not meet these requirements is not entitled to have payment made under the program for any home health services furnished.

(2) Who determines eligibility or need for such benefits under part B?

The actual need for home health services is determined by the patient's physician who establishes and periodically reviews a plan of treatment which depicts the specific items and services to be rendered. Whether or not the prescribed services are covered under the supplemental medical insurance program, however, is determined by the intermediary. The intermediary also verifies that the patient meets the other eligibility requirements, e.g., he is entitled to Medicare benefits, his benefits are not exhausted and he is homebound.

(3) What review process is there once benefits begin?

The responsibility for making determinations of the amounts to be paid to providers of services for covered services furnished eligible beneficiaries has been delegated by the Secretary to fiscal intermediaries because the intermediaries, from past practice, had developed the techniques necessary in processing health insurance claims. In order to effectively carry out its responsibilities, the intermediary must review all bills submitted for payment and identify those which appear to contain a request for payment for noncovered or excluded services. When the intermediary's claims review personnel identify such a case it is referred to the intermediary's professional staff which determines coverage based on guidelines developed by the Bureau of Health Insurance and circulated in the form of manual issuances. If the professional staff concurs in the finding of the claims review staff that the claim may be for noncovered services, the

intermediary may request additional medical information from the home health agency. It may also be necessary to request, through the provider, information from the attending physician. If the additional information provides satisfactory evidence to establish that the claim is for covered services, the claim is processed and paid without further review. This same process is repeated for each bill that is submitted until home health visits cease, the patient's home health benefits are exhausted or it is determined that the services are no longer covered.

(4) How fully have the home health services been used under part B of Medicare?

From the inception of the Medicare program on July 1, 1966, and through July 1, 1972, the Medicare program reimbursed home health agencies over $335 million for paid part A and part B claims. Approximately one-third ($110 million) of this amount was reimbursed for part B paid claims. (See table.)

For 1972, participating home health agencies derived upwards of $60 million from services provided to beneficiaries under both the hospital and medical insurance programs. This averaged $91 per recorded claim under hospital insurance and $55 under medical insurance.

One reason why the average amount paid out under part B was less than the amount paid for part A in 1972 is because part B benefits were subject to the deductible and coinsurance amounts. In addition, most beneficiaries who are entitled to part B benefits also have part A entitlement. Since there was no coinsurance or deductible under part A, if a patient had a prior hospital stay of at least 3 days it would have been more advantageous to him to receive home health benefits under part A. Also, post-hospital or post-skilled nursing facility patients generally require more skilled services for a longer period of time than patients who did not previously receive inpatient care. Since a majority of home health patients are eligible for 100 home health visits under part A, there is no need for them to draw upon part B home health benefits unless they have exhausted their part A benefits.

(5) Why has it not been used more extensively?

One problem with regard to utilization of home health services in general has been the limited availability of home health services. In fiscal year 1969 only four States (Delaware, Maryland, Pennsylvania, and Rhode Island) and the District of Columbia, Virgin Islands and Guam had home health services available to 100 percent of the population. However, 54 percent of the counties nationwide had no home health coverage available. Often services are not available where the need is most acute; about half of all the counties in the country are still not serviced by a home health agency. At the beginning of fiscal year 1969, the Public Health Service with the Bureau of Health Insurance identified 99 counties which had populations of 50,000 or more and did not have an agency available. The Public Health Service and the State agencies in which these communities were located undertook a special effort to get home health agencies established. They have been successful in 35 of the 99 counties. To date, approximately 2,200 home health agencies are participating in the program.

Another problem has been that many physicians are unaware of the presence of home health agencies and, consequently, have not utilized their various services. This could be attributable in part to the fact that many home health agencies have not emphasized their presence in the community. Since the physician has to certify that the patient is in need of intermittent skilled nursing or physical or speech therapy, and draw up a plan of treatment for providing such services, it is necessary that he be familiar with the home health services available in the community.

We anticipate that utilization of part B home health services will increase as a result of the provision of the 1972 Social Security amendments which eliminated the 20 percent coinsurance for part B home health services, making payment for home health services under part B the same as under part A, after the part B deductible has been met. This provision should encourage those individuals to seek home health care who would not otherwise utilize the home health benefit because they do not have the resources available with which to pay the coinsurance amount.

MEDICARE: NUMBER OF HOME HEALTH AGENCY (HHA) PAID CLAIMS AND THE AMOUNT REIMBURSED, FISCAL YEAR 1967–72

Fiscal year	Total		Part A		Part B	
	Number of claims	Amount reimbursed	Number of claims	Amount reimbursed	Number of claims	Amount reimbursed
1967	554,886	$28,947,917	232,766	$15,277,589	322,120	$13,670,328
1968	871,613	49,990,860	442,715	31,160,712	428,898	18,830,141
1969	1,097,655	69,702,776	582,745	44,734,797	514,910	24,967,979
1970	1,105,373	73,044,556	627,988	49,402,833	477,385	23,641,723
1971	801,036	57,705,466	501,027	42,134,534	300,009	15,570,932
1972	735,281	56,380,737	483,181	42,835,063	252,100	13,545,674

Source: Office of Research and Statistics, Social Security Administration.

Senator MUSKIE. Thank you for your patience and your testimony.
[The prepared statement of Dr. Edwards follows:]

PREPARED STATEMENT OF DR. CHARLES C. EDWARDS, ASSISTANT SECRETARY FOR HEALTH, DHEW

Mr. Chairman and members of the subcommittee:

You have asked the Department of Health, Education, and Welfare to present goals for home health services and to discuss the effects of the recent reorganization of the Department on the realization of those goals.

Our goals for home health services are for them to become an effective resource for health services delivery in our pluralistic health care delivery system. Our principal objectives is to develop a full range of alternatives to the often inappropriate institutional care to enable people to maximize their independence and participation in community life while maintaining their health.

It has only been in the past 2 decades that home health services have been recognized and widely acknowledged as one of the promising approaches for responding to the pressures upon the delivery of health care that can more positively assure health care for the American people.

Home health care programs have demonstrated an ability to expand the capacity of our delivery system by providing needed care while conserving scarce and costly resources, both institutional and professional. Home health care service systems may also exert some restraining influence on overall medical care costs.

The Department of Health, Education, and Welfare encourages the development of and access to home health services through the efforts of several agencies. The health service and resource agencies have attempted to be catalysts for community development of effective home health care mechanisms. The health financing agencies have sought to provide financial access to Federal beneficiaries in need of the service of home health agencies. The human resource and service agencies have encouraged the integration of home health services with other service needs of the elderly, the poor and ill or disabled persons.

THE HEALTH SERVICES AND RESOURCES AGENCIES

One of the earliest evidences of HEW interest in home care was a Public Health Service survey of selected programs conducted in 1954 with the Commission on Chronic Illness. That study revealed very few programs in existence. Two surveys conducted in the following 10 years showed slow but steady growth in such programs. The 1964 Public Health Service survey of coordinated home care programs identified 70 operational programs. At that time, it was estimated that there were probably 100 additional programs which, with some modifications, could be considered as coordinated home care programs.

Between 1960 and 1967, many collaborative activities were carried out between PHS and national private organizations interested in furthering home health

care resources. Such organizations as the American Medical Association, the American Hospital Association, the National League for Nursing, Blue Cross Association, National Association of Blue Shield Plans, Health Insurance Association of America, American Public Health Association and the American Public Welfare Association joined with the Public Health Services to conduct national and regional meetings, prepare materials such as the "Guide for Development and Administration of Coordinated Home Care Programs," and to assist with needed data collection.

During this time, the PHS also supported the development of training centers for home care personnel in various parts of the country. Just prior to the enactment of Medicare, there were seven of these centers, training over 2,000 persons per year.

Fifty-three projects in the activity areas of home care, homemaker services, and nursing care for the chronically ill and aged were funded under the Community Health Services and Facilities Act of 1961 (Public Law 87–395). These grants were made during a 6-year period (fiscal years 1962–67) and the total amount of funds awarded for home care activities totaled $6,600,000.

When Congress endorsed the concept of home health services in the 1965 Social Security Amendments, creating the Health Insurance Program for the Aged, there was widespread anxiety concerning the availability of such services to meet the needs of eligible beneficiaries. All but a few States developed plans utilizing Federal and State or local funds to expand these services. In September 1965, a supplemental appropriation of $9 million for formula grants was made available to State health departments to enable them to strengthen agencies already in existence by adding further services and to help establish new programs that could meet the conditions of participation under Medicare. Another supplemental appropriation of $6.7 million became available for fiscal year 1967.

Within the 9 months, between September 1965, when the funds became available, and July 1, 1966, when the benefit became effective, home health services improved as never before. The number of programs increased, as did the range of services offered. By October 21, 1966, 1,256 agencies had been certified under Public Law 89–97 and 300 others, located in every State except Alaska, were operating as local outposts of State agencies or were potentially certifiable in their own right.

Although the enactment of Medicare and Medicaid shifted most public attention concerning home health care to SSA and MSA, the Community Health Service of the former Health Services and Mental Health Administration has continued efforts to promote, develop and expand home health services through organizing workshops and conferences, stimulating nongovernmental involvement in sponsorship, by distribution of literature, development of technical assistance materials and data, and by conducting and funding research and development projects. In the new organizational structure, home health care activities will be centered in the Health Resources Administration.

MEDICARE

Home health services for the aged and disabled are an important component of the coverage provided under the Medicare program, which is administered by the Social Security Administration. Under Medicare, home health benefits were designed primarily to meet specific medically related home care needs of the patient who does not require the continuous intensive care that is provided in hospitals and skilled nursing facilities, but who nevertheless suffers from a condition of such severity that he is confined to his home under the care of a physician and is in need of either skilled nursing care on an intermittent basis, or physical therapy, or speech pathology.

Such coverage is intended to support the use of this alternative to continued inpatient care by aged and disabled patients who might otherwise be forced to obtain services in hospital or skilled nursing facilities. Home health services are covered under both parts of the Medicare program. Payment of the full reasonable cost is available for up to 100 visits under the hospital insurance stay, and for up to 100 visits per calendar year under the supplementary medical insurance program (part B) without regard to whether the patient has had a prior hospital stay.

