BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

AND THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

PART 16—WASHINGTON, D.C.

JULY 17, 1974

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

44-375 WASHINGTON : 1975

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 75 cents

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, New Jersey
ALAN BIBLE, Nevada
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD J. GURNEY, Florida
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, Jr., Maryland
PETE V. DOMENICI, New Mexico
BILL BROCK,* Tennessee

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
VAL J. HALAMANDARIS, *Associate Counsel*
JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

EDMUND S. MUSKIE, Maine, *Chairman*

FRANK E. MOSS, Utah
HARRISON A. WILLIAMS, New Jersey
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

PETE V. DOMENICI, New Mexico
CLIFFORD P. HANSEN, Wyoming
EDWARD J. GURNEY, Florida
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, Jr., Maryland

Barriers to Health Care for Older Americans:
Part 1. Washington, D.C., March 5, 1973.
Part 2. Washington, D.C., March 6, 1973.
Part 3. Livermore Falls, Maine, April 23, 1973.
Part 4. Springfield, Ill., May 16, 1973.
Part 5. Washington, D.C., July 11, 1973.
Part 6. Washington, D.C., July 12, 1973.
Part 7. Coeur d'Alene, Idaho, August 4, 1973.
Part 8. Washington, D.C., March 12, 1974.
Part 9. Washington, D.C., March 13, 1974.
Part 10. Price, Utah, April 20, 1974.
Part 11. Albuquerque, N. Mex., May 25, 1974.
Part 12. Santa Fe, N. Mex., May 25, 1974.
Part 13. Washington, D.C., June 25, 1974.
Part 14. Washington, D.C., June 26, 1974.
Part 15. Washington, D.C., July 9, 1974.
Part 16. Washington, D.C., July 17, 1974.

(Additional hearings anticipated but not scheduled at time of this printing.)

---

*Appointed January 25, 1974, to fill vacancy on committee by resignation of William B. Saxbe (R. Ohio) from the Senate, January 3, 1974.

CONTENTS

Page

Opening statement by Senator Edmund S. Muskie 1527
Opening statement by Senator Frank E. Moss 1529

CHRONOLOGICAL LIST OF WITNESSES

Towles, Bonnie, board member, National Consumers League 1530
Reichard, Pastor Richard, National Lutheran Home for the Aged, Washington, D.C 1539
Crittenden, Wiley, president, American Nursing Home Association 1548
Berman, Prof. Jules, school of social work, University of Maryland 1559

APPENDIX

Letters and statements submitted by individuals and organizations:
Item 1. Summary of recommendations for a long-term care program in national health insurance; submitted by the American Association of Homes for the Aging 1565
Item 2. Prepared statement of the National Retired Teachers Association/American Association of Retired Persons 1566
Item 3. Prepared statement of Marilyn Schiff, National Council of Senior Citizens 1571
Item 4. Letter and enclosure from Raymond Harris, M.D., president, Center for the Study of Aging, Inc.; chief, subdepartment of cardiovascular medicine, St. Peter's Hospital; clinical associate professor of medicine, Albany Medical College, Albany, N.Y.; to Senator Edmund S. Muskie, dated July 12, 1974 1572
Item 5. Letter and enclosure from Barbara Allen Davis, R.N., Ed. D., staff, committee on skilled nursing care, American Nurses' Association, Inc.; to Senator Edmund S. Muskie, dated August 5, 1974 1577

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

WEDNESDAY, JULY 17, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
AND THE SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittees met, pursuant to call, at 10 a.m. in room 1318, Dirksen Senate Office Building, Hon. Edmund S. Muskie and Hon. Frank E. Moss, presiding.

Present: Senator Muskie and Senator Moss.

Also present: Val J. Halamandaris, associate counsel; Elizabeth Heidbreder, professional staff member; Reid Feldman, legislative assistant to Senator Muskie; John Guy Miller, minority staff director; Margaret Fayé, minority professional member; Gerald Strickler, printing assistant; Yvonne McCoy, assistant chief clerk; and Pamela Klepec, clerk.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE

Senator MUSKIE. The subcommittees will be in order.

Earlier this year, the Subcommittee on Health of the Elderly explored the effect on the elderly of the administration's national health insurance proposal. I am pleased that today Senator Moss and his Subcommittee on Long-Term Care will join with us in examining a new approach to long-term care to the elderly and disabled contained in another national health insurance bill, S. 3286, the Comprehensive National Health Insurance Act, proposed by Congressman Wilbur Mills and Senator Edward Kennedy.

This bill would, for the first time, provide for a long-term care program under Medicare. Medicare now emphasizes acute care, particularly hospital care. It does not provide extensive care for chronic and disabling illnesses and impairments, either in the home or in an institution. The Federal-State Medicaid program now does provide for additional assistance in this area, but only to persons who meet low-income tests. Our elderly citizens must first almost pauperize themselves with medical and nursing home bills in order to become eligible.

Several weeks ago, we heard testimony from representatives of the Minneapolis, Minn., Age and Opportunity Center, Inc., which is relevant to our discussion today. The center's imaginative and comprehensive program may well be a forerunner of the type of long-term

care center proposed by S. 3286, for M.A.O. also provides a consortium of medical and social services, and emphasizes the postponement—and, if possible, the avoidance—of institutionalization. The M.A.O. clinic provided us with one model of how comprehensive health care can be provided to the elderly.

The hearing also raised questions about the need for far-reaching changes in our existing Medicare system. For instance, M.A.O. does not require any extra payment for its services. It even goes further and absorbs certain Medicare coinsurance and deductible requirements, since even with Medicare, some elderly people cannot afford medical care. They are forced to choose between pills and food, and choose, of course, to eat.

The Minneapolis program experience, and previous testimony of many witnesses before this committee, suggest that out-of-pocket payments, including the monthly premiums in the long-term care proposal, may raise a real barrier to adequate health care for many of the elderly.

Our recent hearings have also raised questions about improving benefits for "alternatives to institutionalization." Emphasis by M.A.O. on services in the home, in the opinion of its executive director, Daphne Krause, saved many thousands of Federal dollars and "kept the seniors where they want to be."

Home Care More Economical

Last week, the committee heard testimony on this point from the General Accounting Office. The GAO released a report on the use of home health care under both Medicare and Medicaid which concluded that better utilization of care in the home could save money, compared to care in an institution.

The definition of medically necessary services to be given in the home—and those to be covered by health insurance—is, however, a difficult question. Neither the GAO nor representatives of the Department of HEW would provide the subcommittee with a satisfactory answer.

Dr. Jeoffry Gordon, in presenting testimony from the American Public Health Association, also addressed this issue in our hearing last week. He estimated that "at least 10–25 percent of the population now in institutional homes of varying kinds could be cared for and remain in their own homes if organized services beyond episodic nursing and medical care were available. . . ." Yet he cautioned that the association was concerned that in S. 3286, the proposal we are considering today, some of the "broad spectrum" of the services to be provided in connection with long-term care may overburden the health care system with nonhealth services. He suggested that some of these services be provided under another section of the Social Security Act or the Older Americans Act, rather than as part of Medicare..

This comment from Dr. Gordon concerning the possible overburdening of the health system is particularly important with regard to financing.

I am sure that all of us who are concerned about the barriers to long-term care for older Americans welcome the comprehensive approach suggested by S. 3286. The coverage now provided for these services is too often inadequate or, even worse, nonexistent. Yet we must also be certain that the solution offered is appropriate and effective.

I look forward to the additional insights which will be provided to the subcommittees by the testimony of the witnesses we will hear today.

Now, I consider it a special privilege to be cochairing this committee with Senator Moss, who, ever since he came to the Senate, has devoted such time, energy, and concern to the problems of health, especially to problems of the elderly and I welcome his statement at this point.

OPENING STATEMENT BY SENATOR FRANK E. MOSS

Senator Moss. Thank you, Mr. Chairman. It is a pleasure for me to participate this morning in this joint hearing of the Subcommittee on Health of the Elderly and my Subcommittee on Long-Term Care, U.S. Senate Special Committee on Aging, for the purposes of evaluating national health insurance proposals as they relate to the elderly.

As you know, one of the major unmet health needs of older Americans at this time is long-term care. The latest statistics show that Medicare pays for only 6 percent of the Nation's nursing home bill. It is estimated that some 3 million senior citizens are going without the care that they need principally because they cannot afford it. The average nursing home in the United States costs $625 a month and the average retired couple has about $310 in income.

Since few can afford to pay for their needed nursing home coverage, it should be no surprise that 60 percent of today's nursing home patients have their care paid for by Medicaid—the welfare nursing home program. Medicaid's current contribution to the over $4 million industry is fast approaching $3 billion.

In short, few seniors can pay for the care they need. While need becomes increasingly intense with increased age, most seniors must take the pauper's oath to receive assistance.

The hearings and studies of my subcommittee indicate that we must establish a national policy with respect to long-term care. We must decide once and for all what commitment this Nation will make to those who suffer the compound burdens of advanced age and illness. In doing so, we must avoid the pitfalls and mistakes of the past. And we must absorb past successes.

Medicare Basis for Expanded Program

It is my feeling that the Kennedy-Mills bill, S. 3286, contains many essential elements of a comprehensive policy for the infirm aged. First and foremost is its broad coverage and the universal eligibility for benefits. I firmly believe that Medicare should serve as the foundation for an expanded long-term care program for the elderly. I offer my bill, S. 1825, as another example incorporating this principle. A second

and critically important provision in Kennedy-Mills is the philosophy that individuals will be treated first in their own homes with expanded home health and maintenance services, and only when these services are inadequate to the task should patients be institutionalized. This principle is incorporated in my bill and the proposal, S. 2690, sponsored by the distinguished senior Senator from Maine.

I look forward to the testimony of witnesses this morning with the hope that we may build a record upon which to make the important decisions which vitally concern millions of older Americans.

We are going to hear from many knowledgeable and important witnesses. I regret part of the time I will have to be absent because of another committee assignment on the markup of a bill, but I will return as quickly as I can and certainly I will examine the record most carefully when it is completed.

I commend the chairman, the Senator from Maine, for the presage he had on this inquiry which is so urgent at this time and I hope that out of these hearings, we can develop a very comprehensive and adequate policy for our senior citizens, who are deserving of it and now are being deprived of it—the care they need in their elderly years.

Senator MUSKIE. Thank you very much, Senator Moss. May I say on that last point, there is speculation in the press, an expression of hope by Senator Kennedy and expressions of intent by Congressman Mills which expresses there will be a real effort to produce a national health bill this year.

If that overall objective is met, I think it is important we write into it the best concept of long-term care that we can, which adds to the urgency of this hearing this morning.

May I invite, then, as our first witness, representing the National Consumers League, Bonnie Towles, a member of the board of the National Consumers League.

STATEMENT OF BONNIE TOWLES, BOARD MEMBER, NATIONAL CONSUMERS LEAGUE

Ms. TOWLES. Mr. Chairman, Members of the committee: I am a member of the board of directors of the National Consumers League, and am here today to speak in their behalf. As you may know, the National Consumers League is this country's pioneer consumer organization.

We welcome the opportunity to testify at these hearings on "Barriers to Health Care for Older Americans." These barriers have been discussed in detail by others. We would like to concentrate on major remedies for some of the problems described earlier in these hearings.

The National Consumers League endorses the basic features of title II, part D, of the Kennedy-Mills bill, S. 3286, on national health insurance. We would like to emphasize, however, that any plan lacking meaningful, long-term care benefits would be unacceptable to both older Americans and the general public who will be called upon to support, through taxes, any system for national health insurance. Health consumers are less and less willing to accept any health insur-

ance program, private or governmental, which continues to support the fragmented, crisis-oriented care presently provided by our institutions and categorical health programs. Such programs impede the delivery of comprehensive, coordinated services and serve to complicate life for those who receive as well as those who provide services.

The need for long-term care plagues many Americans but especially our growing number of elderly. Inordinately expensive, plagued by uncertain results and often separated from basic preventive or sick care services, long-term care bites deeply into the pocketbooks of the elderly, their families, and the public. The mystery of many of the illnesses brought on by aging, separates the long-term care patient from other health consumers. With little hope of recovery, the victim of chronic illness requiring long-term care, is often psychologically and even physically alone with his pain.

The almost total isolation of the elderly and those with chronic disabilities, has fostered a false sense of security among us. Few of us have witnessed the dismal and often cruel environments in which the old and the disabled must live. Few of the State and Federal laws requiring minimum standards for care of the elderly are adequately enforced and often the existence of conflicting Government mandates means that facilities for the elderly fail to comply fully with either law. The result has been that public money has been used to support what often amounts to criminal neglect.

Adequate Facilities Not Available in Many States

In many States there are simply not enough facilities to adequately house the elderly, nor enough trained staff to attend to their needs. Except for the seriously ill or those who can afford private care, many of the elderly who require public shelter are placed in makeshift boardinghomes which fail to meet even minimum health and safety standards. The rash of fires which have broken out in boardinghomes for the elderly in recent years attest to our failure to insure adequate facilities and care for our elderly.

The isolation of the elderly and their confinement in boardinghomes or in large, State-owned institutions leaves them virtually helpless in protesting mistreatment or in demanding better care. Patients in private nursing homes, while afforded better care in most instances, are aloof from the problems of those less fortunate. Nevertheless, they too suffer from lack of public concern and protection—especially in those homes run purely for profit at the expense of quality care or concern for the patients as individuals.

Long-term care patients are the major consumers of our Nation's health care services, yet they have available to them the most fragmented, uncoordinated health care services. Until the elderly are reintegrated into society through home- and day-care programs, adequately safeguarded by the public through strong controls over the institutions and programs which purport to serve them, and provided with adequate programs, including comprehensive social as well as medical services, they will remain isolated and endangered.

44-375—75——2

Ironically, certain chronic illnesses requiring long-term care might be prevented with adequate preventive care at earlier ages. Accurate medical records, reflecting the patient's medical history throughout his life, might provide important insights to the cause of many chronic disabilities and diseases and enable discovery of effective treatments. But the present fragmentation of services does not allow for such thorough records. Even if we are quick, strong, and wealthy enough to untangle the fragmented elements of health care when we are young, the failure to provide coordinated records of these services will eventually plague us as we grow old.

We think the proposal in the Kennedy-Mills bill is the foundation for a truly consumer-oriented system of long-term care. Let me assure the chairman that the league says this without having participated in the formulation of the proposal. You know its legislative origins in the work of Representative Conable. So, our comments today are not those of a progenitor but rather those of an audience grateful for the articulation of long-felt needs.

The proposed legislation embodies several principles of great value to consumers. Let me enunciate the major ones:

Principle No. 1 is the establishment of community and consumer representatives in the policymaking and administrative activities of community centers that are to provide or contract for the services the consumer will use. We applaud this bill for recognizing that the people eligible for the services should have a major role in making the decisions. The proposal calls for half the members of the governing board of a center to be elderly citizens and a quarter to be elected by the elderly population within the area served by the center. The remaining quarter will be members appointed by the locally elected government officials.

This provision is a welcome signal to the elderly that the Nation wants and respects their participation. It also is a signal to all citizens that there is a place for grassroots democracy in the health services field.