As of June 30, 1972, there were 2,222 home health agencies participating nationwide in the Medicare program. In order to participate, these agencies must meet prescribed standards relating to qualifications of personnel providing

services and to maintenance of appropriate records and other conditions deemed necessary to protect the health and safety of beneficiaries. For fiscal year 1972, home health expenditures amounted to $69 million. Home health benefit payments are estimated to have increased to $75 million for fiscal year 1973 and are expected to increase further to $110 million for fiscal year 1974. The expected increase for fiscal year 1974 is due partly to the extension of home health care coverage to disabled Social Security beneficiaries beginning July 1, 1973, and to the elimination of beneficiary copayments under part B, and partly to expected increases in the utilization of such services generally.

The Social Security Amendments enacted in 1972 contain several provisions which may significantly affect the structure of Medicare home health benefits in the future. At present, Medicare will reimburse the cost of skilled nursing care but does not cover to any substantial degree the cost of homemaker services or other personal services which can be performed by a nonskilled individual but which can often contribute to the welfare of a home-bound Medicare patient. Under the 1972 amendments, we are authorized to conduct experiments to determine whether coverage of homemakers' services or other nonskilled services would provide a suitable alternative (or addition) to present post-hospital benefits. Such experiments could include, for example, covering the services of homemakers for a fixed period following a patient's discharge from the hospital if an individual, thought not needing skilled medical services, cannot maintain himself without assistance. Through such experiments we hope to determine whether such coverage would effectively lower long-range costs by reducing the demand for higher-cost institutional care. These experiments will, of course, have no immediate general effect on home health benefits, but they may be the source of information on the basis of which changes in the coverage of home care can be better appraised.

Another provision of the 1972 amendments will relieve Medicare beneficiaries of personal liability in certain cases where a beneficiary's claim for home health and other services under Medicare is denied because the services were not medically necessary or did not meet level-of-care requirements and the beneficiary is without fault. In such cases, the beneficiary's liability will shift to Medicare or where it is found that the provider of the services has not acted with due care, to the provider.

The 1972 amendments should also improve overall administration of the home health benefit. This provision authorizes us to establish in advance specific numbers of part A home health visits which a patient would be presumed to require following hospitalization. The number of home heatlh care visits a particular patient would receive would be established according to his medical diagnosis and pertinent factors. Coverage of additional visits would be determined according to his particular health needs and status. Implementation of this authority should reduce uncertainty on the part of physicians and patients as to whether or not home health care services would be covered, thereby encouraging prompt discharge from institutional care to the home care setting.

MEDICAID

Title XIX, known as Medicaid, is administered by the Medical Services Administration of the Social and Rehabilitation Service. It provides Federal matching payments for State expenditures for health care for the poor. In fiscal year 1972, 52 States and jurisdictions were participating in Medicaid (Alaska entered the program early in fiscal year 1973, leaving Arizona as the only nonparticipating State). All States participating in the program must provide medical assistance to recipients of cash assistance—poor persons aged 65 and over, low-income blind and disabled individuals, and AFDC families; in addition, States may extend their programs to cover the medically needy—those persons who would be eligible for cash assistance except that the level of their income and resources is sufficient for their maintenance needs but not to pay for necessary medical care (some 27 States have opted to extend such coverage to the medically needy).

Every State with a Medicaid program is required to provide home health care services for all individuals who are eligible for skilled nursing care. The services provided to Medicaid eligibles under home health care are intermittent or part-time nursing care, services of a home health aide, and medical supplies and equipment. Under current regulations, agencies providing home health services must be certified as a Medicare vendor or be eligible to become one. In areas

where there are no title XVIII (Medicare) agencies, an independent registered nurse or licensed practical nurse under a physician's direction may provide services to patients in their place of residence.

MSA's Office of Program Innovation provides States with information about various alternative approaches that can be reimbursed under present law and regulations, and participates in studies and research and demonstration efforts designed to provide information for program improvement.

Medicaid's payments for home health services are expected to be about $30 million in fiscal year 1974 or about 0.4 percent of total payments.

There are a number of reasons why under the ongoing program, home health care has not emerged as a completely viable alternative to institutional care:

(1) The title XIX regulation requiring that agencies providing home health services be Medicare certified has been interpreted by some States to mean that Medicare services, benefits and limitations should also apply to the Medicaid patient. Thus, some States have restricted services to those over 65, to those who potentially needed institutionalization or were discharged from a skilled nursing facility, who required only skilled services as defined by Medicare or were title XVIII beneficiaries. Moreover, no State has utilized the option of including providers who were qualified as but not participating as a title XVIII provider. Further, many States have not opted for the independent RN or LPN and thus have difficulty in providing home health services where no title XVIII certified agency exists.

(2) Low rates of reimbursement in some States also discourage the wider provision of home health care services. Medicare pays either cost or charges, whichever is less. But under some State title XIX programs, the negotiated rate with the home health agency may be less than half the actual cost of providing the service. In addition to low payments, retroactive denials of payment have also discouraged the organization of new agencies and have limited acceptance of patients by certified agencies.

(3) In addition to the above mentioned barriers there are other more general problems related to underutilization. Many physicians lack the knowledge of the advantages of home health care and some seem to actively resist its utilization. State legislatures have not placed home health services among their highest priorities even though such care has often been demonstrated to be an economic alternative to long-term care.

To further encourage the use of home health care, Medicaid is considering revising its current regulations to encourage States to provide services that will help to reduce the amount of institutionalization.

Home health services represent one promising way of serving the disabled and chronically ill, and helping them maintain an independent life style. Experience gained by HEW over the past 2 years of intensified concentration on noninstitutional services has shown the deficiencies inherent in a piecemeal approach. This is true both from the patient standpoint and in terms of costs of services.

We need a comprehensive coordinated approach to the organization, financing, and assessment of health-related care. Most importantly, we need a smooth continuum of care, right from the hospital to the nursing home, to day care, home care and other services. Thus, home care is seen as an important aspect of an integrated package of services available to the individual as needed. Development of any aspect of the service continuum would likely result in an imbalance of services, costs, and patient well-being.

The Medical Services Administration has been analyzing and promoting a number of alternatives to institutional care, and has outlined potential concepts to be tested in these areas. They have also attempted to catalog overall data on long-term care needs and resources.

In 1972, based on these concepts, the Medical Services Administration and the Administration on Aging funded four community-based home health care programs as an alternative to institutional care. Medical funds are being used to determine whether, in fact, persons who would otherwise be placed in nursing homes can be effectively maintained through such a home care program on a less costly basis. This project has great significance for home health services. It will study the impact of such services on the lives of the elderly as well as provide more knowledge on whether these services do prevent acute illness, reduce long-term institutionalization and delay mortality. The projects are also testing a capitation payment system which will provide information that will enable the Federal Government to study possibilities for restructuring the present payment system.

HUMAN RESOURCE AGENCIES

The Administration on Aging administers or assists in several programs related to home health services for the aging, authorized by the Older Americans Act.

Title III of that act authorizes projects to increase the capability of the elderly to maintain independent living. Many of the projects contain explicit home health components and many others have health-related aspects. Besides visiting nurses and home health aid services for the home-bound elderly, services include homemaker, immunization, screening programs, health education, accident prevention techniques, home repairs, and delivered meals. Some title III projects also train geriatric aides to provide services for and monitoring of the home-bound ill. Title III also supports model projects "to develop and test innovative approaches to change those conditions that prevent or limit opportunities for older people to live independently and participate meaningfully in community life." Of the 21 model projects funded last year, 18 had homemaker and/or home health aide components. In 12 of these, home health components were established because of the model project, while in the other six situations, the projects served to link existing home health resources with other project resources.

Under title IV of the Older Americans Act, research and demonstration projects have been conducted to test alternatives to institutionalization for the elderly. The Medical Services Administration and the Health Services and Mental Health Administration have assisted in the funding of these grants. These seek to develop models by which the Department's goal of providing alternate living and service arrangements for older Americans who would require hospitalization without such services.

THE EFFECTS OF THE REORGANIZATION

Presently, the major health and social service agencies of HEW have each exercised a responsibility for some aspect of furthering development of and access to home health services under Federal programs. There have been cooperative grants for projects. There have been cooperative regulations. There has been extensive involvement with professions and communities.

It is my hope and intention to provide leadership in the development and carrying out of the Department's health policy to this end. I have strengthened the capacity of my immediate office, directed a study of and helped to effectuate a realignment of the health agencies, and established direct linkages to the health financing programs that will, I believe, permit more effective policy and program development and consistent application of policy.

The recent reorganization of the Health Services and Mental Health Administration and the incorporation and consolidation of all long-term care concerns in the Health Resources Administration will offer greater opportunity for the pooling of existing interests and expertise, the crystalization of proper Federal, State, and community public roles, and the implementation of a more comprehensive and effective national programming and evaluation effort, with respect to home health services projects and activities.

We hope to be able to better understand why providers have often been reluctant to utilize home health services to provide their patients needs, how resistance by providers, patients and community elements can be overcome, how to assure better linkages between inpatient health care institutions, and home health services, as well as with other health care services and centers which communities need to provide comprehensive health services.

In 1970, President Nixon announced his health care strategy for the 1970's. Preservation or expansion of what is good in our present system is the hallmark of that strategy. Home health services are one of the good parts of the system. It is my pleasure to have a significant role in coordinating the Department's programs to further improve and expand our home health services efforts.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to try to answer any questions you and other members of the subcommittee might have.

Senator MUSKIE. We have another fine witness this morning, Mr. Stanley J. Brody, associate professor, Department of Community Medicine, University of Pennsylvania.

STATEMENT OF STANLEY J. BRODY, ASSOCIATE PROFESSOR, DEPARTMENT OF COMMUNITY MEDICINE, UNIVERSITY OF PENNSYLVANIA

Mr. BRODY. Senator, for the record I want you to know that my statement was approved by my wife as well.

My name is Stanley J. Brody, and I am an associate professor in the departments of community medicine and psychiatry, associate chief of the regional medical program at the University of Pennsylvania; commonwealth fellow of the Fels Center for Government, University of Pennsylvania; chairman, public policy committee of the Gerontological Society; chairman, health section, National Conference on Social Welfare; and member of the social policy cabinet of the National Association of Social Workers.

I will talk somewhat extemporaneously and submit my written statement that you have before you.

Senator MUSKIE. It will be included in full in the record.*

Mr. BRODY. I want to make a statement on something that doesn't really come out sharply in what I have heard so far, and that is the distinction between medical programs and health programs. We keep on using the word health programs to describe medical programs.

For the past 8 years, three or four Congresses and two administrations have focused on comprehensive health care. When you examine every one of these programs such as Medicare, Medicaid, Partnership in Health, Community Mental Health, and the Regional Medical Program, they are all medical programs. So that it is not unreasonable to expect Dr. Edwards to report the gross expenditure is $75 million in home health service.

There is no significant health service. There are only medical programs. When you evaluate the needs of the elderly you recognize that the elderly's needs are essentially for health services. The dysfunctioning of the aged arises out of the problems of chronic illness, not of disease.

SOCIAL AND ECONOMIC BURDEN

Eighty percent of home health services are delivered by families, and research clearly establishes that families do not dump relatives into institutions. It is only when it is impossible for families to take care of their aged, when the social and economic burden for home care becomes overwhelming, does institutional placement occur.

There is a great myth about families dumping their elderly parents into the institution. The latter is always the point, literally, of last resort.

I might point out the size of the problem. We keep on talking about 5 percent of the elderly being institutionalized. That is not accurate. It is 5 percent at any one time. What is really the situation is that 25 percent of all aged could be at one point or another in a nursing home, and as you say, this is usually terminal.

Perhaps another piece to add on to that is that over 80 percent of all of us are going to die in an institution. And that tells you something about the culture in which we are living.

*The prepared statement of Mr. Brody appears on p. 583.

The focus of both Congress and the administration is really a medical focus when you talk about a nursing home. You think about a medical setting. For example, the elimination of social services by H.R. 1, and in the case of Medicare, Mr. Tierney's description of the home health services program as not being therapeutic. Half of what doctors do, then, is not therapeutic. For the laying on of hands, the pastoral role, is a major piece of the doctor's function. Parenthetically it might be observed that virtually every national health insurance program that is before Congress is built on Medicare attitudes and are medically oriented. None have any serious provision for health services.

That is not unique to S. 3. It is not unique to the administration proposal. It is unique to the Congress' vision of what we are talking about.

The one point I would like to speak to is the tremendous growth of the over 75. Aging is not necessarily reflective of a chronological period but rather a developmental process. Nevertheless, of the over 75, almost half of the elderly need home health care.

If that is the case, when you consider that our population tripled between 1960 and 1970 in terms of the over 75 rather than doubled as we expected, the size problem is enormously exploding. Congress should respond to it, as quickly as possible.

There is no Federal overall policy for the delivery of home service. The gross Federal budget for that service is inconsequential. The report by Dr. Edwards on the amount of Federal spending is interesting in that he did not mention expenditures under the adult category programs. Considering the amounts reported for Federal support of home health services the $25 million represented by the public assistance adult categories would have swelled expenditures by one-third.

The elimination of social services in nursing homes and the "Catch 22" administration of the Medicare home health services provision evidences the national disease approach rather than a health approach to problems of the elderly.

Needs of Over-75 Population

Senator Muskie. I would like to emphasize a point made in the middle of your statement. I have two points: "With the rapid rise of the number of very old—that is those over 75, the nonresponsiveness of Federal programs is more pronounced. The developmental understanding of the aging process suggests that the accumulated insults of life crises interacting with universally present chronic illness results in varying levels of dysfunctioning, depending on the individual genetic mold and the availability of social supports."

The next line is one I would like to see underlined in the record: "*It is no surprise that as many as 50 percent of the over-75 population is in need of the social support of a home health program.*"

Mr. Brody. I just want to make one or two more brief points in the few moments that I have to call your attention to the European experience because I think it is important. The Swedish and the British realized, that after they got into a national medical program, the significance of the home shelter service and the need to integrate the two programs.

The medical program was nationally administered. The social service developed under local government. When they tried to put the two

programs together, both Sweden and England encountered major problems. Turf had been built in terms of how these two programs were administered and became an imponderable barrier when they were to be integrated. This was developed in the English green papers and white papers.

The recent regionalization by the English of both programs was with the hope that in a 10-year period there will be a single medical-health program. The Swedish mandated a single program in 1968. It is still to be achieved. I would hope that we would benefit from their experience.

The other point I want to make is in terms of the taxonomy of the services that we keep on talking about. What has happened in the field is that home health services are being described in terms of who is providing the service rather than a functional description of the service.

What I find when I get into the field is that the skilled nurse for example is going into the home doing everything. What is needed is the suggestion of a functional approach, an industrial approach, so we can start looking at the function in response to the needs of the elderly rather than giving them professional names. It is time for that.

In the written testimony a suggestion is made which sets up five categories of function: Personal care, personal maintenance, personal planning, linkage to community services, and skilled home nursing.

One last observation is on research. We lack meaningful research in this field. Like service delivery, research follows the dollar incentive. The Federal granting agencies have not funded any research program on the need for home health services which is based on a population whose need has not been triggered by an acute disease episode.

That is an important point because what we are saying is that you don't have to be in a hospital to get home health service. You don't need to have an acute illness in order to require home health service.

The nature of a chronic illness is that you suddenly wake up one morning and you cannot make it down the stairs. There is no disease element.

There is no study of the federally directed programs of discharge from mental hospitals or nursing homes. The full range of the home health services required by the aged to function adequately in the community has not been evaluated. We really don't know what happens to aged dischargees from the mental hospitals under the community mental health program. We have dumped the elderly out of nursing homes as a result of the medical orientation of the title XIX program without any inquiry or concern as to what happens to them in the community.

Congressional Review Needed

What we need is research. It may require a congressional commission or some committee to get it done. We need to take a look at defining the services along the lines of industrial task analysis as units of service and establish unit costs. Furthermore, evaluation should be built into the enactment of these benefits so that a cost-effective and social-cost analysis will be available for periodic congressional reviews.

This should not only be in terms of dollars. What does it mean to the family? What does it mean to the 17-year-old daughter who has

to sleep in the living room because grandmother has the one bedroom? What does that mean to that family? What is the social cost to that family when a daughter or daughter-in-law maybe has a heart condition and has to take care of the grandparents? That is social cost—the cost to the individual, the family and the community.

To delay inauguration of the program for lack of research would be to fail to recognize the enormity of need demonstrated by testimony this committee has gathered over its lifetime.

I personally have trained, and my colleagues have trained people in this field within a brief period, so the problem of adequate personnel is not an issue.

One option the committee might consider is incremental. We could start with a limited approach, timewise, dollarwise, or unitwise as the first step. But to further delay the availability of home health services federally funded and administered and universally available would be nonresponsive to the demonstrated need of the elderly.

Thank you.

Senator MUSKIE. Thank you very much, Professor Brody. I gather you don't think we need to be more cost effective in home health care.

Mr. BRODY. We need to know this, but I think we have enough knowledge now so we can get started. I think we have done our crawling and walking. It is time for us to take a look at Medicare immediately and assure the inclusion of these kinds of services.

But if we continue our present course, we will face the same problems other countries have faced on the integration of medical and health services. Physicians are tremendously important but only as a piece of the health delivery system. Physicians are tremendously important in the health picture but only as one of the people who have a part to play.

Senator MUSKIE. I think that is an excellent way to close today's hearings. I appreciate your appearance. Thank you very much.

Mr. BRODY. Thank you.

PREPARED STATEMENT OF STANLEY J. BRODY

My name is Stanley J. Brody, and I am an associate professor in the departments of community medicine and psychiatry, associate chief of the regional medical program at the University of Pennsylvania; commonwealth fellow of the Fels Center for Government, University of Pennsylvania; chairman, public policy committee of the Gerontological Society; chairman, health section, National Conference on Social Welfare; and member of the social policy cabinet of the National Association of Social Workers.

For the past 8 years, four Congresses and two administrations have been committed to comprehensive health care. Medicare, Medicaid, Partnership in Health, Community Mental Health, and the Regional Medical Program are major evidence of priority fulfillment.

Yet this week this committee has heard from aged consumers and providers alike reporting on the inavailability of home health services. The Trager report, prepared for the Senate Special Committee, documents the reduction of the number of home health agencies. The total amounts spent for home health services by Medicare was almost halved from 1969 to 1971 ($78.8 million to $49.5 million) and information available for 1972 indicates a continuing of this downward trend. Under the adult assistance categories, $14 million was spent on home services in 1970.

Eighty percent of home health services are delivered by the family. Research has clearly established that families do not dump their aged relatives into institutions. Only when it is impossible for them to bear the social and economic burden of home care does institutional placement occur. In this light, Kastenbaum

points out that while 5 percent of the elderly are institutionalized at any one time, this figure does not reflect the numbers who will use these facilities at some time in their lives. It is estimated that this figure may actually be 23.7 percent with respect to nursing homes and extended care facilities. And when hospitals are included, over 80 percent of us die in institutional settings.

Both Congress and this administration view nursing homes as medical rather than residential settings, as witnessed in part by the elimination of social services in nursing homes by H.R. 1. The administration of Medicare is focused on acute medical conditions. It is axiomatic that services follow funding rather than need. It may be concluded then, that what has been developed nationally is a comprehensive medical care program rather than a health oriented approach.

The comprehensive mental health program has moved thousands of aged from mental hospitals back into the community. The administration's alternative to institutional care programs has enforced medical conditions of eligibility under title 19 and dumped thousands of other elderly into communities where funds and services to support them literally do not exist.

The myopic view of health care as a medical function is nonresponsive to the real health needs of the elderly. The problem they present is one of decreased functioning by reason of physical, mental, and environmental disabilities. Institutionalization in a residentially oriented nursing home is appropriate when the economic and social cost of maintaining them in the community is no longer justified.

With the rapid rise of the number of very old—that is, those over 75—the nonresponsiveness of Federal programs is more pronounced. The developmental understanding of the aging process suggests that the accumulated insults of life crises interacting with universally present chronic illness results in varying levels of dysfunctioning, depending on the individual genetic mold and the availability of social supports. It is no surprise that as many as 50 percent of the over-75 population is in need of the social support of a home health program.

There is no overall Federal policy for the delivery of home health services. The gross funding of these services is inconsequential. Legislation and administrative regulation nullifies any attempt at their expansion. The HUD freeze on subsidized housing with services, the cut back in the adult category social service programs, the elimination of social services in nursing homes, and the Catch-22 Medicare requirement for the applicant for home health services to be sick enough to require acute hospitalization are all evidence of a national disease rather than health oriented programs. Even when home health services are made available, Medicare has required a prior disease oriented hospital stay or an association with the onset of an acute illness.

What few services are available are for the most part under four separate unrelated programs with varying eligibility periods. Medicare, Medicaid, the adult assistance categorical programs, the Veterans services, the few neighborhood health centers and the community mental health centers, present programs multiplely funded and administered at all levels of Government, which are literally insignificant in terms of the health needs of the aged.