Beneficiary Participation Absent in Medicare, Medicaid

This is a contrast to the situation in Medicare and Medicaid, where beneficiary participation is notably absent. Beneficiary participation represents the difference between paternalism and democracy. We believe there should be more patient involvement in the health services system. Indeed, the league recommends that any national health insurance proposal incorporate the principle of beneficiary participation in the conduct of the program. Such participation should occur, not only at the local levels, but at all levels, State, regional, and national.

Principle No. 2 on our list has to do with lodging the responsibility for meeting the variety of needs of the long-term care patient in one place. The Kennedy-Mills proposal is a little wobbly on this principle, since it leaves some aspects of institutional services beyond the jurisdiction of the community service agency.

We believe that the agency should provide for institutional as well as noninstitutional services. It should evaluate the patient's needs, plan and insure the provision of all necessary services, monitor the provision of those services and provide followup, periodic reevaluations to determine how effectively the patient needs are being met. We

believe it would be wrong to restrict the service agency to supervising only noninstitutional services, such as home care.

There should be an across-the-board responsibility, so that wherever or whenever problems are encountered in obtaining needed services, the patient or his family can turn to a single point of accountability and obtain redress of grievances or change of site or type of service. This step is essential if we are to move away from today's irresponsibly fragmented delivery system in which, too often, the patient is pitted against multiple providers of care.

Principle No. 3 is suggested in the bill. We believe that medical and health-related social services must be provided. The care of the long-term patient should not stop at an arbitrary boundary because the service is not defined as medical. Besides care in a nursing home, the Kennedy-Mills proposal covers such benefits as home-health services, homemaker services, nutrition services, plus day-to-day foster home and outpatient services in a community mental health center. To this list should be added planning and evaluation of social needs by a social worker to assist the patient in adjusting to the changes in his style of life necessitated by his illness.

In summary, the National Consumers League recommends that the proposal be changed in several important particulars. It should give the community service agency the same functions and powers over institutional as over noninstitutional care; and it should include health-related social services as one of the benefits provided or supervised by the agency.

To give the agency real muscle in dealing with providers of services, we recommend that the disbursing of funds to cover a patient's care be controlled by the agency. For example, if a nursing home is found to be deficient in making needed services, the agency should be able to stop all or part of the payments to that institution.

Geriatric Training Programs Lacking

We would like now to turn to another set of suggestions. The proposal should have specific provisions for training and education of physicians in geriatric care. There is no chair of geriatric medicine in the Nation's 100-plus medical schools at this time, yet chronic illness represents two-thirds of all illness Americans experience and accounts for the lion's share of the Nation's spending for illness.

We suggest the need for a provision to encourage or require all medical students to have training in at least the general aspects of chronic care. Surely, as the Congress now moves to fashion a new health manpower bill with emphasis on family practice and other primary care specialties, including paraprofessional, some inducement or obligation should be created for development expertise in the care of the long-term patient. It would be entirely consonant with the Kennedy-Mills proposal in long-term care to note that the community service agencies will need the assistance of knowledgeable geriatric health professionals at many levels of training in assessing the needs of the patient and the opportunities for serving him properly. It would be wrong to finance long-term care benefits without considering the number and type of professionals required to insure the proper administration and provision of services.

Another suggestion concerns the need for specific provisions for startup assistance and construction funds for the community service agencies. These should be located so as to be accessible and acceptable to the elderly.

In closing, we would like to stress the need for increased involvement in the planning and evaluation of health services. Such involvement requires consumer education and training and the development and support of well-organized consumer champions in the corporate world of health services.

The community service agency could be such a champion. The need for such help is apparent to the National Consumers League after the first few weeks of the opening of our Health Services Information Center on Massachusetts Avenue. The center offers official Government inspection records on Medicare nursing homes in the Metropolitan Washington area. It is a beginning point to the consumer in search of a nursing home. In its first 2 weeks, there were 99 users—some obtaining information by mail and phone as well as by walking into our office to inspect files. We believe this usage suggests the public's need for well-organized assistance in the area of long-term care, a need which the community service agency proposed in the Kennedy-Mills bill would help to answer.

Senator MUSKIE. Thank you very much, Ms. Towles, for your testimony. I would like to put a few questions.

First of all, with respect to your comments on consumer representation, there is some criticism, I understand, of the Kennedy-Mills provision in this respect as being overcomplicated and difficult. Do you have any observations in that respect or any suggestions for improvement?

Ms. TOWLES. For improving the provisions in the bill?

Senator MUSKIE. Yes; from the consumer's aspect.

Ms. TOWLES. I should and will but I at this moment do not.

Senator MUSKIE. Do you know of any experiments in consumer representation that are taking place in the health field that might be useful to us in evaluating these provisions?

Ms. TOWLES. Yes, I do. I think the problems which resulted from attempts at consumer participation in OEO health centers should provide some lessons in terms of what needs to be provided to insure effective consumer participation.

MEDICAL INDUSTRY OPPOSES CONSUMER PARTICIPATION

My own feeling is that one of the reasons consumer participation failed in these centers was the blatant and continued opposition of the medical industry itself in terms of allowing such participation other than on paper. As in almost all of the Government health programs which provided for consumer participation, such as the federally supported comprehensive health planning agencies and so on, there were no provisions for educating consumer board members. As a result, consumers simply could not cope. Nor should consumers be expected to cope with the medical language or with the planning responsibilities required for active participation on such boards without adequate training and staff support. Without such training, the consumer is at such a disadvantage that he simply fulfilled the bad opinion of him held by the health professionals to begin with.

If consumers are provided with education and training, if they are provided with their own staff, one which is accountable to them, I think they could provide a very valuable service. Certainly, they are the ones to be able to say for certain whether the service is meeting their needs.

Senator MUSKIE. Now, the prepared statement [1] submitted by the representatives of the National Retired Teachers Association/American Association of Retired Persons, concludes that with respect to the election of some board members:

> A more difficult procedure for assuring consumer representation could not have been conceived. Somehow a political campaign for the office of board members of the local community long-term care center seems absurd. There must be a more appropriate method of assuring consumer representation.

Ms. TOWLES. I suppose an election is perhaps a cumbersome means of providing consumer representation. On the other hand, from watching the various ways in which the consumers have been selected, there has been a tendency in Government programs to select the easiest consumer to deal with, that is the doctor's wife, the dentist's niece, the middle-class consumers, who usually have some connection, however inadvertently, with health care providers.

We find the same thing in terms of opening up hospital boards and other boards to consumers. When they say consumers, health professionals have an entirely different idea of what is meant by consumer than do those of us who work with community organizations. Nor are they aware of the need as a balanced representation on planning decisionmaking boards.

In Philadelphia, in Baltimore, and in other cities, where I have worked with consumers, usually some kind of formula is developed after having made some kind of demographic study of the area, including what kinds of people use the services of the institution or agency seeking consumer representation, and then some attempt is made to identify, either through locally held meetings, door-to-door campaigns, and so forth, those people who would be interested in being on the health board or who are at least willing to speak on behalf of others.

CONSUMER REPRESENTATIVES ELECTED

Usually, some local election has been held, with some method for local representatives to be regularly elected. I think for the elderly, in the few successful programs which included the elderly, whether a person had been elected or not was not the main or even a major issue. However, the issue was whether that person was actually representing the elderly or not. Usually, if he was not, he was removed during the electoral process.

Senator MUSKIE. I think these are very helpful observations. In your testimony you suggest that the community services center, provided in the Kennedy-Mills bill, control the disbursing of funds to cover a patient's care.

Now, the bill also gives similar veto power over reimbursements to the State long-term care agency.

Is it your suggestion that that provision be eliminated or that the provision for local control be added to that of the State authority?

---

[1] See appendix item 2, p. 1566.

Ms. TOWLES. I am not sure I can speak on behalf of the league, but I think it would not hurt to have a checks-and-balance system whereby the local agency had a say whether disbursement of funds would be allowed to an institution, at least a review power over the State agency's decisions.

I think the local agency in working with the people, whether an institution was, in fact, providing adequate service, who are being provided services would know best, but that the State should coordinate the various local agencies so it would have some sense of what is going on in the State, as a whole.

Senator MUSKIE. I gather that the review power should be vested in the State agency?

Ms. TOWLES. Right.

Senator MUSKIE. At the end of your testimony, you mention a health services information center, which your organization has established here in Washington. I wonder if you could tell us a little bit more about this project. I am particularly interested in whether or not this center has given you any insight on the question of how much the consumer can shop around for good health care.

Ms. TOWLES. Well, first I will try to describe the center, somewhat. It is very new. It is only about 2 or 3 weeks old. It is simply a small office which has within it files which the Consumers League has collected through an incredibly difficult process. The center has information on nursing homes in the Metropolitan Washington area. We have attempted to identify them and to obtain information about them. Most of the information, to date, has been culled from the Medicare records.

These records attest to, among other things, the fire safety standards, the type of nutrition offered by specific centers, nursing services available, and the medical services provided. Nevertheless, because Federal Medicare records, from which our own records are drawn, have a complicated way of assessing nursing home services. There is no easy method by which a consumer who comes into the center to try to determine which nursing home he would like to use for his elderly mother can make a valid judgment concerning quality of care. He can, from our records, determine certain costs for services, and, by balancing one record against the other, determine the various services available, and so forth.

He must then make his own decision as to which nursing home is best able to care for the person for whom he is seeking care.

Nevertheless, the center is a first step; there is nowhere else that we know of in this area that provides that kind of information free of charge.

The problem in setting up the center and in enlarging it resulted from the various obstacles placed in our way by some Federal agencies and the nursing homes themselves. A major problem was getting a waiver on the cost for xeroxing the Medicare records—25 cents a page—which seemed exorbitant to us.

NURSING HOME DATA DIFFICULT TO OBTAIN

Most of the private nursing homes do not wish to share precise information on the kinds of services they provide and if you are going

to definitely seek services from them and/or to enlarge on the information in the files through personal observation, it is very difficult to obtain entrance into these homes, to really determine whether or not the written record is an accurate one.

I noted in reading the testimony of Nader's group in 1971, that they had in fact had several women working in nursing homes who testified concerning the conditions they encountered. The Health Law project in Philadelphia did a similar study several years ago.

It does not seem that conditions are getting any better in many of these nursing homes and since the Nader testimony in 1971, there is no organized or legal way to determine conditions in these homes other than through the normal Government processes. But for consumer organizations to form an opinion, I think they need more than the authorized Government's records.

Senator MUSKIE. In my opening statement, I made reference to a couple of issues that were raised in our last hearings. One is the question of the extent to which social services or health-related services are to be covered by health insurance programs. I made reference to the GAO suggestion that better utilization of care in the home could save money compared to care in an institution but they would have difficulty defining what they might regard as "medically necessary" services. I also made reference to Dr. Gordon's concern representing the American Public Health Association that too broad a spectrum of services provided in connection with long-term care may overburden the health care system with nonhealth services.

I wonder if you would like to make any observations with respect to those questions?

Ms. TOWLES. I think the problem is a very real one; the definition of what are medically necessary services. The fact is if we do continue to add to the list of services we are willing to provide, the bill will not only be astronomical but coordination of those various services and quality control will become even more difficult than it is now.

VARIETY OF SERVICES AVAILABLE NOW

I think if we look through the number of categorical programs, it is amazing what you can obtain, the variety of services that are already available if you are willing and able to locate them and to determine where they are available, when they are available, who provides them, under what restrictions, and so on.

More important than the kinds of services provided, however, is who provides them, where they are provided, and in what fashion; whether or not the patient feels he has a say in the way they are provided. I really believe this.

I have done consumer education and training for several years off and on and one of the things I do in terms of discussing politics of health is lay out to them a typical health scene, like, for instance. in Philadelphia. I begin to describe all of the programs available in that city and then the restrictions or provisions for obtaining the various services provided by each of these programs. By the time I have finished, the entire blackboard is covered. If you would count them, you would discover 400 or 500 separate programs and services. For any person to make use of so many services is totally impossible. Therefore,

I think we must take the money being proposed for additional categorical programs and use it to coordinate and define those programs that already exist so they are not duplicative.

I do not think we are asking for new programs; most of the necessary services are already provided now.

Senator MUSKIE. Could I put it this way: You stress very strongly in your statement, as well as in what you just said, the importance of a coordinating function.

Now, would it make sense then to make some attempt to define medically necessary services for coverage in this program and seek to augment those under the Older Americans Act, which is one of Dr. Gordon's suggestions.

Ms. TOWLES. Yes, I think you first have to describe what exists, how it is now being provided. Once you do that, then you can determine what still needs to be provided.

Senator MUSKIE. Some of those may have to be expanded.

Ms. TOWLES. Expanded or dismantled. There are certain services that may not be needed or are less needed than others not now provided. But the other thing, in terms of who determines the kind of services to be provided I think this is where consumer participation provides a vital function. It is a very difficult question. Who describes a medically needed service?

Senator MUSKIE. You people have had some experience in this. Could you help us and give us a definition of what is medically necessary?

Ms. TOWLES. I am sure most physicians would take issue with me, but in terms of sitting down with consumers and telling them you have a limited amount of resources and they will have to "bite the bullet" and make some hard decisions to what is more important to them, many of them would disagree with the physicians as to what is really needed. Then you get to the question of who is ultimately responsible for determining needed services—the Medicare providers or health consumers?

SERVICES SOMETIMES WASTED

Should services be provided even though consumers do not agree with physicians that they are needed? I would like to use an example:

I am working now with cancer control programs and have discovered that most cancer specialists are very eager to fit cancer amputees with a prosthesis as soon as possible after surgery. It is medically necessary to do so in order to insure that the limb to be fitted will heal in such a way to insure a proper fit; the least possible pain, and so on. Thus, the physician normally counsels the patient to allow himself to be fitted immediately after surgery for a prosthesis.

What we find on followup, however, is that however necessary or desirable it might seem that the patient wear his prosthesis, something like 50, 60, up to 80 percent of patients do not wear them for any extended period of time, despite all of the money, all of the research, all of the counseling and education of the person that it is necessary to wear them for rehabilitative purposes.

Psychologically, the person does not feel it is necessary, so he will not use it. Now, I think you will find the same thing in certain other

health services and I think it has to be a give-and-take process by which physicians are willing to sit down with the patient or with consumers, discuss with them, in an adult fashion, why they think certain services or procedures are necessary and plan out the kind of programs that should be provided. The patient's desire and needs are important.

Senator MUSKIE. What we are talking about is delegation of authority on something of an ad hoc basis, to define whether they are medically necessary services. Is that what you had in mind?

Ms. TOWLES. By "ad hoc," you mean trying to determine which services will be within the purview of the physician and which within the purview of the consumer and which will remain negotiable?

Senator MUSKIE. That seems to be what you are saying.

Ms. TOWLES. Yes, I think that is the only workable solution, although more difficult.

Senator MUSKIE. It may be more difficult but I was trying to get your view.

Thank you very much, Ms. Towles, for your excellent testimony. If you have any further suggestions on this last question—or any other information for that matter—the committee would very much appreciate any advice you can give.

Ms. TOWLES. Fine. Thank you.

Senator MUSKIE. Our next witness is Pastor Richard Reichard, National Lutheran Home for the Aged, Washington, D.C.

STATEMENT OF PASTOR RICHARD REICHARD, NATIONAL LUTHERAN HOME FOR THE AGED, WASHINGTON, D.C.