The possibility that Medicaid and the adult categories represents, even under the Congressional elimination of the 90/10 requirements for the aged, is nullified by the States' unwillingness or inability to finance and deliver the broad social support needed by the aged in a home health services program. Furthermore, congressional funding limitations constitute a restriction of the expansion of this program.

Research, too, has been inadequate in the home health service field. Like service delivery, research follows the dollar incentive. The Federal granting agencies have not funded any research program on the need for home health services which is based on a population whose need has not been triggered by an acute disease episode. There has been no study which is based on a program that discharges the elderly from a nursing home setting and lays on a full range of home health services to see if individuals are able to function adequately in the community. We do not know what has happened to the elderly summarily discharged from mental hospitals. There is no inquiry as to the results of the stiffening of the medical requirements for nursing home care. There is no acceptable research, other than a series of uncontrolled judgments, to determine how many people do not belong in nursing homes. There is no clear definition in industrial task terms of what home services consist. Furthermore, such a study is a prerequisite to a cost-benefit analysis of community versus institutional placement. There is equally a lack of information as to the social cost of community placement as against institutionalization.

Shanas, Trager and others have pointed out the extensive developments of home health services in European countries. Sweden and England are perhaps the best examples of full programs. A caveat, however, may be taken from these countries' experiences. The home health program was originally developed within the framework of the social services which were administered locally by county or municipal government. At the same time, the medical insurance program evolved on a national basis, regionally administered. As these countries came to recognize the need to integrate the two programs, Sweden and England were faced with artificial fiefdoms of turf which impeded continuity of services.

Sweden, in 1968, legislated a solution by requiring a single regional administration for both programs. It is yet to be substantially implemented. The British have commenced a 10-year program aimed at accomplishing the same results. After many Green and White papers they have regionalized the delivery of both systems, keeping them separate but providing for linkages at the regional level.

It is therefore suggested that Congress immediately take steps to expand Medicare from a medically oriented disease-focused program to one which is responsive to the health needs of the aged.

This will require explicit expansion of service benefits to include the five components of health-social services. A suggested taxonomy are as follows:

(1) *Personal services*—keyed to personal hygiene including grooming, dressing and bathing. Home health aides usually perform these services in the home.

(2) *Supportive or extended medical services* are the role of the visiting nurse and physical or occupational therapist in the home under plan of the physician.

(3) *Maintenance services* are included in housekeeping, environmental hygiene and food shopping and preparation. These tasks are usually the work of the homemaker in the community.

(4) *Counselling and planning*—this function is usually performed by a social worker. It involves listening skillfully, extending help, mobilizing existing resources and enabling the utilization of these resources.

(5) *Linkages*—this set of services is recognized as vital without which available health care is not utilized. Linkages are any services that help connect the elderly to the needed services. Outreach, information, referral, and education are bound together by communication and transportation in assuring utilization and effectiveness of health services.

The need for these services should not be based on a prior acute illness. The criterion of eligibility should be dependent upon the needs for the services to enable the aged to attain maximum functioning in the community or for the prevention of deterioration.

Research should be authorized, perhaps under the auspice of a special congressional commission, to refine the definition of services along the lines of industrial task analysis and units of service costs established. Inquiries should be made as to the needs of all aged for these services so that Congress will be provided with a prospective cost of rendering this program. Furthermore, evaluation should be built in to the enactment of these benefits so that an economic and social cost benefit analysis will be available for periodic congressional reviews.

To delay inauguration of the program for lack of research would be to fail to recognize the enormity of need demonstrated by testimony this committee has gathered over its lifetime. One option the committee might consider is a time, dollar, or unit limitation of services as a first step until hard information becomes available. To further delay the making available of home health services, Federally funded and administered and universally available, would be nonresponsive to the demonstrated needs of the elderly.

Senator MUSKIE. I thank each of the witnesses who have appeared today.

The hearing is adjourned.

[Whereupon, at 1:15 p.m., the subcommittee adjourned, subject to call of the Chair.]

APPENDIXES

Appendix 1

ADDITIONAL MATERIAL FROM WITNESSES

ITEM 1. HEALTH POLICY STATEMENT (DRAFT), "TOWARD A NATIONAL HEALTH SERVICE", SUBMITTED BY MARGARET KUHN, LEADER, GRAY PANTHERS

INTRODUCTION

It was almost a hundred years after the founding of the United States of America that our people came to realize that we must adopt as a national policy the provision of a system of free education for every family if our democracy was to endure and flourish.

Now, a hundred years later, we are finally coming to realize that we must also provide free access to quality health care for every family, and for the same reasons: The health and welfare of our whole society demands it; and the independence and self-realization of every individual person in the society requires it.

The failure of twentieth century America to keep up with the rest of the industrial nations of the world in this respect is not due to a lack of medical technology. Nor is it due to any fancied impoverished economic position, though the excuse that "We cannot afford it" is often heard. It has been due solely to our irresponsible failure to adapt our national priorities to the needs of our people.

We have failed to perceive that not a financial but a social issue is involved and so we have neglected to establish a national policy and a social commitment to meet the needs.

Although we have the financial means, the medical knowledge and skill, and a productive capability second to none, the United States has failed to translate these strengths into a health system able to assure all of our citizens good health service. Although we have the capacity to lead the world in health care, we actually fall behind most of the developed countries of the world in the standard statistics used to compare the health service of different nations.

Our present mechanisms for financing and delivering health care are so obsolete that a complete overhaul and restructuring of the present system is necessary. This can be done effectively only on a national scale, involving national resources. The people in general are finally demanding action; and Congress is at long last preparing to address itself to solving this problem.

We, the Gray Panthers, see our function as threefold:

(1) To stimulate interest among the people, and action by the Congress to enact needed legislation promptly.

(2) To conduct research to determine what structure and provisions in a national health care system are the best. To do this, we are examining the features of foreign and U.S. systems and models that suggest characteristics of an ideal system, and exploring the question of what changes are politically feasible given our present medical and political situation.

(3) To warn against, and prevent as far as possible, dangerous and costly mistakes in the planning, financing, administration, or control that might creep into a national health care plan. The most subtle and injurious of these, in our opinion, would be any reliance on commercial, voluntary insurance companies or other provider designed and serving institutions in the drafting or implementing of a public health care program.

Our system of free public education is still far from perfect. Our projected system of free public health care will not start out as a perfect system. What we we can do is to structure our system in such a way as to make it more of a possibility that it can be perfected and improved. In our view, the greatest barrier to such a possibility is commercialism. As the central motivating and driving impulse, the profit motive is out of place in a system of health care as it would be in a system of education.

FORWARD

Only three obstacles stand between the American people and a system of health care that would deliver quality service to all:

(1) First of all, we have a warped sense of national priorities. Our society gives the highest priority to the production and consumption of goods; to profit-making; to the waging of or preparation for needless wars; and to the defense of wealth, which is often the cause of the wars. It does not set a high priority on the welfare and health of the people. Associated with this is the widespread impression that this richest Nation in the world "cannot afford" a free public health care system which smaller and poorer nations have been affording for years.

(2) The second obstacle is the organized opposition and effective, well-financed lobbying of those groups which have the most profit and power to gain from maintaining the present haphazard, one-sided nonsystem of health care delivery.

Among these groups, the American Medical Association has for decades occupied a place high on the list of obstructionist organizations. Government health insurance was considered for inclusion in the Social Security Act of 1935, for instance. It was shelved because of the opposition of the AMA.

During World War II the Wagner-Murray-Dingell bill for national health care delivery was fought with the slogan "Compulsion, the key to collectivism" and was killed during the McCarthy hysteria against communism. In the middle sixties, the AMA waged the largest and most costly lobbying effort in American history in an attempt to defeat the Medicare and Medicaid programs.

(3) The third obstacle standing in the way of our progress toward an acceptable health care system is simply the shortsightedness of the majority of our people in failing to recognize our own essential needs. This has resulted in a lack of national commitment to develop a governmental policy to insure a just and adequate health care service to everyone. This apathy has been encouraged by the medical profession when it tells us to leave health care completely in its hands and tries to convince us that only it is qualified to make decisions about how health care should be provided.

As a result of these barriers, we must seek our health care from a costly, confusing, outdated kaleidoscope of health care institutions and agencies. From the health consumer's point of view, this translates into the stark reality: Millions of Americans are not getting adequate health care.

CHILDREN

Fourteen countries in the world do a better job of preventing the death of infants at childbirth and during the first year of life.

WOMEN

Since 1950 we have fallen from first to seventh among the nations of the world in maternal mortality.

MEN

A 45-year-old man can look forward to a longer life in 28 countries than in the United States.

MINORITIES

The average lifespan of an American Indian is 43 years. Infant mortality rates for minority race members are twice as high as for whites; maternal mortality rates are four times as high.

THE POOR

A poor person is four times as likely to die by age 35, or have an activity-limiting condition than a nonpoor person. Medicaid is available to less than a third of our low-income citizens. One half of poor children are not immunized against common childhood diseases.

To these and many other segments of our population, our health system is more of a barrier than an aid to maintaining good health care. What is wrong with our health care system? What would a better one look like? How did the Gray Panthers arrive at the conclusion that a national health service is the best alternative to what we have now? We can delve into all of these questions by taking a close look at the question.

. . . .

What Are the Indispensable Characteristics of a Quality Health Care System Adequate To Serve the Current Health Care Crisis?

UNIVERSAL

All Americans should be able to receive the benefits of our health system. Health services should be made equally available to every person regardless of age, income, sex, race, geography, social class, etc. None of these conditions ought to be a barrier to receiving medical help when one needs it.

This implies that there should be sufficient numbers of health professionals and workers, facilities, and medical schools. In addition, health care should be financed, administered, and delivered in such a way as to make universal access to health services a reality.

To put it a different way, health care should be a right of every American, not a privilege enjoyed by only a few of us. This is the most important of "indispensable characteristics of a quality health care system". The 11 criteria that follow enlarge on this feature, make clearer what kinds of services should be available to everyone, or set up safeguards to protect this right.

ACCESSIBLE

For health care to be a right, it must be accessible. At present, many people don't receive adequate health services because the services for one reason or another are too inconvenient or inaccessible. For example, physicians are far more accessible to people living on Manhattan's Upper East Side where there is 1 doctor for every 500 people, than they are a few miles north in Harlem or across the East River in Williamsburg where in places there is 1 doctor for every 100,000 people.