Mr. REICHARD. Mr. Chairman, I do plan to depart briefly from the written testimony.

My purpose in being here is to offer you the perspective of a practitioner in long-term care. At the National Lutheran Home in Washington, where there are 285 residents, the average stay is more than 5 years. I have been in this field for 8 years, since before the advent of Medicare and Medicaid and I have developed some feelings and will doubtless incorporate them along the way to a certain degree with your permission.

Senator MUSKIE. Please proceed in any way you want.

Mr. REICHARD. I am representing the American Association of Homes for the Aging and am a member of the ad hoc committee on national health insurance of that association. That committee met several weeks ago and concentrated its effort and analysis on the provisions of the Kennedy-Mills national health insurance proposal.

As the national organization representing nonprofit homes for the aging—both skilled care and health-related institutions as well as residentially oriented facilities—we are vitally interested in seeing that any national health insurance program enacted takes into account the health care needs of the so-called old elderly. Among the 295 residents in our home, the average is 80 years, so in the area of long-term care, we are talking of both "long term" in its fullest sense and the "old elderly" in their fullest sense, and most especially the needs of the aged who find themselves in institutions already, or who may develop the need for care in an institution.

Elderly Population Increases

Not only has the elderly population increased dramatically since the turn of the century—from 3 to 10 percent of the total population—but so, too, has the population in the upper end of the aged spectrum. Between 1960 and 1973, the population aged 65 through 74 increased 20 percent, but the population aged 75 and over increased 46 percent. More than 1.6 million Americans are 85 years of age or over. The needs and characteristics of this group of "old elderly" not only differ greatly from those of the under-65 population, but they also differ substantially from those of the "young elderly."

Only 14 percent of the population aged 65 and over suffer from no illnesses or chronic diseases of any kind. The "old elderly" very often suffer from multiple chronic illnesses, and their potential for full recovery and rehabilitation from diseases or impairments decreases with their age. We believe it is essential that the Nation address itself to the realities of long-term care of the aged, and further, that the Congress and the administration recognize that the problems of people needing long-term care require a fundamentally different approach from that taken for the rest of the population.

Until very recently, the debate on national health insurance has focused almost exclusively upon the needs of the younger population whose health care needs tend to be acute care oriented and episodic. The needs of that segment of our population requiring long-term care have been largely overlooked in the development of these proposals.

I would like to add, about 5 years ago at a quality care conference, I had the chance to ask a question of Senator Kennedy, who was proposing his federally paid, National Health Insurance Act—it was reported to be comprehensive, but its provisions for long-term care are similar to current Medicare provisions—100 days plus.

I asked him why, in a bill purported to be comprehensive, there was such a minimal benefit for long-term care. He was very frank and honest with me and said in his opinion, it was simply not possible to do all that needed to be done at once, at least at the beginning. I appreciated that answer.

I appreciate very much more what is in the Kennedy-Mills bill which goes much farther in addressing some of the real problems of long-term care.

I would like to comment on the basic features of the Kennedy-Mills bill, but at this point, I am departing from the statement.

In my 8 years at the National Lutheran Home, I have seen hundreds of people who have become medically indigent, who have gone through the means, or the "demeans" test, as you might wish to call it, and I have seen their lives devastated—the lives of independent, strong-willed people, being Lutheran, they are largely of German origin and of solid stock—and it seems to me somewhat of a national disgrace to have people become indigent, simply and solely because they have been sick.

Long-Term Care Insurance

I like very much the idea of insurance as it is proposed in the Kennedy-Mills bill in title II, the part D provisions which permit an individual to insure himself, in a participatory sense, against the costs of long-term care.

In my manner of thinking, all of the other comments that will be made will not be as important as that: The opportunity for people over 65 to insure themselves against long-term care. And I certainly note from your statement, Senator, that you also regret very much the requirement for indigency prior to the time that some sort of aid can come into effect.

Among the three major national health insurance bills under the most serious consideration, the following basic approaches to long-term care have been taken:

First, the administration bill, S. 2970, continues a residual Medicaid program for long-term care.

Second, the Long-Ribicoff-Waggonner bill, S. 2513, basically continues the approach now taken in the Medicaid program, but it federalizes this program.

The legislation introduced April 2, 1974, by Senator Edward Kennedy and Representative Wilbur Mills, S. 3286, represents, in our view, the first proposal sponsored thus far which addresses itself in a serious way to the long-term care needs of our "old elderly" population. We applaud the initiative of Senator Kennedy and Representative Mills.

Mr. Chairman, we believe there are three major principles which should be considered in designing any long-term care program for the aged:

There should be a comprehensive range of services—both in noninstitutional as well as institutional settings—offered to those needing care.

The distinction between strictly medical and health-related social needs should be eliminated, inasmuch as nonmedical, social, and psychosocial problems faced by the old elderly very often play a role as important, if not moreso, than medical diagnoses in necessitating long-term care provided in institutions.

That statement is a part of my experience which I can relate to you later, if you wish.

There should be created a delivery system especially designed to meet the needs of this age group, which tailors the package of services to meet the individual long-term care needs, and which provides for continued contact and followup to assure that any arrangements necessary are satisfactory.

Although any of the major pending national health insurance bills might be amended to incorporate a long-term care program based upon these principles, we applaud the recognition of these elements as reflected in title II, part D, of S. 3286. Whichever approach to national health insurance the Congress decides to pursue, we hope that a long-term care program for the aged based on the principles stated above will be incorporated in the final legislation.

At this point we would like to comment specifically on some of the features of title II of S. 3286 in the hope that our reactions will be useful to you.

Mandatory Versus Voluntary Coverage

In its present form, participation in the program established under title II of S. 3286 is voluntary. Any individual eligible for part A of Medicare or Supplemental Security Income and part B of Medicare may elect to participate by paying a $6 monthly premium.

We believe that voluntary enrollment is undesirable in that it will result in problems of adverse selection. It is likely that with voluntary participation and open enrollment periods each year, many people will not elect to enroll until they have a change to health status and anticipate the need for extensive services. Thus the system would work to the disadvantage of the trust fund.

We endorse the trust fund idea and know that the money has to be generated to meet these requirements and, therefore, we call for mandatory instead of voluntary participation in part D.

There is also a second problem in that many who need the services will not voluntarily enroll simply because they will need the amount of the premium payment for daily living expenses. Thus we can expect much of the low-income population to lose the benefits of the program.

I should like to add that there is a lot of psychological denial going on within everyone of us. One of the unfortunate realities which we tend to deny is the image of ourselves being in a long-term care situation, debilitated and disabled. That impact of psychological denial, in a sense, in which it also relates to death in our society, will also result, I think, in many persons not wishing to enroll themselves in part D, or at least, not wishing to face that question of enrollment.

Accordingly, we recommend that participation be made mandatory.

We endorse the idea of participation in the financing of the program on the part of beneficiaries, and believe it is appropriate that those who will use the services provided make a financial contribution to the program. However, we do not believe that persons whose incomes are so low as to make them eligible for Supplemental Security Income should have to bear the burden of the monthly $6 premium. We recommend that the bill allow States to buy into part D for SSI beneficiaries. Moreover, under current Medicaid law, the States can buy into part B of Medicare for aged recipients of Medicaid. Since Medicaid would be repealed by the proposed program, we recommend that the bill be amended to carry over the buy-in provisions so that States could buy into both part B and part D established by S. 3286 in behalf of SSI recipients. This change seems particularly essential inasmuch as persons must be enrolled in part B of Medicare in order to qualify for part D.

We also wish to note that there is an income group just above those at the SSI eligibility level for whom the $6 premium could be a hardship. We suggest that the subcommittee may wish to consider a graduated premium related to income, to lessen the burden which would otherwise fall upon those at the lower end of this middle-income spectrum.

That is to say, those who earn more would pay more for this coverage.

Community Long-Term Care Centers

S. 3286 establishes community long-term care centers which would be charged with the responsibility of providing—or arranging for the provisions of—services covered by the program. The centers are also intended to serve a monitoring function by making periodic checks on the beneficiaries' status and their need for any change in services.

We favor the concept of locally controlled community centers which would perform the evaluative, packaging of services, and monitoring functions called for in this bill. It is important that the centers be

controlled locally and be responsive to, and reflective of, local needs and capabilities. Also, we endorse the provisions of the Kennedy-Mills bill which provide for community nonprofit sponsored agencies to serve as long-term care centers. We consider this preferable to the use of governmental agencies.

We believe that the size of the service areas served by each center is a factor of great importance. The service areas must be small enough to be human and responsive to human needs, yet large enough to be able to assume the array of functions with which they are charged.

We strongly endorse the broad scope of services offered under this program and the broad definition of long-term care which is implied. Major problems have resulted from current law which seeks to place chronically ill persons in rigid slots labeled "levels of care." We favor abandoning the levels of care concept altogether. The Kennedy-Mills bill does this by adopting an approach which recognizes the need to tailor services to people rather than people to predetermined categories of service.

Dental, eye, and foot care are not covered, however. Given the great need among aging persons for these services, we recommend that the scope of covered services be extended to cover these items. We also believe that health-related social services should be included as a covered item.

Transition From Medicaid to Part D

Given the broad scope of the responsibilities which would fall to the community centers established under this bill and the amount of time which would be required for States wishing to participate in the program to set up the necessary mechanism, we believe that the Medicaid program should be retained in each State until the necessary arrangements are in place. This transitional approach would provide a bridge between the current Medicaid program and the totally new concepts called for in this bill. It would also allow for time to test the program and work out problems. Unless Medicaid is retained until the appropriate mechanisms and arrangements are in place, many people will be excluded from necessary services.

Although S. 3286 provides for a system of reimbursing community care centers, it is silent on the question of provider reimbursement. Inasmuch as title II amends Medicare, we assume that, given no special statement on the question of provider reimbursement, the provisions which currently apply in Medicare would apply here also.

We believe that the Congress took a significant step forward in 1972 by providing for reasonable cost-related reimbursement under Medicaid for skilled nursing and intermediate care facilities. Although the regulations for section 249 of Public Law 92–603 have yet to be issued, we believe the principles established by this provision are sound. We recommend, therefore, that the provisions of section 249 of Public Law 92–603 be incorporated into S. 3286.

There are several places in the bill where a bias in favor of noninstitutional long-term care services is mandated or introduced through fiscal incentives. For example, in section 1887 of the bill, which lists the functions of the centers, it is suggested that placement in institutions be considered only as a last resort. Also, in section 1890, financial

incentives for using noninstitutional services in lieu of inpatient institutional services are provided.

This bias seems to reflect a widespread attitude that, in our view, is based upon three faulty assumptions: Namely, that because there are many substandard or poor nursing homes, institutional arrangements are always bad; second, that care outside of an institution is always more desirable than care within the institution; and third, that noninstitutional services are always more economical. None of these assumptions is true. We challenge these assumptions about so-called alternatives to institutionalization, as well as the apparently common assumption that high percentages of people now in skilled nursing and intermediate care facilities do not require the services provided therein.

In any event, we believe that the reimbursement system established by this bill should be neutral, rather than biased in favor of, or against, institutional or noninstitutional services. Decisions governing the services arranged for individuals needing long-term care should be based upon professional judgments of those who assess their needs, as well as upon the individuals' desires and self-concepts, and these judgments and desires should not be countermanded by rigging the financial mechanism.

These, then, are our recommendations on what we view as the most important and significant elements of long-term care as it relates to national health insurance.

We appreciate the opportunity to submit this statement. I appreciate the opportunity to testify before you and I will be happy to attempt to answer any questions you might have.

Senator MUSKIE. Thank you very much, Pastor Reichard.

First, with respect to mandatory coverage, would you propose—I just want to be clear on this point—that the premium be imposed in a mandatory fashion on all individuals?

Mr. REICHARD. We believe the person upon becoming age 65 should begin to pay this premium, quite similar to part B, except that it would be mandatory rather than voluntary.

Senator MUSKIE. How would we impose the mandatory feature of the premium?

Mr. REICHARD. The implication of the mandatory enrollment would be that individuals would not elect enrollment but that it would be mandatory for them, with the provision that the poor and near-poor would be cared for in the same sense that they are now cared for by public authorities as appropriate.

Senator MUSKIE. I was going to get into that. But first, could we explore this question: If they refuse to pay the premium, how do you enforce that? Are you simply saying that you make it clear in the law that, unless they pay the premium, the benefits are denied them?

METHOD OF PREMIUM COLLECTION

Mr. REICHARD. The only practical way I can see the premium would be assured, would be through automatic deductions from the monthly Social Security benefit check.

Senator MUSKIE. If they are recipients?

Mr. REICHARD. Yes; if they are participants in Social Security.

Senator MUSKIE. With respect to the payment by the States for SSI beneficiaries, do you have any estimates of the costs of that proposal?

Mr. REICHARD. No, I have not. There are significant "buy-in" programs now in place, as you know. All of the part B premiums for everyone, for example, in our home, under Medicaid, are being paid for by the authorities of the District of Columbia.

Senator MUSKIE. So that covers every patient?

Mr. REICHARD. Everyone who is a beneficiary of the Medicaid program. Our Medicaid participation is about 60 percent at this point.

Senator MUSKIE. In your statement you suggest that the service area of a long-term community care center be small enough to be human and responsive to human needs, yet large enough to be able to assume the array of functions to which they are charged.

Is it your view that this definition of a service area be left to regulations or do you have a standard in mind to suggest in the legislation itself?

Mr. REICHARD. I would suggest the standard in the legislation itself, perhaps relative to the numbers of persons in a service area to be served. Some of the elements, as at least I understand them, of the regional medical program, were in great difficulty because of the size of the service areas.

The same would be true of the community mental health center legislation in various communities. The service areas are simply too large and vague and people need assistance.

Senator MUSKIE. I think S. 2806 says service areas must be no larger than PSRO areas, but those are sometimes as large as an entire State. That would be cumbersome, in your view?

Mr. REICHARD. I think that a service area encompassing an entire State would be cumbersome. There may be instances where a formula rather than numbers of people may be used. I would admit we are quite vague, but I would simply emphasize a feeling of the importance of the size of the service area.

Senator MUSKIE. I am not entirely sure I understand your proposal for abandoning the "level of care concept." Would you expand on that?

Mr. REICHARD. That is one of the great difficulties that our facility—which is a multilevel facility—providing individual care for people from residential through skilled nursing care confronts. The levels of care concept is, in our opinion, an economic mechanism which was created after the initial impact of the Medicare program became apparent. With the vast utilization, because of the need that existed, the categories of skilled and then intermediate care, which were created are artificial because of the rapidly changing needs of the persons served in long-term care facilities. But the levels of care requirements became so rigid that certain areas of the home were designated one thing or another; the impact on individuals being that they are moved or presumed to be moved, literally from one end of the corridor to the other.

We talked about the 60-day corridor problem which you talked about before. Persons to regenerate a spell of illness have to be outside a treatment setting for 60 days and having been outside that area, they regenerate the opportunity to use their Medicare benefit.

We think this is unreal. We think that there are competent professional individuals who can evaluate persons' cases, person-by-person, patient-by-patient.

LEVEL OF CARE EVALUATION

In the State of Maryland, for example, having read the report there of the State nursing home commission, the way they establish the levels of care assignment is first by having an intensive scrutiny by medical and social personnel of that individual's case history—social as well as medical—and then they make a determination for fitting into the level of care.

In most States, such as the one in which our home functions, it is far more carelessly done. Someone downtown is shuffling papers around and in those papers is an individual and depending, we believe, on what the economic structure will bear at that moment, the levels of care assignments are made on the basis of very poor and faulty information.

We believe that there are persons involved here and they deserve a better hearing than they are getting in terms of what their actual needs are and we believe the Kennedy-Mills bill does propose a far more individualized scrutiny than is now the case under what we believe to be impersonal and quite inhuman aspects of Medicare and Medicaid. Also, there are financial and economic reasons to recognize for which levels of care exist.

Senator MUSKIE. What would be your response to the issue raised this morning of whether or not we ought to focus on medically necessary services being put directly into this program and then related to other services?

Mr. REICHARD. I believe "medically necessary" is a term which is quite limited in my own feeling. My own experience with older people in the past 8 years is that most of what is going on in terms of their changing life situation is not necessarily medical.

In fact, it is a concept with which I will bore you just a moment, of shrinking life space, to which I have latched on; it refers to all of the shrinkage and loss which occurs in old age—medical shrinkage, even shrinkage of bones, people getting shorter as they grow older. But the other kinds of shrinkage are shrinkage of work roles, loss of peer group, death of family, movement from a house to an apartment, to a room—all of which can be constructed as the various kinds of shrinking going on. Yet, only one of those is medical, and the term "medically necessary," it seems to me, goes only about one-eighth of the way into assessing what the situation is with regard to older people.

Environmentally necessary, socially necessary are equally valid and perhaps far more important concepts than medically necessary.

I suppose the reason we think that way is that in nonprofit long-term care, we are doing more than providing nursing care. Our home is not a nursing home. It has become a long-term care center in its own right, long before Medicare and it will be a long-term care center long after community long-term care centers become a reality.

Let me summarize by saying how very deeply I believe in the integration of social and medical and environmental services. There are professionals in all of these areas. We are concerned not only with the medically necessary but with the health-related factors. The term "health-related," I believe, is far more appropriate.

Senator MUSKIE. By integration, meaning inclusion in a single integrated program?

Mr. REICHARD. Yes, a single integrated program which recognizes that as human beings, we are more than just physical.

REIMBURSEMENT SYSTEM

Senator MUSKIE. In your statement, you say you believe "the reimbursement system established by this bill should be neutral, rather than biased in favor of, or against, institutional or noninstitutional services." As I understand the provision with which you take issue, the purpose is not to establish a bias in favor of noninstitutional services but rather to establish neutrality with respect to their use, so they are given the consideration that institutional services are now given. But you do not see it that way?

Mr. REICHARD. I would say, with that interpretation as you have just made, we would have no serious problem because then no bias exists.

I suppose our reaction at that point——

Senator MUSKIE. Sometimes you have to overcompensate to swing the pendulum.

Mr. REICHARD. I think that is what occurred. My own feeling is that, as a provider in the field of long-term care—having read testimony from this committee by Lionel Cosins and others over the years, in which he will make a flat-out statement that 50 to 60 to 70 percent of people in nursing homes and other long-term care facilities or institutions do not belong there—I suppose I just view that as the most brash kind of generalization that may or may not be applicable in England. I know it is not—I believe it is not applicable—in this country.

In any event, if the system of social scrutiny, as well as medical scrutiny, is in place before persons go into the home, then, presumably, with the integrated system, people will not be there who do not belong there.

The other side of the issue is that in nonprofit, philanthropic, and church-related, long-term care institutions, there are people who wait for years with the desire to come into the home. So it depends, I suppose, upon one's view of the institution.

There are people in our home who are there because they have waited to come in as their social or physical needs arose. They have planned and counted for years and years on coming to our home and I believe there are hundreds of nonprofit, philanthropic, church-sponsored, and other types of homes in this country of which that is true.

I only mention that because we have extreme difficulty fitting into the legislative slots, again because we are not nursing homes. Our mandate, given usually by our denomination, arising out of social concern, is far broader than that. It is our belief that our services generally exceed those required by these programs before they ever even come into being.

I regret that sounds rather boastful but we do believe in, and we are proud of what we are doing in nonprofit long-term care. We think the orientation of the bill toward that approach and in that direction is valid.

Senator MUSKIE. What is your view with respect to what would happen if noninstitutional services were available, commensurate with the need? Would you expect the institutions and the elderly to decline?

Mr. REICHARD. I believe it would be highly desirable to have a strong noninstitutional range of services in this country, in every community.

Statistically, you and I are aware of what is going to be occurring in this country by the end of this century, if not long before. In terms of the institutions which exist, they will be needed very, very much. Hopefully, by that time, whether proprietary or nonprofit, they will be real experts at providing institutional and community services. But the strong community emphasis of noninstitutional services will be very much needed. It is clearly both and not either/or.

Senator MUSKIE. Thank you very much, Pastor Reichard. I appreciate your testimony. It is obviously thoughtful and based on some very real experience.

Mr. REICHARD. Thank you.

Senator MUSKIE. I now welcome Wiley Crittenden, president of the American Nursing Home Association.

STATEMENT OF WILEY CRITTENDEN, PRESIDENT, AMERICAN NURSING HOME ASSOCIATION; ACCOMPANIED BY BRUCE THEVENOT, ASSISTANT LEGISLATIVE DIRECTOR, AND IVAN NESTINGTON, LEGISLATIVE CONSULTANT

Mr. CRITTENDEN. Good morning, Mr. Chairman. My name is Wiley Crittenden, president of the American Nursing Home Association. I am a nursing home owner and administrator in Greenville, S.C., and with me is Bruce Thevenot, assistant legislative director, and Ivan Nestingon, legislative consultant to our association.

The American Nursing Home Association is a nonprofit organization which represents approximately 7,200 nursing homes throughout the United States with more than 500,000 patient beds. It is the Nation's largest nursing home organization with a membership made up of both proprietary and nonproprietary facilities.

As spokesman for this vital area of health delivery, ANHA recognizes its responsibility to encourage and support a program of national health insurance which includes comprehensive coverage of long-term care. As one part of our effort to meet this responsibility, ANHA several years ago developed the Chronicare program and has since sought to bring to the attention of the Congress the principles of long-term care delivery which it embodies.

I am grateful for the opportunity to appear here today to discuss the proposed Comprehensive National Health Insurance Act (S. 3286). Title II of this bill is similar in important respects to the Chronicare program and apparently is motivated by a similar philosophy concerning the need for a comprehensive approach to long-term health needs.

CURRENT PROBLEMS IN LONG-TERM CARE

In considering what our Nation's system of long-term care should be, we may begin by considering the problems which today face older Americans who require long-term care. The chief and overriding problem for these elderly citizens is simply that they cannot, on their own, afford the cost of the high quality long-term care. The daily charge for nursing home care, which includes full-time nursing services, rehabilitation, social and recreational programs, and room and board

is typically less than the cost of a night in an ordinary hotel. Nevertheless, these costs continued over a period of time are more than most older Americans can afford.

Mr. Chairman, as you and the members of the committee are aware, most older Americans possess only modest financial resources. The most recent figures which we have available indicate that the median income for a married couple, both of whom are over 65, is about $5,000 per year. The median income for single males over 65 is about $3,700. Single females over 65 have a median income of only $2,000 per year.

For the majority of older people who lack the resources to pay for long-term care out of their own pockets, the alternatives are few and unappealing. Private health insurance covering long-term care is difficult to obtain even for the young and healthy. For the high risk older population, it is virtually nonexistent.

The Medicare program contains some skilled nursing facility and home health benefits, but these are restricted by statute to posthospital rehabilitation in connection with an episode of acute illness. In its zeal to reduce Government expenditures, the administration has by regulation tightly limited even the narrow scope of nursing home and home health benefits which the Congress had intended to provide under Medicare. In any case, the present Medicare program does not cover the chronic health needs of those who must have long-term care.

Impact of Medicaid Program

For most older Americans, long-term care services can be obtained only by reliance on the Medicaid program. To qualify under Medicaid, an individual and his family must reduce themselves to poverty in order to meet an income qualification test. Furthermore, in most cases an assets test, or rather a "no-assets" test, must be met.

For thousands of elderly Americans, carefully husbanding the modest acquisition of a lifetime's work, the need for long-term health care means the loss of the very financial resources necessary to ever regain their place as an independent member of the community. If the patient has a living spouse, he or she will also be reduced to poverty. In view of these considerations, there is little wonder that many aged and infirm individuals delay seeking long-term care for as long as possible. It is equally apparent that this long delay in seeking care—and the continued deterioration of the patient's health which accompanies that delay—substantially reduces the likelihood that rehabilitative techniques will be effective.

Critics have charged that nursing homes are "warehouses for the dying." We reject that blanket indictment, but to the extent that grim description contains a grain of truth, the blame does not belong with our nursing homes. The blame rests on the tragically widespread attitude in our society that the old and sick are worthless discards. Believing this, we have created a system of Government assistance restricted by preconditioning so demeaning that the elderly turn to it only out of desperation. That our society's attitudes and the system which reflects them join to create a self-fulfilling prophecy is too obvious to require further elaboration.

It does not have to be this way. The Congress has before it legislation which would establish a system of Government benefits to assure every older American the long-term health care he needs, when he needs it, and at a cost to him which he can afford. Were such legislation to be enacted, it would provide elderly citizens with the opportunity for increased independence and a decent quality of life during their remaining years.

The process of aging is not reversible, but many of its symptoms are. At least, the processes of physical and mental debilitation can often be substantially slowed. Recent years have seen a growing recognition that all Americans have a right to health care. This is especially so for those elderly citizens whose special needs for care have grown at a time in their lives when their resources have diminished.

In addition to the threshold question of the ability to pay, older Americans face severe problems which stem from the limited alternative modes of long-term care available to them. The most common problem in this connection is the overutilization of hospitals by patients who could be better treated in nursing homes. Not only would these individuals receive more appropriate care, that care could be provided at a cost which averages less than 25 percent of the cost of hospital care.

Unfortunately, due chiefly to a lack of information, few patients, and for that matter, few physicians consider the nursing home alternative to hospital care. Furthermore, neither private health insurance nor the Medicare program as designed to provide incentives to use the most appropriate care.

Although nursing home care is the primary concern of our association, we recognize the need to provide long-term health care for those who are able to remain in their own homes. We believe that home health and homemaker services, nutrition services, and day care are particularly important aspects of any program intended to provide comprehensive long-term care.

HOME HEALTH AND HOMEMAKER SERVICES

The combination of home health and homemaker services would allow many older people who would otherwise have to seek institutional care to remain in their own homes. Furthermore, there is an element of outreach in connection with home health that cannot be duplicated by inpatient health facilities. By going out into the community to provide health services, home health agencies have the potential to reach elderly people who could not on their own locate the health service they need. This problem of finding even these health resources that presently exist is particularly serious among the old who are often extremely limited in their mobility and avenues of communication.

Lack of good nutrition is one of the most important health problems of the elderly. Although in some cases the need for special diets is involved, the most common nutritional problems of the elderly stem simply from the difficulties many encounter in shopping and preparing their meals. A general indifference to food may result from the partial loss of the sense of taste common among older people and an

aversion to eating alone. Whatever the reason or combination of reasons that lead to nutritional problems, an effective program of nutrition services for the elderly could deal with this basic health problem.

Finally, day care programs have enormous potential to meet the long-term care needs of the elderly, while delaying or avoiding the need for full-time institutionalization. Day care programs offer the opportunity for nursing care, rehabilitation and social services, and nutrition services on a part-time basis. Families in which all adult members are employed may be able to keep elderly relatives with them if day care services are available to assure adequate care during working hours.

Patients' Needs Should Predominate

It is the position of the American Nursing Home Association that these alternative types of long-term care services should be available to all elderly Americans with the minimum of artificial restrictions or limitations. On the other hand, we have noted a tendency in some quarters to assume that home health care is invariably preferable to nursing home care. We are not certain whether this bias is based on an assumption that all elderly patients prefer the home health approach or whether it is believed that home health services are necessarily less expensive. In either case, we believe the assumption is mistaken.

The fact is that the health needs of many patients cannot be met except under the conditions of full-time care provided in an institutional setting. Moreover, while there are undoubtedly many elderly individuals who, with some assistance, can be maintained in their own homes, there are many others who require the level of care only possible in a nursing facility.

Similarly, while the home health approach may be able to meet the needs of some patients more cheaply, its cost will be dramatically affected as more intensive or frequent services will be required. The relative efficiency of home health care will also be affected by the nature of the geographic area in which it is provided. In sparsely populated rural areas, for example, personnel may find themselves spending more time traveling than delivering health care.

We recognize that the Government has a responsibility to avoid excessively costly modes of health delivery, especially where it has committed itself to bear a portion of those costs.

We believe, however, that the primary factor in determining which of several alternative types of care are provided should be the individual patient's health needs. To the extent possible, full consideration should also be given to his personal preferences, and the wishes of his family.

The Potential Contribution of Nursing Homes

ANHA not only believes that alternative modes of long-term care should be provided, we believe nursing homes could make a substantial contribution toward assuring the early and efficient availability of such services. America's nursing homes are experienced in dealing with the special problems of the elderly, they employ the largest single concentration of personnel skilled in meeting these problems, and nursing

homes are already present in almost every town and neighborhood throughout the country. We believe that nursing homes could become a focal point for the delivery of a comprehensive range of long-term services throughout their communities as well as within their own walls.

We hope and trust that should the Congress establish a program of assistance for these services, artificial barriers will not be erected against any class of providers. The only test should be the providers' ability to extend high quality care at costs which are reasonable.

Finally, major problems are raised by the payment systems to providers under our current Government programs for delivery of long-term health care. In our view these payment systems neither provide incentives to high quality care, nor protect the Government against unreasonable costs, nor assure providers of fair compensation for their services.

ANHA believes that payment to both proprietary and nonproprietary providers of long-term care services should be made under a system which allows for the development of alternative prospective payment methods. These methods should be developed cooperatively by providers and State governments under Federal guidelines.

The present system of retrospective cost reimbursement to hospitals and nursing homes under Medicare (and under Medicaid in many States) has been a major factor in the inflation of health care costs. The Medicare reimbursement approach imposes expensive and time-consuming auditing and cost-finding requirements, results in retroactive denial of payments, and offers little incentive for institutions to hold down costs.

Only by implementing simplified prospective payment methods which are based on predetermined budgets can we achieve the efficiency and cost effectiveness that is made possible by sound management practices. In combination with an effective program of independent professional review of the appropriateness and quality of care, such an approach would make it possible to reasonably relate cost and quality in the payment system.

We regret that little apparent progress has been made by the Department of Health, Education, and Welfare in carrying out the experiments in prospective payment methods which were authorized by section 222 of Public Law 92–603. However, we are encouraged by the fact that a prospective payment approach is called for in several major national health insurance proposals, including title I of the Kennedy-Mills bill.