The result is that hundreds of thousands of New Yorkers depend on the emergency room of the nearest city hospital to be their "family doctor" and have to put up with the long waits, overcrowding, confusing clinic hours and hospital procedures, a different doctor every time, etc.

In our view, these inequalities are due to the fact that our health system is built on the profit-motive rather than on the idea of service to the community. Thus where the need is greatest, there are often the fewest services. Imagine if our fire departments operated the same way.

COMPREHENSIVE

Health services available and accessible to all Americans should be complete and include everything, and if possible, should be located in one place. This obviously is not the case now. There is an overabundance of some kinds of services; surgery, for example. We have twice as many surgeons per thousand people as England does. (They perform twice as many operations as take place in Britain as well and we aren't noticeably healthier. It probably is pertinent that surgeon's incomes are the highest of any specialty.)

On the other hand, some important kinds of care don't receive enough emphasis in our health system. This is certainly the case with early checkups and other kinds of preventive care. One reason is that most insurance policies cover hospital care but not doctors visits.

Also at present, health services are so fragmented and scattered around the city that many people don't even know what is available, let alone being able to get to it or being able to pay for it. The hospital is in one place, the doctor another, one child's hearing specialist is across town, the baby's pediatrician is in a clinic in the other direction, schoolchildren have to be taken to the public health station at another location.

An adequate health system should provide the whole range of health services necessary to meet the needs of the whole person—physical, dental, mental, social, environmental. Frequently needed services should be located at the community level in every neighborhood and should include emergency services, basic medical

care, preventive care, health guidance, diagnostic and screening services, home care, mental health services, etc. Efforts should be made to eliminate all unnecessary administrative and other barriers in order to encourage people to seek care. There should be direct linkups with more specialized diagnostic, treatment and rehabilitative facilities. One aspect of comprehensive health care is that care should also be continuous.

CONTINUOUS CARE

Another problem in our health system at present is that certain kinds of care an individual needs over the months and years are neglected. For example, many women still give birth without ever having received any prenatal care—this is the case for one-third to one-half of the women who deliver in public hospitals. A medical system that fails to insure that infants have the benefit of such care is clearly not acceptable.

Another instance of the inadequacy of our system when it comes to providing continuous care has already been mentioned—the emphasis on surgical operations to correct diseases that are in many cases well advanced, while early diagnosis of those diseases receive considerably less emphasis. In addition, many of those recovering from such operations are well enough not to need hospital care costing $120 a day or more, yet we have far too few intermediate care facilities for such patients.

A final instance of the lack of continuity of care in our system is the problem of transferring medical records when a person moves, even across town, or is on vacation, or needs medical care while at work or shopping at another part of the city.

Health care should be continuous, from pregnancy through childbirth to adequate care of both mother and child after birth; from diagnosis to treatment, rehabilitation, and recovery; from childhood, through adolescence, to maturity and old age. Care should not be interrupted as one grows older, as one needs different kinds of services, or as one moves from place to place. What these characteristics all point to is that health services should be better planned.

PLANNING

There is a lot of planning going on in the health industry by hundreds of institutions and agencies. The problem is that planning is uncoordinated and carried out according to priorities that are often not in the best interest of the community as a whole.

For example, two neighboring hospitals in New York each installed expensive units for treating chronic kidney disease without consulting each other. Meanwhile, neither hospital provides adequate emergency room or clinic care for the residents in the local area.

To cite another illustration, the South Bronx is almost without health services. In some areas, people are two bus rides from health care. At the same time, $100 million of our tax funds are going to build the new North Central Bronx Hospital, a city institution, right in the middle of the Montefiore medical complex, one of the heaviest concentrations of health facilities in the world.

Planning should be done on a communitywide basis so that such wasteful duplications and disgraceful gaps in service are not allowed to occur. Second, health planning ought to be guided by different priorities than a hospital's interest in having flashy new equipment or in adding bed space to further its teaching and research and its control of the health facilities in the community.

Planning in health should be done by councils of local community people. Such community councils would be in the best position to know the real health needs and priorities of the community. In addition, they would also be in the best position to responsibly make such decisions since they have to use the services they are planning. The doctors and other experts would certainly provide valuable input in their areas of expertise, but the ultimate responsibility must be shifted to the community for health care to be improved.

Planning ought to be improved on another level if our health care system is to be as good as it can be. The broad changes that need to be made in American health care need to be guided by a national health policy and carried out by a single national health agency. Such an agency would set national standards for the licensing of medical professionals, accreditation of facilities, quality of health service, etc. Furthermore, this agency would be responsible for the distribution of personnel, and the broad allocation of funds for research, education, construction, etc.

Between this national health agency and the local community councils, regional planning organizations would be formed from representatives of the various community councils in a given area to develop areawide plans. These organizations in turn would be coordinated by State or regional bodies.

QUALITY

Everyone wants and expects good health care. Because of the way our health system is set up, however, the quality of health service is frequently uneven between urban and rural, public and private, paying and nonpaying patients. The standards of quality that do exist are often not enforced or enforced by the providers of service. Thus, most doctors know of colleagues who shouldn't be practicing medicine. Once a physician gets his degree, it is virtually impossible to prevent him from practicing. He is under no obligation to take courses to sharpen his skills, no one ever checks to see if he might have forgotten what he learned in medical school, or if it is out of date now and he should have learned new techniques and skills.

On one level, there needs to be an ongoing effort to develop better standards of quality and better mechanisms for enforcing those standards. These mechanisms need to be adequately funded to do their job and have sufficient power and indepencence to insure compliance with the standards.

There is a second level in quality control that needs attention, and that is the broader question of governance discussed in the last section on planning. The tremendous advances that have been made in the past decades in developing new medical technologies has given the health consumer the right to expect high quality health care. That promise has all too often not been fulfilled, and for this reason: it was developed out of and is controlled by interests that are at times in conflict with the interests of the patient. The research and teaching priorities in our large medical schools and hospitals are often greater than consumer interests. What is needed is a system that puts the health technology at the service of the people. In short, health services need to be made accountable.

ANSWERABLE TO THE PEOPLE BEING SERVED

In much the same way that health planning is presently being done by the providers of health care, and for their own interests, so we find health institutions being operated by and for the providers of care, rather than by and for the community as a whole. The operation of the health system must be made directly accountable to the general public at all levels of policy formation, administration, and decision-making.

On the local level, local consumer councils defined earlier should have the power to decide what their needs and priorities are and how they should work to improve health services. For this to be effective, there needs to be a strong effort to develop an informed public with the ability to make wise decisions on its own behalf, and able to create health care services and institutions conducive to personal and community health.

Two distinctions need to be made. First, the consumers' role is a policy not a medical role. A consumer council would decide whether to increase the size of the emergency room but would not tell doctors what drugs to prescribe there or how to handle a cardiac arrest. (It might insist that the doctors conform to certain standards and might supervise the development of those standards, but the standards themselves would be established by experts, in general, doctors). The second distinction is implied in the answer to the first, the role of consumers is not simply to bettter "regulate" a system that is controlled by the providers of health service. Rather, the people as a whole must actually own and, through its representatives, control the health system if it is to serve the people. One outcome of this change in the control, or accountability, of the health system is that it has the potential to become more patient oriented.

PATIENT-ORIENTED SYSTEM

The health system should take as its starting point, service to the community, specifically, those individual patients who have health needs at a given time. At present, this is rarely the case. Clinic hours are set up first of all in terms of the convenience of the doctors. Questions that a patient might have about how a prescription will affect him, why it is given, etc., must be phrased delicately if the patient wants an answer. A recent Harris poll identified this problem when

it revealed that fully two-thirds of the people polled believed that "most doctors don't want you to bother them."

Such a response would be fine if the doctor were operating on himself and the patient were merely a curious bystander. Needless to say, that isn't the case, which leads us to the conclusion: No priority or interest should be allowed to become more important than the needs and interests and rights of the patient.

These rights begin with the right of the individual patient to ask questions of his doctor and get straight answers. The patient has a right to know the alternative forms of treatment available to him and the consequences of each. He should feel free to consult other doctors or professionals. Finally, if he feels his rights are being violated, he should feel free to resort to grievance procedures. On a second level, the patient has a right to participate on the consumer council and represent his interest and the interest of his community there. On both levels, we obviously have a long way to go before the health consumer feels that health care is really a *service* to him, that he has the right to ask questions, to be treated with dignity, to be a part of the decisions that affect his life. There is another side to this coin. The health system should be fair to workers.

SAFEGUARDING RIGHTS OF WORKERS

All of this discussion should not be taken to mean that health professionals don't have rights, too. While the primary purpose of a health system is to serve the community, health workers have rights and interests that need to be safeguarded. For instance, no job in the health field should be demeaning. Wages should be fair. Hours should be reasonable.

While quality controls and accountability need to be improved, they should support the integrity and dignity of health workers. Authoritarian controls can only lead to sterility and demoralization.

Our present health system is far from being fair to all health workers. An obvious example is the unjust way that work and responsibility is divided between doctors and nurses. Nurses are used to doing the jobs that doctors don't want to do and work the hours that are undesirable. Nurses are given far less responsibility and freedom than their training has equipped them to handle. Finally, like all health workers below the M.D., opportunities are severely limited for moving up the ladder to more responsible positions in the health system. Health care roles today are as unfair and out of date as India's caste system.

Recruitment of health personnel should better reflect both the real needs of the health system and the different cultures and segments of the society. Only a tiny percentage of doctors are black or Puerto Rican. Only Spain of all the countries in the developed world has a smaller percentage of women doctors than the United States.

FLEXIBLE

One of the most obvious problems of our health system has been its ability to hide from, ignore, and resist necessary change. We are a long way from having and adequate health system in America. Such a system will be achieved only by means of a complete restructuring of health financing and delivery. Even after this occurs, and a more satisfactory system of providing care is in operation, ongoing research into new and better methods of serving people needs to take place. Research has for too long been limited to technical, medical research. Not enough attention has been paid to improving the ways by which these advances can be passed on to the community.

EFFICIENT

Clearly, a country with the wealth of America has the resources to provide good health care for everyone if those resources are not wasted. Presently there are many inefficiencies in our health system. Hospitals use their complicated equipment for only a few hours of the day. Between a fifth and a third of the people in a hospital at a given time shouldn't be there. For many of them, it is the only way their insurance will pay for their health care. Others are there for the convenience of their doctors or for tests that could as easily be done outside the hospital.