Comprehensive National Health Insurance Act (S. 3286)

The foregoing considerations have formed the basis for ANHA's own review of the major national health insurance proposals now before the Congress. Of these bills, the proposed Kennedy-Mills bill clearly goes farthest in assuring the availability of high quality long-term care to all those who require it. We, therefore, urge the adoption this year of legislation which contains the general approach set forth in title II of this bill.

We believe the Kennedy-Mills bill sets forth in broad form the kind of program of long-term care assistance which the Nation will someday provide for its elderly. We hope that day will be soon.

Title II of this bill would establish a new, voluntary part D program under Medicare to provide a comprehensive range of long-term care services to all Medicare eligibles who choose to enroll. This program would be administered by an independent Social Security Administration through State long-term care agencies and community long-term care centers. The program would be funded by the premiums of enrollees together with the State contributions and supplementation from Federal general revenues.

Mr. Chairman, I would now like to discuss a number of recommendations with regard to S. 3286 which I hope will be useful to this committee in your evaluation of this legislation.

We believe that by making long-term care benefits available to all Medicare eligibles who choose to enroll, this legislation would take the single most important step necessary to preserve the dignity of those older Americans who require long-term care. Furthermore, even those who are fortunate enough to remain in good health will be freed from the fear that some future long-term illness will drive them into poverty.

We are concerned, however, that no provision has been made in this bill for those, including the mentally retarded, who require long-term mental health care. Since the Kennedy-Mills bill would abolish the Medicaid program, the mentally ill and retarded might be left with even less Government assistance than at present. I can think of no rational basis on which to justify selective deletion of this group of individuals from coverage under the bill.

Uncertainty also exists with respect to the over-65 population which for any reason has failed to enroll in this part D program and with respect to those under 65 who are disabled, but have not yet met the 2-year waiting period required before they can be deemed qualified for Medicare.

This bill would provide the broadest range of long-term care benefits of any major national health insurance proposal. In addition to nursing home care, the bill would provide the home health, homemaker, nutrition, and day care services which our association believes are fundamental features of a sound long-term care program. The bill would also provide foster home services and the outpatient services of community mental health centers. Consistent with our view that coverage of the mentally retarded and mentally ill must continue under a Federal program which replaces Medicaid, we believe that inpatient services in facilities for the mentally ill and mentally retarded should be added to the benefits contemplated under this bill.

Under the Kennedy-Mills bill as presently drafted, a community long-term care center would be responsible for the long-term care services provided within the geographic region which it is designated to serve. This center would screen patients and determine their long-term care needs. Afterward, it would maintain a continuous relationship with each patient to assure the quality and appropriateness of the care provided him.

Center's Role in Delivery of Care

With respect to the actual delivery of care, the center would be authorized to contract with providers of care as well as to deliver some health services directly. In our view, it would be a serious mistake to

allow community long-term care centers to engage in the direct delivery of care. Since these centers would have complete control over Federal financial assistance for long-term care, anything less than an arm's length relationship between such a center and the actual providers of care could lead to abuses. Unquestionably, at least the appearance of abuses would be a constant danger.

Where a community center itself engages in the delivery of care, an obvious conflict of interest arises between its responsibility to deliver the care and its duty to oversee the quality of that care. Furthermore, the fact the center would have a direct financial interest in the delivery of some types of care could lead to the overutilization or underutilization of certain services based on considerations other than the needs of the patients.

Under the bill as presently drafted, the center would indirectly provide long-term health services by means of contracts with providers. It appears that the center would have virtually unlimited freedom to contract with whichever providers it chooses while excluding others. Likewise it would seem to be free to contract on whatever terms it chooses, including the terms which relate to payment for services.

It is our view that participation in this program should be open to all providers who qualify under a uniform and public system of standards designed to assure high quality care. We believe that provider agreements should be executed between the provider and the State long-term care agency. Patients who qualify for a particular level of care should have the freedom to choose treatment by any qualified provider.

It is also our view that the terms of the provider agreement should be on the basis of a system developed and operated at the State level. The States should be given flexibility in determining the terms under which providers would deliver care, subject to Federal guidelines.

Under these arrangements, community long-term care centers would be free to serve as a vital resource to the beneficiary population in its area, performing such functions as initial health screening and periodic reevaluation, referral for services, education and outreach, and data maintenance. By performing this role, the center could effectively assist individuals in gaining ready access to the services they need.

We believe that with certain amendments, the payment system proposed in section 2042, title I, of the Kennedy-Mills bill would be a sound and equitable approach to payment of providers under both the national health insurance and long-term care programs. This proposal meets a fundamental requirement of good management by establishing the principles of prospective payment for services. A second important quality of the approach set forth in section 2042 is that it would allow a diversity of payment formula within Federal guidelines.

In this regard, we believe certain changes in section 2042 are necessary. Under the section 2042 formula, the prospective rate would include a factor based on an annual determination of the rate of return of other comparable investments. This return would be measured against the equity invested in the facility. If equity invested means net equity then we must strongly object to this standard.

Since the rate determined annually by the administration will determine the actual payment to providers, the choice of a particular base

against which to measure the rate does not "lock in" any higher cost to the Government or special advantage to providers. The important criterion of the base is simply that it be one which does not distort the payment system so as to discourage sound management practices. To determine the rate of return on the basis of net equity gives preeminence to the wholly irrelevant issue of a particular provider's capital structure.

We believe that a rate of return based on the fair value of total investment would be the soundest approach and would avoid the possibility of the unintended and unproductive discrimination.

A quality management payment such as that contemplated under section 2042 is an essential part of an efficient payment system. We believe that such a system must be operated with care, however, to avoid discriminating effects. In measuring the performance of a facility, appropriate subcategories must be established to assure that cost considerations beyond the facility's control are not weighed against it. For example, providers in higher cost metropolitan areas should not be required to compete in cost savings with those who operate in lower cost rural areas.

"Prior Hospital" Requirement Criticized

In addition to the long-term care benefits which would be provided under title II, the Kennedy-Mills bill would provide for coverage of skilled nursing facility care under its title I national health insurance program. However, these skilled nursing home benefits are limited to posthospital care. This prior hospitalization requirement should be deleted under title I of this bill and under the current Medicare part A program.

The requirements of a prior hospital stay serves no useful purpose and contributes substantially to hospital overutilization. In appropriate cases, on the other hand, direct admission to a skilled nursing facility would greatly reduce costs while providing an earlier start toward effective treatment.

An additional important consideration is the need to liberalize the definition of skilled care in the current Medicare program as well as the new programs contemplated by this bill with respect to nursing home and home health care.

We believe that a redefinition of coverage which recognizes both medical and nonmedical aspects of a patient's condition is urgently needed in order to reverse the present tendency toward classifying all long-term patients in the intermediate care category. Similarly, we believe that the Congress should recognize that intermediate care is not a lower level but a different kind of care which costs approximately the same as skilled nursing care.

We are aware of the concern of this committee about the artificial level of care distinctions in our programs. ANHA hopes that a workable solution of this problem develops in the course of the current deliberations on national health insurance.

Mr. Chairman, the foregoing comments reflect our major concerns in relation to the Kennedy-Mills bill. Naturally there are numerous less crucial considerations which we hope to raise as the legislation moves through the Congress.

I am grateful for this opportunity to appear here today to discuss the vital issue of national health insurance. As I have indicated, there is in our view no more important health need in our country than to adequately provide for the long-term care of our elderly. It is our hope that national health insurance legislation, including coverage of long-term care, will be enacted this year.

I would be happy to respond to questions.

Senator MUSKIE. Thank you very much, Mr. Crittenden, for your comprehensive statement. It is valuable to our record.

I have two questions I would like to pose. In your statement, you mention that nursing homes could become the focal point for the delivery of long-term services.

How do you see nursing homes related to other forms of care, such as day care and homemaker care?

NURSING HOME AS A CARE HUB

Mr. CRITTENDEN. I would like to perhaps respond to that in a total context, Mr. Chairman. I would feel that, since the long-term facility is already established in the community and is community oriented, it is already open 7 days a week, 3 shifts a day with the staff and the health care resources—such things as a day care center associated with the long-term care centers can prevent or postpone institutionalization. It is a method of preventing institutionalization.

We are already in the food business, for instance. We can provide nutritional programs for a particular community. Many of our facilities in the Nation already have specific contracts to provide these nutritional programs to the home setting. They are delivering hot Meals-on-Wheels to particular people, shut-ins and such.

Outpatient rehabilitation service can be provided, where you could bring elderly people in, or you could take the services to the elderly persons. The product is already there.

It is a matter of expanding that product or that service to meet the total needs of that community's elderly.

Senator MUSKIE. Would you see the nursing home as operating a referral service which would determine the kind of service a patient required or do you see it as part of a coordinated service supervised by an independent agency or a consumer-oriented agency, perhaps the center that would be established under title II of the Kennedy-Mills bill?

You are talking about that kind of integration; you are not talking about the nursing home running all of these programs?

Mr. CRITTENDEN. No.

Senator MUSKIE. You are talking about the nursing home as part of the coordinated approach?

Mr. CRITTENDEN. Yes. Let me go back to the Kennedy-Mills bill, where we addressed ourselves to the community center. That is one of the reasons we believe strongly that a community center should not be a source of payment.

It should be a source of determining the needs of the people in that community and finding the institution or agency that can meet those needs. Therefore, that particular long-term care center could, in turn, contract with providers to deliver all the various services that are

already under various programs, and to be consolidated into a central setting, if you would like.

Senator MUSKIE. Now, your view of the community long-term center differs from that of an earlier witness, Ms. Towles of the National Consumers League.

I think you are in direct conflict on one point and that is the point of whether or not the centers should have any role to play with respect to disbursements to providers. You believe that they should not?

Mr. CRITTENDEN. Yes; I think it is a conflict of interest for a center to be confronted with payment responsibilities, as well as referrals.

Senator MUSKIE. You did not mention in your discussion the monitoring function of the center with respect to the quality of services or the kinds of services provided. Would you challenge that?

COMMUNITY CENTER MONITORING FUNCTION

Mr. THEVENOT. I think we mentioned that in our statement. We had included a lot of the functions which the community long-term care center would perform; a central function would be a monitoring function, and we envision a coordination between that function and professional standards review procedures, perhaps creating a separate focus on long-term care needs, which has to be addressed independently or in conjunction with some sort of mechanism exactly like this.

We would certainly not recommend that monitoring be deleted from those functions.

Mr. CRITTENDEN. I would expand on that and say there is a way we could tie the concept, the philosophy, of PSRO into the community center.

We could also tie that into the elimination of level of care, based on the monitoring system, and perform services to meet the needs of these people, in one institution, instead of moving from one hall to the other hall, or outside, or across town.

Senator MUSKIE. At our last meeting, we discussed the need for liberalizing the skilled nursing requirement for home health care.

In your statement, you mention such a need for both nursing homes and home health. Since your organization has endorsed my bill, S. 2690, do you agree that simply taking out the word "skilled," as that bill does, liberalizes the home health benefits sufficiently and yet does not downgrade the level of care given?

Mr. THEVENOT. We did, in fact, at the time, express our support for it and we still do. I think it addresses a need that we covered in our oral presentation about the overly restrictive determination of what constituted skilled care.

I think we are seeing that part of this was the result of a uniform definition of covered care under the Medicare and Medicaid programs, without there being a recognition that the individuals who usually receive care in these programs are very different kind of individuals in terms of their overall condition, the length of stay, and other factors.

Senator MUSKIE. I think this committee has determined that there is an inordinate amount of activity going on right now of classifying individuals as in need of intermediate, rather than skilled, nursing care. This presumably is part of a cost-savings program.

I think the solutions which you propose would provide for something more than just a nursing analysis of the patients' needs.

Mr. CRITTENDEN. I think that is imperative, both in the home health and institutional setting.

SKILLED NURSING REQUIREMENT DISCRIMINATORY

Senator MUSKIE. I am sure you have heard the charge that one reason nursing homes object to the skilled nursing requirement is that it has the effect of discriminating against nursing homes which, perhaps, ought to be discriminated against.

I know there has been a constant improvement in nursing homes but that charge is still made. I wonder if at this point it might not be an appropriate time to let you respond to it?

Mr. CRITTENDEN. We have had a lot of charges made against our industry, Mr. Chairman. I do not feel alone in this particular committee room when it comes to charges being made.

I see so many discriminating effects as it relates to definitions of skilled care right now, since Medicare and Medicaid have a simultaneous definition.

I find States using this definition to prevent Medicaid coverage, that is, if Medicare is not covering the patient, then, how in the world can Medicaid cover it? Therefore, I think we are subject to an undue amount of criticism because of the classification of patients into intermediate care facilities.

Many intermediate care facilities might become "dumping grounds" because of the definition of skilled care at the moment.

Senator MUSKIE. I would assume that in every nursing home there are patients who require skilled nursing care and there are patients who do not; so with respect to nursing homes, it seems to me that the nursing homes ought to have skilled nursing care available, even though all of their patients do not need it.

Now, is that a valid distinction? How do you respond to that analysis?

Mr. CRITTENDEN. I totally agree with the previous witness in that I do not believe there are 50 or 60 percent of the skilled patients in nursing homes that could be housed or accommodated somewhere else.

I do agree that we need to expand the availability of services in one facility so as to cover the needs of a patient on the basis of his condition on that day, or that week, or that night, instead of having to reclassify that person or find a different level of care in a different institution.

It brings us back to the artificial definitions of levels of care. It would be no different than me living in a hotel, requiring a certain type of accommodations and having you meet my needs for those accommodations and another fellow having a different accommodation in a single room.

I think that we could appropriately come to a method of providing more and more concentrated care in one area than trying to artificially dilute it in the bulk of our facilities.

Senator MUSKIE. Mr. Crittenden, thank you very much for your testimony. I am sure you could make other expansions on the recom-

mendations which you have made. We would welcome them for the record.

Mr. CRITTENDEN. Thank you, Mr. Chairman. We appreciate the opportunity.

Senator MUSKIE. Our next witness is Prof. Jules Berman of the School of Social Work, University of Maryland.

STATEMENT OF PROF. JULES BERMAN, SCHOOL OF SOCIAL WORK, UNIVERSITY OF MARYLAND

Mr. BERMAN. My name is Jules H. Berman and I am a professor at the University of Maryland School of Social Work and Community Planning in Baltimore. Until my association with the University, some 4 years ago, I was a member of the HEW policy staff working in the area of income maintenance, social services, and medical care on the welfare side of the Department's organization.

I am pleased to have this opportunity to come before this committee, for I have long been interested and concerned, about the long-term care needs of the aged. This concern began with my HEW experience where my responsibilities brought me into contact with all three dimensions of the long-term care problem: Income maintenance, social services, and medical care. I have continued my interests since in connection with my teaching and writing. I am very much aware of the complexities and difficulties in developing a plan to deal with the needs of the aged who are simultaneously poor, in need of substantial social services, and whose physical and mental conditions may well have deteriorated. Long-term care is a mixture of medical care, domiciliary care, and social services and as such it falls between the health and income maintenance areas. Social services emerge from another system increasingly unrelated to medical care and income maintenance.

It is obvious that the first direction public policy should turn in dealing with this problem is prevention. There is nothing new about this proposal, for it has been the subject of many hearings before congressional committees and study by other groups. Long-term institutional care can be postponed, at a minimum, and even avoided entirely by some aged individuals if the community can muster a complex of services responsive to the needs of the marginally ill aged person. I am pleased to see that S. 3286 recognizes this point and makes provisions for a number of useful preventive services.