Many other people wouldn't be in the hospital if our methods for detecting diseases early were more widely used. A recent study indicated that we have three times as many open-heart surgery units in the country as we need. Fully a third of the ones that exist didn't perform a single operation the previous year.

ADEQUATELY AND FAIRLY FINANCED

Health financing needs to be completely restructured. The first step is to create a single system of financing to replace the hundreds of insurance companies and Government financing programs. The notion that large Government operations are less efficient than private means is a myth in health care. Only 2 percent of the money taken in by the medicare, medicaid, or social security programs is not returned to people in benefits. Private insurance companies keep nearly 11 percent of the money the receive to cover operating expenses, fancy office buildings, advertising, and profits.

This inefficiency might be tolerable if our health bills were being paid by the private insurance industry. As anyone knows they aren't. Workers who have low paying jobs get insurance plans filled with loopholes and clauses that make them pay a substantial part of the bill. Executives pay large amounts of money for larger policies. If health care were a luxury item such a difference might be acceptable. People can't choose when to become ill. Few illnesses will wait until the patient can go out and earn the money needed to pay for it.

Private health insurance has other grave weaknesses. Some high-risk individuals find they can't even get insurance. Others who have an illness can't get coverage for that illness. The result is that the people who need health insurance most aren't able to get it.

Clearly, a national financing system is in order, administered by the Federal Government. The means of collecting money should be progressive like a graduated income tax so that the burden is distributed fairly over the population. The income of the health system can thus be made more dependable so that health care financing is not subject to frequent political changes, yearly legislative appropriations, or executive whim.

CONCLUSION

What do these characteristics of a good health system suggest to us regarding how such a system should be structured? Our research thus far has lead us to conclude that the best model for a national health system, one that would best meet these 12 criteria, is a national health service. This structure would provide the national financing and administration for our health care system that is so necessary if the widespread changes that must take place are to occur.

Thus the control and ownership of the health system would be in the public sector rather than in the hands of private enterprise. The greatly increased local consumer participation would prevent the national health service from becoming just another "top-heavy bureaucracy." A Cabinet level national health agency would provide the direction and leverage to make the changes that need to be made on a national scale.

No piecemeal solution is acceptable. Medicaid for the poor, Medicare for older people, another program for children, cancer patients, or American Indians—such solutions cut us off from each other, are inefficient, and will never be adequate. Half-way steps like national health insurance are no better. Paying the bills for an unfair and inefficient health system would be a step backward in our view. Nor is better "regulation" of the health industry an improvement. Regulatory agencies more often than not are controlled by the interests they are supposed to regulate. What is needed is a change in the basic structure of our system that would affect financing, delivery, and regulation of the health care system.

One final word of warning: while we must be clear about what we want, we must also be clear about the dangers that lie ahead. There are two dozen national health insurance proposals in Congress. The Republicans and the Administration are looking anxiously for ways to improve their image. Powerful commercial interests are lobbying intensively for bills that would give them a piece of the lucrative national health insurance action. The AMA and other medical interests are working hard to guarantee their control of the health care system.

An immediate danger is that a combination of such forces might take advantage of the national clamoring for a civilized system of health care and push through a plan that would actually set us back 10 years. We do need a national health care plan, but we need one that will be controlled by and serve the general public, one that is financed fairly, one that will have the leverage to bring about changes in the way health care is provided. Now is the time to put together the pressure that can fight for and bring about a National Health Service.

ITEM 2. "DO WE NEED A NATIONAL HEALTH SERVICE", AMA ALTERNATIVE CONFERENCE, COSPONSORED BY THE GRAY PANTHER HEALTH COMMITTEE

Saturday, June 23, 1973, Good Shepherd Faith Church

Introduction, 10:15 a.m., Maggie Kuhn—Convener, Gray Panthers.

Keynote Address, 10:30 a.m., "The System That Failed," Marshall England—Chairperson, Harlem Health Alliance; Chairperson, New York City Coalition for Community Health.

Morning Workshop (choose one), 11:10 a.m., "American Health Care and the Aging":

Pat Scott, moderator—Director of Information, New York City Office of Aging.

Sharon Curtin, R.N.—author, "Nobody Ever Died of Old Age".

Alan Greer—para-legal associate, Philadelphia Health Law Project.

Elma Greisel—Director, Ralph Nader's Retired Professional Action Group, Washington, D.C.

Herbert Shulman, M.D.—chairman, National Task Force on Aging, Medical Committee for Human Rights (MCHR); Director Geriatrics Clinic, Lincoln Hospital.

"The Politics of Health Care":

Louise Lander—Health Policy Advisory Center (Health-PAC).

Judy Wessler—MFY Legal Services.

"Minorities and the American Health System":

Cenie Williams, moderator—president, Association of Black Social Workers.

Ralph Alverado—vice-chairperson, community advisory board, Lincoln Hospital; president, South Bronx Community Health Corporation.

Charles Wang—assistant director, Chinatown Planning Council.

Angie Williamson—Community Health Organizer, St. Clements Episcopal Church.

Health Lunch (free), 12:30 p.m.

Afternoon Keynote Address, 1:20 p.m., "What We Want in a National Health Service," Maggie Kuhn—Convenor, Gray Panthers.

Afternoon Workshops (choose one), 2:10 p.m., "Lessons From the Unions":

Jim Lynch, moderator—Manhattan coordinator, United Farm Workers, AFL–CIO;

Kier Jorgensen—Research department, Textile Workers Union of America;

Walter Newburger—District chairman emeritus of the Retired Members Local of District 65; vice president, National Council of Senior Citizens; president, Congress of Senior Citizens of Greater New York;

Lillian Roberts—associate director, D.C. 37 A.F.S.C.M.E.

"National Health Service: International Perspectives":

H. Jack Geiger, M.D.—Visiting professor of medicine, Harvard Medical School, Boston;

Liz Rodgers—Health planner, Health Services Administration; representative, Radical Political Economists (RPE).

"National Health Insurance: Will It Be the Answer?":

Sylvia Hunter, moderator—Director, Community Council of Greater New York Health Task Force;

Betty Dooley—Director of Regional Organization for the Health Security Action Council (Committee of 100);

John Ehrenreich—coauthor, "The American Health Empire" (Health-PAC); Department of Health Sciences, SUNY at Old Westbury.

Closing Session, 3:40 p.m., "Strategies for Change":

Mayer Vishner, moderator—Journalist, antiwar activist;

Dorothy Carroll—Coordinator and consultant on Aging, YM–YMHA of Greater New York; Chairperson, Interprofessional Committee on Aging of Brooklyn;

Mark Starr—Former Education Director, I.L.G.W.U.

Concluding Remarks, Maggie Kuhn—Convenor, Gray Panthers.

Endorsers of the Conference

District Council 37, A.F.S.C.M.E.

District Council 65, A.L.A. National Council of Distributive Workers of America

Harlem Health Alliance
Health Policy Advisory Center (Health-PAC)
The Interprofessional Committee on Aging of Brooklyn
Medical Committee for Human Rights (MCHR)
New York City Coalition for Community Health
Textile Workers of America
United Farm Workers, AFL–CIO

"I commend the Gray Panthers for their efforts on behalf of all the people in setting up this conference. It is because of active groups such as this that we will one day see a truly effective national health plan."

June 18, 1973.

(From the statement of Paul O'Dwyer, Democratic candidate for City Council President.)

ITEM 3. PRELIMINARY POSITION PAPER ON NATIONAL HEALTH CARE, SEPTEMBER 1971, MEDICAL COMMITTEE FOR HUMAN RIGHTS, SUBMITTED BY DR. HERMAN SHULMAN, CHAIRMAN, NATIONAL TASK FORCE ON AGING, AND DIRECTOR, GERIATRICS CLINIC, LINCOLN HOSPITAL, NEW YORK

(The paper you will be reading is a preliminary draft. It was assembled with the hard work of many authors. We are aware that much more thinking and planning lies ahead before a practical, radical transformation of the health care system is defined. We urge you to read this paper critically. We welcome and encourage your reactions and we seek you criticisms and fresh ideas. Because of the importance of our task and the seriousness of our purpose, we expect this process to take many months. Eventually, with your help, we can evolve a program that will meet all our health needs.)

The Health Care Crisis in America Continues to Deepen

Working Americans are less and less able to pay for care. Philadelphia, New Jersey and New York Blue Cross, have raised their rates over 40% in less than two years.

Health insurance, public and private, is totally inadequate. Private insurance pays only ⅓ of the average person's health bill. Medicare pays only 45% of costs for the elderly. And Medicaid has been cut back in New York and California: 18 states have threatened to cut their programs in 1971.

Fewer and fewer doctors practice in rural areas, leaving many people with no services at all. More than 100 counties have no doctor.

Services for millions in urban ghettos are hopelessly inadequate and are getting worse. In New York City alone, thousands of health jobs have been eliminated in the past year.

The number of personal or family doctors declines: in 1930 twice as many family doctors were available per population. Patients are sent from one specialist to another, and no one takes responsibility for the patient's health.

Non-white Americans, compared to whites, have almost twice the infant mortality rate and four times the maternal mortality rate. 50% of poor children are not immunized and 30% have anemia.

Taxes to pay for health care are going up for working Americans. Yet rich people pay few taxes. In 1961, 56 millionaires paid no income tax at all.

The causes of this crisis lie at the roots of our economic system; solutions will require fundamental change.

The Medical Committee for Human Rights (MCHR) believes certain principles should underlie any health care system in America:

(1) All Americans are equally entitled to complete and preventive health care, with no charge at the time of service. Health services should be easily accessible in every community.

(2) Health care should be paid for by a progressive national tax on total wealth—a tax without loopholes that makes the very rich pay their share.

(3) No one should gain profit from the sickness, misery and death of others. There should be an end to profit making in health care.

(4) Health care institutions should be locally controlled by representatives of patients and health workers.

(5) Race and sex discrimination should be ended for health workers. Minorities, women and the poor should be justly represented in all health jobs.

MCHR has looked for these principles in the various national health insurance proposals presented to Congress by President Nixon, Senator Kennedy and others. We do not find them.

Under the national health insurance proposals, equal health care is not guaranteed to everyone regardless of income. Working Americans—through taxes or insurance premiums—would continue to pay for health care while the rich would not be justly taxed. Drug companies would remain in the hands of doctors and corporations—the same people who created the present inadequate system. Minority people and women would continue to hold the lowest paying health jobs.