I think that the sponsors of S. 3286 should be commended for their willingness to face the problem of long-term care in their bill and to include provisions to deal with this as a part of health insurance. It is rare for health insurance proposals to include any recognition of long-term care together with health insurance. It should be noted that the administration's health insurance bill omits long-term care and provides for the continuation of the long-term aspects of Medicaid.

Although I welcome the inclusions of part D "long-term care services program," I have some concern about its specific provisions. My concern is substantially around the issue of Federal versus State responsibility. I have had a long experience working with States in the provision of basic services to people. Although the record of performance of a number of States is commendable, for many others, the

record of willingness to mount the program, to provide the State share of the financing, the capability of the State to secure the personnel and to provide the leadership, is deficient. The creation of Medicare and the Supplemental Security Income program and the valiant attempt to reform the welfare system which would have federalized the program, suggests that there is a generally accepted position that the Federal Government should take primary responsibility for the key human services programs of income maintenance and medical care. Thus, I have concern that the long-term care services program as described in part D in S. 3286 depends upon State initiative and some State funding. Some States will respond to this offer of Federal aid willingly, and will have no difficulty in fulfilling the plan requirements spelled out in the proposed section 1884 as to what a State must do to have its long-term care plan approved. Other States may not respond and even if willing to do so, may have difficulty in fulfilling the plan requirements.

Why State Administration of Funds?

Even the minimum requirement of 10 percent State cost sharing may be too much for some States, even though the enactment of part D would mean the end of State responsibility for the most expensive part of Medicaid. Indeed, a serious question can be raised about the wisdom of initiating a program which the States would operate but would be almost entirely financed by the Federal Government. The question needs to be faced of why State administration at all? Why not federalize the entire operation and thus avoid the impasse that would arise if a State does not initiate the program? I do not necessarily favor total Federal administration, but I think that the justification for State involvement needs to be carefully analyzed.

Another concern I have about part D of S. 3286 is the insecure financing provisions. The program is voluntary and for an individual to join, he must either pay the required $6 a month or, if he is a beneficiary of a public retirement program, like Social Security, authorize the $6 as a deduction from his cash benefits. We all are aware of the great pressures on the retired aged caused by inflation. Unless the aged are unusually foresighted and are willing to look ahead to the time when they might need the services authorized by part D, or unless the individual is shortly to be in immediate need of such services, he is unlikely to agree to any deduction from his benefit check.

I do not think that is an unreasonable attitude for the aged to take, given the circumstances they now face with rising prices and benefits often too low for a decent level of living. Thus, the trust fund will not build up as the sponsors apparently anticipate, and the program is likely to be saddled with a large number of poor risks.

Another issue the voluntary nature of the program raises is what happens if an individual did not join up when he had an opportunity, yet now needs the services of the program. He will clearly be ineligible, under the terms of part D, yet he cannot be denied admittance to an institution, if he is in need of such services. I anticipate that the States will be very suspicious of these provisions for they will foresee their continued involvement in a Medicaid-type program, even if they are

agreeable to initiating a long-term care service program. This alone might contribute to State hesitation to get involved with part D.

Federal Responsibilities for Medicaid?

I know that it is often easier to identify problems than to suggest solutions. I have some suggestions, however, how the two major problems I have identified might be dealt with. My proposed solution goes back to the issue I raised of the appropriate distribution of responsibility between the Federal Government and the States. I think that it is desirable, and indeed essential, that as much of the Medicaid program as possible be made a Federal responsibility. S. 3286 does that substantially, but not enough. Medicaid has been criticized by many authorities for the consequences of having title XIX—Medicaid—be a State responsibility. One of the valid criticisms of that program is the uneven manner in which the States have carried their responsibility. Services offered have differed from State to State and the adequacy of the benefits has also been adversely affected by the responsibility States have to set rates for most of the services offered. The quality of institutional care offered under Medicaid has been especially uneven and to a large extent of poor quality. Congress has amended title XIX several times to achieve an improvement and HEW regulations have also attempted to secure a higher standard of care. I think it is a losing battle. I am for taking the institutional aspects of Medicaid out of State-run programs and making it a part of a federally run social security health insurance program. Thus, I would take "institutional services," as defined in the proposed section 1889(e), and add that to health insurance services available to all.

The removal of the institutional aspects of the long-term services program from a Federal-State structure to the Federal Government, added to health insurance, raises the question of how to handle the preventive aspects of the long-term services program. Although I am not entirely satisfied with my proposal, I think it should remain a State responsibility, with Federal direction and cost sharing. In contrast with income maintenance and health care, for which one can easily aspire to uniformity of benefits and service, social services are more difficult to federalize. They derive so much from the local scene, local needs and resources, that I think, at least for the immediate future, this should remain a State responsibility.

Thus, I would propose that the preventive programs encompassed under part D continued to be a State-administered program with much of the content now in part D. I would eliminate the insurance aspects of the overall program—the $6 a month beneficiary contribution.

I recognize that my proposal for the incorporation of the long-term institutional aspects of the care of the aged under health insurance and the elimination of the $6 a month beneficiary contribution raises the cost to the Federal Government of the overall program. It would certainly add significantly to the cost of health insurance.

I am aware that the States are being relieved of substantial Medicaid costs, by S. 3286, as introduced, and as I would amend it. I am not sure that I know all the range of possibilities of charging back to the States the costs which they have been assuming and which will now be

carried by the Federal Government. One possibility that occurs to me is to have the Federal Government forego the State contribution now going into the program and have that be identified as a portion of the revenue-sharing money the States are now entitled to under the State and Local Fiscal Assistance Act. I would like to see some such charge-back effort, for the Federal Government should not have to bear the entire burden of financing these costly programs.

I have a few more comments on the proposal in S. 3286. There is a certain duplication between the services proposed under S. 3286 and those which are now possible under title VI of the Social Security Act, grants to the States for services to the aged, blind, and disabled. While the HEW regulations issued to implement this statute are restrictive, probably unnecessarily so, there is a potential for considerable duplication of authorization. I think that these provisions should be drawn more closely together with S. 3286. I also believe there is a similar duplication of authorization between the nutrition program described in S. 3286 and that authorized by the Older Americans Act.

Thank you, Mr. Chairman.

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

PREVENTIVE SERVICES

I have a few questions. You discussed at some length, especially in the concluding portions of your testimony, the role of preventive services. But you do not define what you mean by that term. Are you referring to the noninstitutional services provided in the proposal or do you equate social services with preventive services? What is the distinction?

Mr. BERMAN. I think ultimately it would be broader than just noninstitutional services described in the bill. I would include a broader range of social services.

I think it is difficult to distinguish between what might be called health-related services and other type of services. I think that distinction should not be tried.

It raises all sorts of issues of definition—audit exceptions, eligibility provisions, and the like. I would see a wide range of services being available, including those which are described in the long-term care provisions of the bill, together with some others, and they should be available to people in the community.

They would have health-related implications, naturally, but they need not all be directed to persons who, if they do not receive them, have no other place to go but to an institution.

Senator MUSKIE. Now, how would those programs be financed?

Mr. BERMAN. There is some financing for it now under the social services provided under the Social Security Act. There is a $2½ billion ceiling which has been reduced somewhat by the appropriation request to $1½ billion, I believe.

I believe that is funds which are substantially available, but I think it would require some additional money in a grant-in-aid device to the States to help them in providing for these kind of services.

Senator MUSKIE. But if the range of services is to be left to the discretion of the States or to the State Governors—did you say that?

Mr. BERMAN. No, I said that the selection of the agency would be

left to the Governor. I think it differs from State to State as to which agency has the greatest capability.

I would not suggest that the range of services be left entirely to the States, although you have to leave some leeway there to take account of where the State is in the development of its own programs.

I think they would start out with a certain basic core of services, which States would have to provide, literally at the outset, and then gradually expand that to make it quite comprehensive.

Senator MUSKIE. I am glad to get that clarification because I had a different interpretation of what you said.

What you are talking about is establishing a program of social services—I do not know what the synonyms of that are yet—preventive services, noninstitutional services.

Mr. BERMAN. They would include the services that we have been used to dealing with in the past; homemaker services, home health services, nutrition services, some personal social services, counseling, and such.

Senator MUSKIE. In effect, what you are talking about is establishing those programs as a separate Federal categorical assistance program, locally financed with Federal funds?

Mr. BERMAN. Not necessarily wholly financed with Federal funds. I think it is possible to capture some State money under it.

Senator MUSKIE. With the usual formula of $9 Federal money to $1 State, or how?

VARIABLE FORMULA FINANCING

Mr. BERMAN. Well, I do not necessarily favor the 90–10. I think the State involvement would be kind of—so small, perhaps the Federal Government ought to administer it directly itself, but I would think there would be a kind of variable formula, taking into account the fiscal capacity of the State and it might go up to 90 percent in the very poor States, but less than that in the States of greater ability.

Senator MUSKIE. I doubt that is politically possible. I do not know of any grant-in-aid program that incorporates any such sliding scale of State contributions.

Mr. BERMAN. There is. The Medicaid program itself has a sliding scale in it.

Senator MUSKIE. But the States themselves decide what range of services.

Now, the two points go together and that is why I put them together in my first question. If the Federal Government will decide the range of services, then it seems to me that persuading the States to accept a sliding scale of State contributions is a very difficult thing to do politically.

Mr. BERMAN. I can certainly agree with that point you make, Senator. I had in mind that there would be some leeway to the States involved in the amount of services, in the variety of services they could provide.

There would be a certain core of services which I think would be necessary, protective services for the aged, services of that sort.

Senator MUSKIE. Is it your view that all noninstitutional services would fall under this treatment?

Mr. BERMAN. Yes.

Senator MUSKIE. Home care, day care, hot meals, the whole bit—all of that should be separate from the institutional health insurance aspects of the program?

Mr. BERMAN. Yes, to me that is the most advisable plan, I think.

Senator MUSKIE. Would it make sense to bring it under the Older Americans Act, rather than try to bring it under this legislation at all?

Mr. BERMAN. The Older Americans Act could be expanded. I would like to see it for people who do not necessarily come within the scope of the Older Americans Act; that is, younger people as well. This is preventive aspects for all people.

I think if people are classified as older Americans before we look for prevention, it may be too late. People come into that stage of life with a deficit of living, within marginal circumstances and with unmet needs so I would not see this coming under the Older Americans Act. It could be a separate piece of legislation to the Social Security Act or something of that sort.

Senator MUSKIE. That proposal for bringing it under the Older Americans Act was made, as I indicated in my opening statement this morning. I wonder whether you would support that?

Mr. BERMAN. I would have no objection, except I think it would be limiting to have it under an act that concentrates just on the aged.

Senator MUSKIE. Well, thank you very much, Mr. Berman. I appreciate your testimony. You have given us something to think about.

If a witness has succeeded in doing that, he has succeeded very well.

That brings this morning's hearing to a close. The next hearing will be at the call of the Chair.

[Whereupon the subcommittees adjourned at 12:20 p.m.]

APPENDIX

LETTERS AND STATEMENTS SUBMITTED BY INDIVIDUALS AND ORGANIZATIONS

ITEM 1. SUMMARY OF RECOMMENDATIONS FOR A LONG-TERM CARE PROGRAM IN NATIONAL HEALTH INSURANCE; SUBMITTED BY THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

1. The health care needs and characteristics of the "old elderly"—those in their 80's, 90's, and 100's—not only differ greatly from those of the under-65 population, but they also differ substantially from those of the "young elderly"—those in their 60's and 70's. It is essential that the Nation not only address itself to these needs, but further, that the Congress and the administration recognize that the problems of people needing long-term care require a fundamentally different approach from that taken for the rest of the population so far as national health insurance is concerned.

2. Title II, part D, of S. 3286 (the Kennedy-Mills bill) represents, in our view, the first national health insurance proposal sponsored thus far which addresses itself in a serious way to the long-term care needs of the elderly, and we applaud the initiatives taken by Senator Kennedy to assure that national health insurance does not overlook long-term care.

3. Three major principles should be considered in designing any long-term care program for the aged:

(1) There should be a comprehensive range of services—both in noninstitutional as well as institutional settings—offered to those needing care.

(2) The distinction between strictly medical and health-related social needs should be eliminated, inasmuch as nonmedical, social, and psychosocial problems faced by the elderly often play a significant role in necessitating long-term care services.

(3) A delivery system especially tailored to the individual long-term care needs of the elderly should be created, and the system should provide for continued contact and followup to assure that any arrangements necessary are satisfactorily provided.

4. Although we endorse and applaud the recognition that is given in title II, part D of S. 3286 to the long-term care needs of the elderly, we recommend the following modifications:

(a) Participation should be mandatory, rather than voluntary, lest the program result in problems of "adverse selection."

(b) The bill should be amended to allow States to buy into part B of Medicare and part D established by S. 3286 in behalf of recipients of Supplemental Security Income, and consideration should be given to a graduated rather than flat monthly premium, to lessen the burden upon those at the lower end of the middle-income spectrum.

(c) We favor the concept of locally controlled community long-term care centers which would perform the evaluative, packaging of services, and monitoring functions called for in S. 3286.

(d) We endorse the broad scope of services offered in the long-term care program established by S. 3286, and we are especially pleased that the bill abandons the current "levels of care" concept built into current Federal long-term care policies. The Kennedy-Mills bill recognizes the need to tailor services to people rather than people to predetermined categories of services. The scope of services should be broadened further, however, to include dental, eye, and foot care.

(e) We believe Medicaid should be retained until the necessary arrangements for participation in the new program are in place, to allow for time to test the program and to work out problems.

(f) Title II, part D is silent on the question of provider reimbursement. We recommend that the provisions of section 249 of Public Law 92-603, relating to cost-related reimbursement under Medicaid, be incorporated into S. 3286.

(g) Title II, part D establishes a bias in the reimbursement system in favor of services provided outside institutions. We believe the reimbursement mechanism should be neutral, and that decisions governing the services arranged for individuals needing long-term care should be based upon professional judgments of those who assess their needs. These judgments should not be countermanded by rigging the financing mechanism.

ITEM 2. PREPARED STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS

I. In General

In order to evaluate the merits of the Medicare long-term care program proposed under title II of the Comprehensive National Health Insurance Act and determine its potential effectiveness in accommodating the long-term care needs of the aged, the proposed program should be considered not in isolation, but rather within the context of the bill's creation of the national health insurance program, modification of the Medicare program, and repeal of the Medicaid program.

Viewed as a whole, the bill is a patchwork, with each piece seemingly related to the others more by accident than by conscious design. Frustrated by a lack of internal consistency with respect to policy, the bill's ambitious and truly laudable goals of providing "comprehensive health services" to all United States residents and emphasizing "the maintenance of health as well as the treatment of illness" are never quite achieved. Replete with citation and other technical errors, the bill must have been developed in great haste. The ramifications of certain policy decisions were apparently not considered and the consequences of other decisions were not applied consistently.

While simultaneously repealing the Medicaid program, the Comprehensive National Insurance Act would attempt to achieve the goal of "comprehensive health services" through a separate and augmented Medicare program and a voluntary long-term care program for the aged and through a national health insurance program for everyone else.