For these reasons, we are presenting here our own proposal for health care. **MCHR calls for a neighborhood-based, community-worker controlled, progressively financed, non-discriminatory system which abolishes the profit motive from health care.**

1. COMPLETE, ACCESSIBLE HEALTH CARE WITH NO CHARGE AT THE TIME OF SERVICE

The present situation: People now pay, or are billed, for most of their health care at the time of obtaining service. And many people, even if they can pay, have a hard time finding the right kind of doctor.

National health insurance proposes: None of the current national health insurance proposals sufficiently alters this situation. The Nixon plan makes most people pay large sums at the time of obtaining care. The Kennedy plan is far better in this regard, but still leaves 30% of health costs to the patient. National health insurance does not adequately increase the number of health personnel, it fails to train general physicians so that everyone has a personal or family doctor, and it does insure doctors and other health workers in every urban neighborhood and rural town in America.

What MCHR wants: Everybody in the United States will receive total health care without any charge at the time of receiving service. The health care system will be converted from a fragmented collection of geographically maldistributed specialists, hospitals and drug stores to an orderly arrangement of community health centers, general hospitals and specialty medical centers.

Each community will have one or more community health centers for general health care. The health centers will provide medical care for adults and children, obstetric care, mental health services, X-ray and laboratory services, pharmacy, dental and eye care, preventive, educational and rehabilitative services, transportation, child care and home care. Each individual or family will be able to choose a personal physician or a personal health care team.

Each community health center will be linked to a general hospital for inpatient care, specialty consultation, or specialized diagnostic or treatment procedures. General hospitals, in turn, will be linked to regional specialty centers for particularly difficult problems such as open-heart surgery. Such a system insures that all people can obtain general care in their own community, and have easy access to more specialized care when needed. This type of organization combines high quality personal care close to home with accessible modern technical medical knowledge.

Care in community health centers will generally be given by teams of physicians, dentists, nurses, pharmacists, and other health workers. Patients will be able to choose a health care team, and a community health center. No one is required to use the health center in his neighborhood. A physician from each community health center will be accessible 24 hours a day for emergencies.

In order for everybody to receive health care in his own community, massive changes are needed in the numbers, types and distribution of health workers. An enormous effort will be made to train enough health workers to meet the needs of all communities in the country. In order that there be enough personal physicians for everyone, the numbers of doctors allowed to enter specialty fields will be limited so that many more doctors become general or family-oriented doctors. In this way the growing shortage of general doctors (general internists, pediatricians and family practitioners) and the oversupply of certain specialists (especially surgeons) will be corrected.

It is necessary that health personnel be fairly distributed in the country's neighborhoods and towns. To accomplish this, mechanisms will be set up allowing each community to obtain the health personnel it needs. One mechanism

might be that recent medical school graduates work several years in communities unable to attract enough doctors. Health workers who have lived and received training in a community will be encouraged to continue to work in that community.

Preventing disease is at least as important as caring for the sick. Community health centers will offer door-to-door preventive health care checks. These checks will insure that everyone has easy access to those services that improve health: prenatal care, well baby care and immunizations, measurement of blood pressure, tests for anemia, blood lead levels, Pap smears, glaucoma screening, and so forth.

However, prevention of disease does not end with these activities. Social and environmental factors such as poverty, racism, poor nutrition, occupational health hazards, and pollution are major causes of disease. MCHR, though it does not deal with these factors directly here, recognizes that true prevention of disease requires a solution to these problems. This means a radical redistribution of wealth, and the transfer of power to consumers and workers in all walks of life: ownership and use of land, production and processing of food, transportation, housing, and so forth.

2. WHO PAYS FOR HEALTH CARE?

The present situation: Health care is presently financed through out-of-pocket payments, private insurance premiums, social security and taxes. Each of these methods of payment heavily burdens working Americans: none makes the rich pay their share.

National health insurance proposes: The national health insurance proposals do not change this injustice. Nixon's plan leaves enormous payments to the patient at the time of receiving service. Both Nixon's and Kennedy's proposals finance health care by two unsatisfactory methods: employer-employee payroll deductions, which fall heavily upon working class people; and income taxes which spare the very rich. Because of income tax loopholes for wealthy people, the government fails to collect $50 billion in taxes each year. Under national health insurance, then, working Americans will continue to pay more than their share for health care.

What MCHR wants: All health care will be paid for by a new type of national tax. Revenue will be collected by taxing those most able to pay at a higher rate than those less able to pay. Thus low income people will be exempted from taxation, working people will be taxed at a low rate, and rich people will be taxed heavily. The tax rate will increase as income and wealth increases. All forms of income and wealth—whether from salaries, cash savings, stocks, bonds or real estate—will be taxed; no tax advantages can be gained from obtaining income from, or by placing one's wealth in, particular loophole categories.

In this way, the very rich will finally pay their share, and tens of billions of extra dollars will become available as public funds.

3. AN END TO PROFIT IN HEALTH CARE

The present situation: The health care system is organized as a profit-making business, not primarily as a service. The main profit makers—drug and medical supply companies, individual doctors charging excessive fees, the health insurance industry, and nursing homes—use over $7 billion each year for profit and for unnecessary profit-creating advertising and administration. In addition, the profit orientation grossly distorts medical practice by stimulating more operations than are needed, excessive use of dangerous drugs, overhospitalization and overtesting of those who can pay, and neglect of health care for poor and minority people.

National Health insurance proposes: National health insurance will strengthen the profit makers by giving them public subsidies. Much of the money taken from working people in payroll deductions and taxes would go to drug companies, insurance companies, and the new profitable health maintenance organizations National health insurance, then, creates a guaranteed source of profit for these corporations. And health care will continue to be distorted in dangerous ways by the greed of these corporations.

What MCHR wants: No profit making by institutions or individuals will be allowed in the health care system. Profit making institutions include both private corporations which distribute excess income to stockholders and so-called non-

profit institutions which pay excessive salaries or use excess income for unnecessary operating costs or expansion. The operation of profit making hospitals, nursing homes, drug companies, and medical supply companies will be turned over to non-profit public control. Insurance companies have no place in the health care system and must be abolished. Doctors will not be paid on a fee-for-service basis, since this practice encourages the profit motive to enter into decisions which should be humanitarian.

4. CONTROL OF HEALTH CARE INSTITUTIONS

The present situation: Health care institutions are generally controlled by the same people who profit from health care—doctors, businessmen and bankers on hospital boards of trustees, big insurance and drug company stockholders and executives. Industrial health care in factories is run by companies, and is geared toward putting workers back on the job with minimal financial loss to the company. And medical schools are largely run by specialists who profit from the prestige of research and from training more specialists.

National health insurance proposes: National health insurance will leave the health care system in the hands of these same doctors and businessmen. The people who created the present crisis will benefit the most. National health insurance will bring financial stability to insurance companies, hospitals and health maintenance organizations, and with stability comes greater control. The priorities of patients and health workers will be ignored; there will be no one to hear and respond to people's complaints.

What MCHR wants: Every institution providing health care will have a democratically selected policy-making body of people who use the institution and people who work in it. These community-worker councils will run community health centers, hospitals, nursing homes, and medical schools.

Health care will be locally controlled and regionally coordinated. Community-worker councils running health centers and hospitals will set budgets and hire personnel. Each local council will send representatives to regional health councils. Regions will include an urban center and the surrounding rural area. Regional councils will plan and coordinate health services in the region. They will determine the number of hospital beds needed, number and location of specialized personnel and will authorize high cost facilities such as open heart surgery units.

A national health council of patients and health workers will be chosen from the regional councils. The national council and its staff will have limited powers; it will set general policies (such as prohibition of race and sex discrimination in health care institutions), with the training, distribution and licensure of health workers, and with research priorities.

The details of community-worker control will vary between one community and another. One possible mechanism might be that neighborhoods and rural areas with populations between 5,000 and 25,000 define their boundaries and constitute themselves as communities. Health services in such communities would be run by a community health council. Some council members would be consumers chosen at a community-wide election: others would be health workers representatives, elected at a general meeting with each worker having one vote. Communities containing significant racial or cultural minorities would insure the representation of these minorities on the council. Following their election, new council members would be offered training in appropriate subjects. All information regarding the policies of health care institutions would be public—available to everyone in the community. The quality of health care would be monitored by community-worker councils in cooperation with doctors.

Other communities might employ different mechanisms of community-worker control. Some neighborhoods might combine to form larger areas with one council running several health care institutions. One area might have stronger consumer representation, others a stronger worker voice. Certain groups might set up institutions such as women's health centers, migrant worker clinics, or Indian centers, which are not organized along geographical lines.

Any health care institution conforming to a few general principles—democratic control; no charge at the time of service; no profit making; no race, sex or class discrimination, etc.—will receive money from the national tax-collecting mechanism. The money will be passed to the community-worker councils on a formula basis, determined by the number of patients using the institution. Communities

with poorer health might require somewhat more money per patient than healthier neighborhoods.

In this way, democratic local control can be preserved even though money is collected nationally. The health care system will be truly pluralistic with patients and workers able to choose among many different types of institutions.

Health care provided in factories and other places of work will be controlled by those employed in the place of work. Industrial health care, then, will be run by the factory workers rather than by the factory owners. This care includes not only treatment for injuries and illness, but also prevention of accidents and industrial disease by worker-initiated and worker-enforced health and safety codes. Only in this way will the health of workers take priority over the profits of management.

5. ENDING RACE, SEX, AND CLASS DISCRIMINATION IN HEALTH JOBS

The present situation and the effect of national health insurance: Most doctors are white middle-class males while nurses' aides and people who keep hospitals clean are poor black women. There is almost no job mobility for health workers because of legal constraints and educational rigidities. The national health insurance proposals make no significant impact on this situation.

What MCHR wants: Each health job must have representation from minority groups, women, and poor economic classes in proportion to their numbers in the general population. In order to reverse the gross over-representation of white middle class males among doctors, medical school applicants from the under-represented groups should be given preferential admission.

Training of all health workers will be done at public expense. Integrated health worker schools encompassing all health care skills will replace the present fragmented collection of medical schools, nursing schools, schools for laboratory and X-ray technicians, etc. The schools will tailor the curriculum to the student's past experience. Courses will be available for orderlies to become practical nurses, for practical nurses to become registered nurses, for nurses to become doctors, etc. On-the-job courses will enable people to continue working while in training. People could become doctors directly from college, or by moving from other jobs in the health care field without a college or high school degree. In addition, jobs will be redefined to make the various categories less rigid.