Each health insurance program (parts A, B, and D of title XVIII and title XX) would have its own benefit package and eligibility provisions. This furcated approach to comprehensive care is particularly unfortunate and likely to be unsuccessful. There are too many fissures into which intended beneficiaries could fall. Moreover, even considering the contemplated programs in their intended combinations, they fall short of the full realization of the goal of comprehensive protection. The Comprehensive National Health Insurance Act promises more than it is capable of delivering.

From the program and benefit scheme, it is apparent that aged individuals who are entitled to hospital insurance protection would have to rely upon that program for their primary long-term care benefits; all other aged individuals would have to look to the national health insurance program for primary long-term care protection. With enrollment in the proposed Medicare long-term care program conditioned on the payment of premiums, the long-term care provisions of the national and augmented Medicare programs must certainly be considered primary, with those of the voluntary program considered as secondary or supplemental.

In its present form, the intended program-benefit scheme is objectionable. If comprehensive care is to be achieved through an augmented title XVIII for the aged and through title XX for everyone else, title XVIII should have been augmented by combining into a single program the existing part A and B programs and the proposed part D program. There should have been a single benefit package combining items and services already covered, adding additionally needed services and eliminating durational limitations with respect to services. There should also have been a single set of eligibility requirements pursuant to

which all resident citizens and most resident noncitizens who come within the aged category would have been entitled.

Even if this bill's intended multiplicity of health care programs for the aged were not objectionable per se, the intended program-benefit scheme has a number of problems which tend to frustrate it and which, therefore, require attention. First, entitlement to benefits under one of the primary programs does not, because of the manner in which the eligibility provisions of the national program are drafted, automatically preclude entitlement under the other. Second, while there is an attempt to coordinate the benefits which would be available under the proposed long-term care program with those which would be available under the augmented Medicare program in order to avoid duplication, the approach is less than the best. Third, there is no attempt to coordinate the benefits of the voluntary program with those of the national program. Finally, if entitlement to benefits under one of the primary programs is not to preclude entitlement to benefits under the other, then in order to avoid duplication of benefits, a provision should be included designating which program's provisions are to govern in the case of dual eligibility.

II. Eligibility for Long-Term Care Benefits Under the Primary Programs

Dual eligibility under the primary benefit programs was apparently not intended for the aged. However, since paragraph 1 of subsection 2021(a) attempts to cover under the national program everyone who is "fully" or "currently" insured for Social Security cash benefits, that intent was not carried out. The failure expressly to exclude from eligibility persons who are entitled, or upon application would be entitled, to benefits under the hospital insurance program may render such persons eligible for such benefit under both programs. Coordinating changes must be made to remedy this confusion.

Since Medicaid would be abolished, those aged individuals who are not entitled to hospital insurance but are entitled to Medicaid would be dependent on the benefit package of the national health insurance program for their primary long-term care protection.

The fate of the 24-month disability insurance recipients who are presently covered for purposes of Medicare also deserves attention. The apparent intent of the Comprehensive National Health Insurance Act is to cover this group and other persons who are disability insurance recipients under the proposed national program only.[1] However, the bill lacks an amendment to § 226 of the Social Security Act appropriate to achieve that end. The result may be that the 24-month disability insurance recipients may also end up with dual eligibility.

If a § 226 provision were added, and the 24-month disability insurance recipient were deprived of entitlement to hospital insurance protection, they would also be ineligible for benefits under the proposed long-term care program and would be forced to rely for their long-term care protection solely upon the national program. With respect to such care, this would be a great leap backward for this group. As a matter of policy, it would seem advisable to cover all disability insurance recipients under the Medicare program and thereby render them eligible for benefits under the proposed long-term care program.

III. Long-Term Care Benefit Inadequacies Under the Primary Programs

In view of the fact that some of the aged would be dependent for their primary long-term care benefits on the national health insurance program, it seems advisable to evaluate the adequacy of these benefits. Extended care benefits are subject to a post-hospital requirement and to a 100-day per calendar year limitation.[2] Home health services are subject to a 100-visit per calendar year limitation.[3] Intermediate care facility services are not covered. Financial incentives to encourage the States to supplement the national health insurance benefit package (at least for low-income individuals) are absent. Items such as homemaker services, nutrition services, day care and foster home services, and community mental health center outpatient services would be covered under the long-term care program but would not be available under the national

[1] See Comprehensive National Health Insurance Act, § 101 ("2021(a)(3)").
[2] See Comprehensive National Health Insurance Act, § 101 ("2011(a)(1)(E), (b)(1)").
[3] See Comprehensive National Health Insurance Act, § 101 ("2011(b)(2)").

program. Therefore, any aged individual who could not afford to enroll in the long-term care program or who otherwise fails to enroll, would have to do without.

Pursuant to the proposed changes in the benefit package of the Medicare program, the long-term care provisions would be slightly improved as a result of the elimination of the post-hospital requirement for home health services under hospital insurance. But, as with the national program, such essential services as intermediate care facility services, would not be available in the absence of enrollment in the long-term care program.

Neither the national nor the augmented Medicare program would provide the full spectrum of long-term care services essential to comprehensive health care protection. Indeed, with respect to home health services, the national program is more inadequate than the Medicare program. That these primary programs simply ignore the whole issue of chronic illness is a rude shock. The failure to provide the full spectrum of services under these programs obviously necessitates a supplementary and coordinated long-term care program.

While the Comprehensive National Health Insurance Act recognizes the need for long-term care, its response to that need, the proposed long-term care program is less desirable than a direct response through the primary programs.

IV. Medicare's Long-Term Care Program

A. THE NATURE OF THE LTC PROGRAM

At this juncture, it is important to note that in some States, the only long-term care services available may be those of the primary programs. Such a result would be attributable to the non-Federal nature of the LTC program. Since the availability of benefits within a State would be contingent upon the State's designation of a qualified long-term care agency, the States have complete discretion as to whether the program will be operative within their respective borders. Given the 10 percent State expenditure,[4] the program is unlikely to be national. In order to preclude this undesirable result, two alternative courses of action are recommended: either include a "march-in" provision pursuant to which the Federal Government will act if a State fails to do so or recast the program as a Federal program utilizing, for limited purposes, State agencies in accordance with the established Medicare pattern.

B. ELIGIBILITY

Eligibility for enrollment in the new program would be conditioned, in part, upon entitlement to suplementary medical insurance benefits. In view of the proposed repeal of Medicaid, pursuant to which many States are paying the part B premium for low-income aged and disabled individuals, this eligibility condition would be more restrictive than would appear at first view. Since enrollment in the program is conditioned upon a $6 per month premium payment, the combined premiums under the program and under part B of Medicare could preclude low-income individuals from obtaining long-term care protection. It should also be recognized that certain aged SSI recipients who are not entitled to hospital insurance but who would be entitled to national health insurance would be taxed on their welfare benefits for coverage under the latter program. This situation must be remedied. Financial incentives to the States to pay the part B and part D premiums would certainly help.

This modification should be combined with certain others. Enrollment should be made mandatory for persons who are eligible. SSI benefits should be increased by an amount sufficient to cover the program's premium cost and these increased SSI amounts should be transferred automatically to the long-term care trust fund. Mandatory enrollment would have the additional advantage of avoiding the problem of "adverse selection" which could otherwise produce a substantial increase in program costs.

C. BENEFITS

With respect to the long-term care benefit package, it is unfortunate that health-related social services are excluded and that covered nutrition services do not extend to meals served in congregate settings. The addition of these items would certainly be desirable.

---

[4] See Comprehensive National Health Insurance Act, § 201(a) ("1888(a)").

D. DELIVERY SYSTEM

Under the proposed program's scheme for delivering covered services, the "community long-term care center" would be the primary vehicle. While the vehicle itself and the State context in which it would be organized and operated make it analogous to the Health Care Corporation contemplated under the National Health Care Services Reorganization and Financing Act (H.R. 1), a number of its ambiguities must be clarified and some changes made. First, since under the definition a community long-term care center would be limited to providing either directly or by arrangements with others, covered items and services other than inpatient institutional services, who or what is to furnish skilled nursing or intermediate care services to beneficiaries of the program and under what arrangements?

Second, the prohibition against the center's certification of the necessity for inpatient institutional services in the absence of a finding that noninstitutional services cannot satisfy a beneficiary's needs, tends to bias the program against institutional services.[5] That the hospital insurance program is biased in favor of institutional services is no justification for this proposed program's anti-institutional bias. The program should be neutral.

Third, since the evaluation and certification of beneficiary needs is crucial to the availability of the appropriate level of care under the program's benefit scheme, the description of the persons who are to perform these functions is of paramount importance. "A team composed of individuals with the skills necessary for such evaluation or certification" is inadequate for this purpose.[6]

Fourth, with respect to the requirements necessary for an organization to qualify as a community long-term care center, to require simply that it have policies established by a "group of professional personnel" is vague and inappropriate.[7] The type of policies contemplated should be described. Moreover, a physician should be specifically included in the group of "professional personnel."

Fifth, if there must be a partially-elected, and therefore, quasi-public, "governing board" such a governing board should, of course, include representatives of consumers;[8] but if it is not to assume a nature analogous to that of a local school board and become susceptible to domination by individuals not necessarily concerned with, nor knowledgeable of, long-term care, it would seem advisable to include within the membership of this governing board, representatives of long-term care providers. With respect to the election of some governing board members, a more difficult procedure for assuring consumer representation could not have been conceived. Somehow a political campaign for the office of board member of the local community long-term care center seems absurd. There must be more appropriate means of assuring consumer orientation and public accountability.

Sixth, if community long-term care centers are to be the primary means of benefit package delivery, such centers must first be organized or at least assisted in meeting the qualification tests. Where is the "seed money" to provide this organizational incentive? If such seed money is not to be provided, then the advisability of limiting long-term care centers to nonprofit organizations should be reconsidered.

As the primary long-term care delivery vehicle, the community long-term care center vehicle is ill-conceived. Unless corrected, the primary delivery vehicle for this program may well be the State long-term care agency.[9]

E. PROGRAM ADMINISTRATION

With respect to the proposed program's administration, one of the functions contemplated for the State agency is the certification "under regulations" of conditions of participation for long-term care centers.[10] While it would appear from the definition of a community center that the Social Security Administration is to prescribe such regulations,[11] the matter should be clarified in the

[5] See Comprehensive National Health Insurance Act, § 201(a) ("1887(a)(2)" last sentence).
[6] See Comprehensive National Health Insurance Act § 201(a) ("1887(a)(2)(B)").
[7] See Comprehensive National Health Insurance Act, § 201(a) ("1889(a)").
[8] See Comprehensive National Health Insurance Act, § 201(a) ("1889(b)").
[9] See Comprehensive National Health Insurance Act, § 201(a) ("1884(a)(9)").
[10] See Comprehensive National Health Insurance Act, § 201(a) ("1884(a)").
[11] See Comprehensive National Health Insurance Act, § 201(a) ("1889(a)(7)").

provision describing State LTC agencies. Also with respect to administration, if the program were recast as a Federal program, the Federal Government should reimburse the States for administration costs to the same extent that it does under parts A and B of Medicare when State agencies are used for similar purposes.

F. PAYMENT PROCEDURES AND STANDARDS

While the long-term care program contemplates the establishment of prospective payment procedures for community centers, the provisions of the program are silent as to whether prospective payment is to be made on the basis of provider agreements. The program should contain a provision pursuant to which a qualifying organization would have to agree, as a condition precedent to participation, to accept the prospective payments as payment in full, subject to year-end adjustment under limited circumstances. If the program is to be recast as a purely Federal program, such an agreement should be made with the Social Security Administration.

It should also be observed that the prospective payment procedures contemplated [12] are rather obscure—even more so than those contemplated for the national health insurance and Medicare programs.[13] The same questions must be raised with respect to both sets of prospective payment provisions—does the term "financial incentives for efficiency" mean the "quality management payments" contemplated by § 2042(c)? Do provider budgets and derived schedules of charges have to be submitted in advance for approval and if so, to whom? What role is to be authorized for carriers? The program's guidelines for the development of prospective payment procedures must be made more definite. Moreover, there should be eliminated from the guidelines any requirement that prospective methods include financial incentives for using noninstitutional services.[14] This requirement tends to promote the program's bias against such services.

Under the payment scheme of the program, payment to the community centers or the appropriate designated State agencies, as the case may be, is to be made by the individual State with reimbursement by the Federal Government to the extent of 90 percent of the State expenditure.[15] If recast as a Federal program, payment should be made by the Social Security Administration or by its fiscal intermediaries directly. Such a procedure need not preclude coercion of State contributions to the long-term care trust fund. Also with respect to the payment scheme, a provision precluding payment under the program for any service for which payment may be made under part A or B under Medicare or under the national health insurance program should be substituted for the provision of subsection 1891(a) which precludes from coverage under the long-term care program any item or service covered under Medicare.

G. FINANCING

With respect to the financing of the program, the cost would be met primarily from premiums, State contributions for the first 3 years, and State expenditures equal to 10 percent of the amounts paid to community centers. A Federal trust fund would be established for purposes of receiving the premium payment and initial State contributions. While the trust fund would also be authorized to receive Federal appropriations, the trust fund provision [16] unfortunately lacks any provision for the appropriation of general revenues. Surely it is not anticipated that 90 percent of the yearly cost will be covered by the required premiums. The matter of appropriations must be corrected.

V. CONCLUSION

One of the standards which must be used to evaluate the acceptability of national health insurance legislation will be the degree to which it achieves the goal of providing comprehensive health care protection for the country's health care needy—the aged and disabled. Comprehensive health care protection necessarily implies the inclusion of a full spectrum of health care services including long-term care services.

---

[12] See Comprehensive National Health Insurance Act, § 201(a) ("1890").
[13] See Comprehensive National Health Insurance Act, § 201(a) ("2042").
[14] See Comprehensive National Health Insurance Act, § 201(a) ("1890(c)(2)").
[15] See Comprehensive National Health Insurance Act, § 201(c)(1).
[16] See Comprehensive National Health Insurance Act, § 201(a) ("1886").

That the Comprehensive National Health Insurance Act recognizes the need for a broad spectrum of long-term care services is evidenced by its proposed Medicare long-term care program for the aged. While this recognition is certainly commendable, the multiple program approach to comprehensive care adopted by this bill is unfortunate and likely to fail. There are simply too many gaps. Furthermore, even considering the various programs in their intended combinations, they fall short of the full realization of the goal of comprehensive protection. The bill promises more than it delivers.

Considering the bill in its present form, the intended program-benefit scheme is objectionable. If comprehensive care is to be achieved through an augmented title XVIII for the aged and through title XX for everyone else, title XVIII should have been augmented by combining into a single program the existing part A and B programs and the proposed part D program. There should have been a single benefit package combining items and services already covered, adding additionally needed services and eliminating durational limitations. There should have been a single set of eligibility requirements covering all aged resident citizens and most aged resident noncitizens.

Even if the bill's intended multiplicity of health care programs for the aged were not objectionable per se, the intended program-benefit scheme has a number of problems which tend to frustrate it and which, therefore, require attention. If basic change in the bill's approach to comprehensive care either cannot or will not be made, it is important that the proposed long-term care program not be considered in isolation from the national and augmented Medicare programs, since an aged individual, under the bill's benefit scheme, would have to look to the long-term care program plus one of the other two primary programs for his long-term care protection.