Health worker training will be conducted mostly in community health centers rather than in specialty hospitals. This training will be controlled by community-worker councils so that it interferes as little as possible with patient care. Community-worker councils will play a large part in selecting people for admission to medical schools and other training programs.

CONCLUSION

Improved health care costs more money. However, the rapid rise in costs of the past 10 years have not led to better care; they have led to higher profits. Thus, the elimination of profitmaking from health care will save billions and will slow the rise in costs. Also, vast sources of money for health care will become available by taxing the rich.

Adequate health care might cost $20 billion per year above the present $70 billion expenditure: salaries for additional health workers, construction and maintenance of community health centers, and new educational programs to train large numbers of health personnel. At the same time, about $7 billion will be saved by eliminating profits and by stopping wasteful sales and advertising practices. This $7 billion derives from the following sources: $3 billion from insurance companies, $1.5 billion from drug companies, $1.5 billion from excessive doctor fees, and $1 billion from hospital suppliers and other profitmakers.

The net increased expenditure, then, is in the range of $13 billion, which is easily financed by justly taxing the rich. In fact, the lower and middle classes might end up paying less for health care since extra taxes from the rich can pay for far more than the additional $13 billion.

MCHR does not expect an adequate health care system to be legislated from above. Decent health care can only be realized through action taken at the local level. Patients and workers can achieve MCHR's health care principles only by working in their own institutions and communities; for democratic control, for progressive taxes, for on-the-job training and worker mobility, etc. As a result of such local efforts, the MCHR vision can be made into reality.

ITEM 4. "NOBODY EVER DIED OF OLD AGE," BY SHARON R. CURTIN, BOOK REVIEW FROM THE NEW YORK TIMES, BOOK SECTION, FEBRUARY 4, 1973

(By Edward Hoagland *)

There is a naked, maverick excellence to this book about old people which is nearly as straight as speech itself, adorned only by anger on their behalf and admiration for them. It's by a young feminist from Douglas, Wyo., Sharon Curtin, who went nosing around in a deliberately idiosyncratic, inexpert way, to California, Kentucky, New York City, finding out about the demeaning of the old, both within institutions and outside them; and it made me sweat for my own future, just as she fears for hers.

We must take her as she is, a guide—shabbily dressed, furious, radical, with an odd, hardshelled compassion and the impatience and bluntness of that good generation that grew up during the 1960's and tried to change a great many things. She had just left her marriage and had laid for a week in a coma after an automobile accident, outraged in lucid moments because she was going to die stupidly as a traffic statistic and then, when she was well, set off in a reckless, rather desperate mood, a mood for role playing if necessary, to see what life was like for those who really faced death, the old. "Like conspirators the old walk all bent over, as if hiding some precious secret . . . The body seems to gather itself around the vital parts, folding shoulders, arms, pelvis like a fading rose."

Twenty million United States citizens are over 65. Fifteen thousand are over 100, and each receives a Christmas card from the President. Miss Curtin begins, naturally, with the tale of her grandparents, a crew of devils and saints, as well as other old people she knew in Douglas when she was little. For weeks she once followed a recluse who collected garbage in a long sack, wanting to see his face but afraid to look. He was afraid of her, too, and finally she hid in a garbage can so that she would be forced to look at him close up when he lifted the lid.

She has gone to similar lengths for the sake of her book, shoplifting alongside the shoplifters, living in welfare hotels, penetrating the mental wards of state hospitals with her nursing credentials, working as a Visiting Nurse, eavesdropping in bus terminals, and caring for the rich. Most of her conversations with Letty the Bag Woman, who lives on the Lower East Side out of two shopping bags, occurred while Letty was waiting in Medicaid lines.

Several of these stories might be like Joseph Mitchell's or Edmund G. Love's except that she puts in no funny twist, no color. She chronicles inadvertent cruelty and a grinding down of the humble. Old people in an expensive nursing home are not permitted to talk to each other, are made into speechless infants by the attendants for better handling convenience. A retired furniture salesman in good health wishes to become a professional carpenter but is baffled in his attempt at every turn "as if the whole edifice of Western civilzation rose up to destroy one man's dream." An evicted immigrant couple wind up as permanent residents of a mental hospital because of a series of irrevocable strokes of bad luck. At another old-age home the people start helping to care for the children at a home for the retarded down the block, but their very success seems to challenge the bureaucracy at both institutions and the project is quickly smothered.

Few psychiatrists find old people "interesting" patients; they consign them to custodial care instead. Most physical therapists feel the same way, preferring to work with the injured child, the crippled war veteran. Miss Curtin has no convincing solutions to offer. She suggests that the old combine in a common fight like the blacks or go in for consciousness-raising like women's lib. Mainly her plea is that ageless one—for humaneness. Maybe the most cheerful aspect of her book is its picture of her, because here, if we've wondered, is what those marvelous idealists of the sixties are growing up to: straight-eyed, invaluable investigators.

The core of the book speaks of another matter, however. "I sometimes have a dreadful fear that mine will be the last generation to know old people as friends, to have a sense of what growing old means, to respect and understand man's mortality and his courage in the face of death," she says. "Mine may be the last to have a sense of living history, of stories passed from generation to generation, of identity established by family history." By sequestering the old away out of

* Edward Hoagland is the author of six books, including a forthcoming collection of essays, "Walking the Dead Diamond River."

sight, sanitizing old age, sterilizing death, we break the cycle, the unity of life, denying the possibility of bravery in old age and denying that death too is part of experience and of an integrated life.

Viewing old age as an unproductive infantile state is as if we wanted to view our lives as devoid of meaning, with the dependency and childishness of old age wiping out the accomplishments of adulthood. "Avoiding looking at the entire life cycle, pretending that death doesn't exist, or is somehow in bad taste, robs the old of their chance to complete their life. . . That is the final robbery, the last indignity we impose on our aged." Such a petty vision of life asks them to die feeling they are nothing and that death is nothing, she says.

Appendix 2

LETTERS FROM ORGANIZATIONS

ITEM 1. LETTER FROM RUTH CONSTANT, R.N., M.S., DIRECTOR, REGION VI, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES, TO SENATOR MUSKIE, DATED JULY 20, 1973

July 20, 1973.

DEAR SENATOR MUSKIE: It has been called to my attention by Mr. Donald Trautman, legislative chairman, National Association of Home Health Agencies, that at a recent Senate hearing, information to the effect that the reason there were so few home health agencies still in operation was that agencies had consolidated, reflecting a fewer number in operation. This, however, is not true in the state of Texas.

Since the inception of the Medicare program in July 1966, 122 agencies have been certified in the State of Texas. As of July 15, 1973, there are 41 certified agencies remaining. Of the 81 agencies that have discontinued service, 79 voluntarily closed down due to financial hardship brought about by retroactive denials, slow reimbursement for services rendered, or inability to cope with the ever-changing and/or inconsistent and multi-interpretations of the conditions of participation. Two agencies were closed involuntarily due to their inability to meet the minimum standards of operation. Of the two, one agency was involuntarily closed because it was not in compliance with the conditions of participation, and the reason it was not was because their payment for services rendered was so slow that they could not meet their payroll and were unable to maintain a full-time registered nurse.

The above information can be confirmed through the Texas State Department of Health, Division of Home Health Services, Austin, Tex.

May I take this opportunity to sincerely thank you for the work you have done on behalf of all home health agencies.

If I can personally be of any assistance to you or the committee, I would be most happy to do so.

Very truly yours,

RUTH CONSTANT, R.N., M.S.,
Director, Region VI.

ITEM 2. LETTER FROM FLORENCE J. WILLS, R.N., M.S.N., EXECUTIVE DIRECTOR, COMMUNITY HEALTH AND NURSING SERVICES OF GREATER CAMDEN COUNTY, COLLINGSWOOD, N.J., TO SENATOR MUSKIE, DATED JULY 26, 1973

July 26, 1973.

MY DEAR SENATOR: This letter is in response to the figures cited by you and Dr. Charles Edwards relating to home health benefits under medicare.

It is this agency's experience as well as many other home health agencies that HEW and fiscal intermediaries have become increasingly restrictive about eligibility for medicare.

Our statistics are as follows:

	Medicare income	Visits (nurse, physical therapist)
1969	$138,786	13,029
1970	146,464	13,572
1971	123,143	10,146
1972	110,085	8,394
January to June, 1973	50,937	3,303

Note: Expected income for 1973 is $100,000.

The service needs still exist and the funding burden has fallen upon the agency to find other sources.

From 1971 to 1972 morbidity home care for which there was no source of payment except part paid by the patient doubled. The total cost was $30,148; patients paid $11,330 leaving a deficit of $18,818.

Home health agencies rank last among all the providers receiving medicare funds. Furthermore and most significant is the fact that most home health agencies are nonprofit.

Very truly yours,

(Miss) FLORENCE J. WILLS, R.N., M.S.N.,
Executive Director.

ITEM 3. LETTER FROM THELMA M. PIERRON, R.N., EXECUTIVE DIRECTOR, BELLINGHAM VISITING NURSE ASSOCIATION, BELLINGHAM, WASH., TO SENATOR MUSKIE, DATED JULY 3, 1973

JULY 3, 1973.

SENATOR EDMUND MUSKIE: Regarding difficulties which are barriers to providing health services to the aged:

Nursing: The interpretations of medicare regulations by Washington State Blue Cross, regarding a skilled service, are many times restrictive and repetitive in nature, for example, questioning the homebound status of a single old person whose diagnosis is pneumonia with laryngitis and who is on a potent antibiotic, where the provider has asked for two followup visits, as requested by the physician.

Physical therapy: For example, questioning the necessity and reasonableness of attempts to rehabilitate an older person, a patient in an old folks home, who was almost completely dependent. As a result of the provider challenging the intermediary and after much paper work, having the service covered (outpatient PT). The end results being that the patient now ambulates, feeds herself, et cetera.

In general terms, an insurance which requires a deductible to be met, presents barriers to everyone, the patient, the provider, and the intermediary. Many of the clients carry extra insurance to help them meet the deductible and other costs, but older people find the whole system confusing and difficult to process. We as providers find ourselves frustrated with the delays in processing, mainly because we have few other financial resources.

Our agency has worked with other community agencies to establish, well adult clinics at the senior activity centers in the city and county, and are presently talking with the local housing authority about well adult clinic's in the housing units. Our agency has established a home health aide program at a lesser cost to the client than it costs to provide service by the registered nurse, for nonskilled services.

Respectfully submitted,

THELMA M. PIERRON, R.N., *Executive Director.*

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