At this point in the legislative process, it must be recognized that in order for the Comprehensive National Health Insurance Act to become a vehicle for national health legislation acceptable to the aged, the entire bill, not merely the long-term care program, will require considerable study and change.

ITEM 3. PREPARED STATEMENT OF MARILYN SCHIFF, NATIONAL COUNCIL OF SENIOR CITIZENS

Messrs. Chairmen: And members of the subcommittees; my name is Marilyn A. Schiff. I am an attorney with the National Council of Senior Citizens, a nonprofit, nonpartisan organization made up of 3,000 affiliated clubs throughout the country with a total of 3 million members. I am employed as national director of the nursing home ombudsman program, a program funded by the Department of Health, Education, and Welfare to help improve nursing home care by providing patient advocates for nursing home patients. My testimony represents the views of the National Council of Senior Citizens, and of its executive board and members.

My testimony today relates primarily to the long-term care program contained in S. 3286. I would like to state, however, that the National Council of Senior Citizens does not support that bill. At its convention on June 13–15, 1974, the National Council of Senior Citizens, by resolution, reaffirmed its support of the National Health Security bills (S. 3 and H.R. 22), but stated that those bills should be amended to include a provision on long-term care. The president of the National Council of Senior Citizens, Mr. Nelson H. Cruikshank, testified on June 28, 1974, on the issue of national health insurance before the House Ways and Means Committee. I would like permission to place in the record a copy of his testimony.[1]

Responsibility for all long-term care would be centered in "community long-term care centers" whose governing boards would include consumer representatives. At least half of the governing board would be made up of people eligible for long-term care and at least one-fourth of the board would be elected by people eligible for long-term care. We approve of the establishment of a single umbrella agency to coordinate the many different services needed by recipients. We are also pleased with the provision for substantial consumer representation on the governing board of the community long-term care centers.

---

[1] Retained in committee files.

LONG-TERM CARE PROVISION ENDORSED

We strongly endorse the concept of the long-term care provision of the bill. The provision would cover both institutional and noninstitutional care, but it is designed to avoid institutionalization by enabling beneficiaries, whenever possible, to receive services in their homes.

The goal of the long-term care program is to enable beneficiaries to live at home and to use institutions only as a last resort. We endorse the goal, but we feel that more services must be offered if the goal is to be achieved. As the bill is drafted, the only services that could be provided in a beneficiary's home would be the health services now available under Medicare (but without the requirement for prior hospitalization), and in some instances, nutrition services and homemaker services. These services are not sufficient. For the older people confined to wheelchairs and for the many more who have difficulty walking, shopping, and transportation are the main problems. Heavy snow makes these problems most acute in northern States. The bill must be amended to authorize these services, as well as social services and counseling, if people are to be kept in their own homes. The relative ineffectiveness of the home health provisions of Medicare has demonstrated that a person's health needs cannot be divorced from his other needs. Unless the long-term care program offers home help in the chores of daily living, it will not accomplish its purpose.

There are other self-defeating restrictions in the long-term care portion of S. 3286. As the bill is drafted, nutrition services (such as Meals-on-Wheels) and homemaker services may be provided only for someone who also needs other services provided under the long-term care title of the bill. As a result, a person who needed only homemaker services or only nutrition services in order to continue living at home could not receive them, and he would be forced to enter a foster home at greater expense to the program. Since the bill requires that need for any service be certified by a team of skilled individuals, the program should offer a single service where only a single service is needed.

The bill should also expand the concept of "foster home care" to include care given a person in the home of a family member. As the bill is drafted, a foster home is a home licensed by the State and having no more than three residents receiving care. The care given in such foster homes is often of the same type that could be provided by family members, particularly adult children of the beneficiary if they could afford the additional cost involved. If the beneficiary prefers to live with his children rather than in a commercial foster home, provision should be made for reimbursing the family some fraction—perhaps three-fourths—of the amount that would be paid to the commercial foster care home.

I would like to turn now to the other aspect of the long-term care—skilled nursing homes and intermediate care facilities. It is here that the bill is most deficient, since it incorporates without change the portions of the current Medicare law dealing with skilled nursing facilities. It is clear to anyone at all familiar with the area that current nursing home laws and regulations do not work—that care given in many Medicare certified nursing homes is grossly inadequate and even inhumane, and that nursing home owners are reaping great profit at the expense of the ill. At the very least, the bill should be amended to bring nursing homes within the control of the community long-term care centers, and the governing board of each center should be required to approve for participation each nursing home in its area. This approval should be in addition to other controls, and would help make nursing homes responsive to consumer needs. At its recent convention, the National Council of Senior Citizens passed resolutions proposing other changes in the laws relating to nursing homes. These, too, should be adopted as part of any new long-term care program.

Thank you.

ITEM 4. LETTER AND ENCLOSURE FROM RAYMOND HARRIS, M.D., PRESIDENT, CENTER FOR THE STUDY OF AGING, INC.; CHIEF, SUBDEPARTMENT OF CARDIOVASCULAR MEDICINE, ST. PETER'S HOSPITAL; CLINICAL ASSOCIATE PROFESSOR OF MEDICINE, ALBANY MEDICAL COLLEGE, ALBANY, N.Y.; TO SENATOR EDMUND S. MUSKIE, DATED JULY 12, 1974

DEAR SENATOR MUSKIE: I read that your committee will conduct hearings on "Barriers to Health Care for Older Americans." You may be interested in my

views on this subject and I enclose a paper on "Breaking the Barriers to Better Health Care Delivery to the Aged" presented at the Gerontological Society meeting in November 1973. It contains suggestions which I would like to bring to your attention since you can demolish such barriers through appropriate legislation and recommendations.

Best wishes for success in this area.

Sincerely yours,

RAYMOND HARRIS, M.D.

[Enclosure]

BREAKING THE BARRIERS TO BETTER HEALTH CARE DELIVERY FOR THE AGED

Five major medical barriers to health care delivery for older Americans, documented in hearings before the Subcommittee on Health of the Elderly of the Special Committee on Aging, U.S. Senate (March 5 and 6, 1973), include:

(1) *Rising medical costs which have outpriced all but the most affluent elderly.* In my experience as a physician and medical school professor, costs of health and medical care delivery to older people have been needlessly increased by inept bureaucratic interpretation of Medicare and Medicacid regulations.

(2) *Lack of coverage under Medicare which denies needed services for millions of older people ineligible for Medicaid but too poor to pay for such services out of their own pockets.* Again, in my experience Medicare, as presently constituted, does not cover enough critical, medically related services required by older people—drugs, dentistry, podiatry, medical appliances, mental health care, and home health services. This lack of coverage often requires expensive and unsatisfactory alternatives by city, State, and Federal governments to meet the needs for such services.

(3) *Fragmentation and depersonalization of health and medical services* which prevent an older person from receiving required broad and comprehensive medical care.

(4) *Greater number of more serious, multiple health and medical problems, usually chronic, which require considerable recurrent medical care.* Older persons 65 and over visit their doctors on the average of 7.2 times per year compared with 5 visits yearly by people 45–64 years of age. Furthermore, the rate of elderly hospitalized exceeds that for the total population. At ages 45–65, about 1 person in 7 is hospitalized each year—at ages 75 and over, about 1 person in 4.

In addition, older people tend to stay longer in hospitals. In 1970 the patient over 65 years of age stayed almost twice as long as the younger patient—the older person averaging 12.7 days per stay as compared to 7 or fewer days for those under 65 years of age. Such longer hospital stays may arise because older people have no one at home to care for them, and good nursing homes, health home aides and homemakers may be in short supply in the community. Thus, in effect, the lack of available home or nursing home care in the community, rather than the illness or availability of Medicare to cover hospital bills, contributes to the seemingly excessive hospital stays of some older patients.

(5) *Lack of a good health system which recognizes the deeper human resources in life.* Any health system for the elderly must be concerned with the medical, health, psychological, socioeconomic, institutional and other problems, including his growing alienation from society and fellow man, that complicate the life of an aging person in our society. Only by understanding what we are doing to the older person can we hope to improve the health care delivery service.

These five major barriers to health care delivery have been briefly commented upon. It is now time to see what must be done to break these barriers, focusing upon: (1) The needs of the client (patient); and (2) The needs of the health care delivery system.

I. THE NEEDS OF THE CLIENT (PATIENT)

The average recipient of health care delivery services is a person 65 years and over with many basic human needs, including good physical health, social acceptance, a satisfying occupation, recreation, freedom of choice and a mutual exchange of human affection. Any effective health care delivery system must satisfy these basic needs as well as the emotional needs of aging people, such as personal hopes, aspirations and expectations, self-esteem, self-respect, and independence. Otherwise, societal, physical, mental, and medical restraints and limitations or diseases opposing these important physiologic and psychologic needs of aging people may lead to unsuccessful adaptive aging patterns which eventually provoke mental illness.

Overall planning for better health and medical care delivery systems must identify problems of the well-aged and the sick arising from the normal aging process. Changes in sensory perception as a result of this aging process limits their ability to hear, see, taste, smell, adapt to light and perceive color and may initiate reverberations in the psychologic sphere, induce personality changes and complicate interpersonal relations. The aging process may also cause physical problems affecting motivation, vigor and mobility as a result of neuromuscular changes, muscular weakness, incoordination, adaptive shortening of muscles, immobility of joints, muscle spasms or spasticity. Bad hearing, poor eyesight, loss of balance or equilibrium, inability to climb stairs or dizziness, even in the absence of disease, may further aggravate such problems. Organic disease, superimposed upon the changes of the normal aging process, may further limit the elderly person's activity. The leading organic causes of such limitation of activity in order of importance in people 65 years and older (U.S. National Health Survey, 1965–67) are as follows:

1. Heart conditions—21.9 percent.
2. Arthritis and rheumatism—20.2 percent.
3. Visual impairments—9.1 percent.
4. Hypertension without heart involvement—7.0 percent.
5. Mental and nervous conditions—5.8 percent.
6. Impairment of lower extremities and hips—5.4 percent.

Such planning must also provide high quality health and medical care delivery programs which not only supplies proper treatment, appropriate illness support and sensible preventive health measures but also allows for this individual idiosyncrasies of ailing people, particularly older ones. Into the system must be built comprehensive care programs which include the psychosocial and emotional needs of human beings and the practical aspects of community organizational patterns.

Elderly Shun Medical Advice

The older person himself at times constitutes a barrier to good health care and delivery. For example, it has been noted that many older people are reluctant to seek medical advice, even in Great Britain where under the national health services the cost is borne by the government rather than the individual. One study of the British health system estimates that only one person in four with symptoms seeks medical advice.

Denial of illness, one of the most common defense mechanisms of ailing people, constitutes another barrier. A patient who denies his illness is not only trying to conceal his excessive anxiety from the physician, but also from himself. Such a patient may simply ignore somatic complaints, attempt to minimize their importance or attribute them to a variety of innocuous causes. He is clearly unprepared to cooperate with therapeutic plans or to take his prescribed medication consistently or for any great length of time. He tends to ignore most medical advice.

Proper management of this condition requires breaking through this patient's defenses to learn what illness really means to him and why the idea of illness arouses such undue anxiety in him. Is his excessive anxiety based on deeply repressed apprehensions concerning his specific illness? Does he equate being ill with dependency upon others or consider illness a threat to his self-image? He may think he is not being told the whole truth about his condition. Through skilled questioning, even in a session as brief as 10 minutes, the physician can often elicit the answers if he allows the patient to do most of the talking to bring repressed anxieties to the surface. Counseling and reassurance can relieve most such anxieties, but when anxiety appears unduly severe and persistent, additional antianxiety support with drugs may occasionally be required. The system must allow time and flexibility for such treatments.

Periodic and screening health examinations should be available for proper health maintenance and prevention of illness. Much serious disability and illness can be prevented if diseases are detected early. Common screening tests are widely available for the major chronic illnesses of old age, diabetes, glaucoma, heart diseases, tuberculosis, and cancer. Annual general health evaluations should include routine blood tests, electrocardiogram, chest X-ray, and urine analysis as a minimum. Screening programs should include an effective followup and referral service to insure that proper medical care is given when needed. Health programs should also include immunization against influenza and other diseases.

For good health, the well aged and the chronically ill aged also require adequate nutrition, recreation and regular physical activity programs to maintain their well-being, muscular strength and tone, proper joint movements, good circulation, and digestion. Regular physical activity provides an emotional outlet for the worries of daily life, enhances the feeling of well-being, reduces free-flowing tension, inhibits aggression and hostility, provides kinesthetic stimulation and emotional satisfaction.

Greater health education of the elderly and their families is also an important need. Better educational materials and audio-visual programs on health must be made available to assist older people and their families to recognize early symptoms of disease. Very often the elderly do not utilize proper health services because they attribute their complaints to growing old rather than to disease or remediable disorders. Health education programs should provide details of all benefits to which elderly patients are entitled. For example, legally blind people may be entitled to reduction of various taxes and access to programs, talking books and other measures which help them to live better, but not enough of them are aware of such available benefits.

II. THE NEEDS OF THE HEALTH CARE DELIVERY SYSTEM

The problems of an already overextended and inadequate health care delivery system have been compounded by demographic population changes resulting from the increased life expectancy of people. Today, every tenth person is 65 or over and there is a total of almost 20 million men and women age 65 or more. This segment of the population over 65 will reach 25 million by 1980 and 28.2 million by the year 2000 (Harris, 1970).

The strains on this system can be improved by (1) easier access to health care, (2) more effective high-level planning, and (3) improvement in financing of programs.

(1) Easier access to health care requires community health services of the *right kind*, in the *right place*, at the *right time*. These include trained physicians available and willing to care for older people, community related ambulatory care centers affiliated with medical schools, well managed hospitals, and other health-related facilities such as the nursing homes, convalescent homes, day care centers, visiting nurses, and home health aides. Vocational and social rehabilitation services as well as adequate housing, home safety, good sanitation programs, home visiting programs, and multipurpose senior citizens centers should also be provided so that older people can live active lives in spite of age and disease.

Since the health care system does not begin operating until the patient takes the initiative by visiting a physician or clinic, usually too late in the progress of disease, an interventionist approach must be inaugurated so that physicians and other health workers can reach out to elderly people who, for genetic reasons, occupation or way of life, have a special predisposition to disease. Such intervention in the early stages of disease will be most effective in preventing the progress of disease.

Nurse-practitioners, improved screening facilities and health fairs to unearth illness will also facilitate access to health care services. Better training of health professionals and primary care physicians as well as modernization of existing facilities and the development of innovative methods for providing medical manpower in rural districts, the inner city, and other areas will also improve access of individuals to the health system.

(2) High level planning for better education of physicians and other health professionals is essential to reduce the chaotic spasms of the present health care delivery system which is oriented primarily toward the treatment of acute phase of illness and does not offer a complete spectrum of health care with sufficient alternatives to acute care, proper financing for the alternatives and education of physicians and patients in accepting these alternatives. Current medical care is far too concerned with organic pathology and problems of disease and too little with the hopes, aspirations and lifestyles of aging individuals. As a result, many older people are expensively overtreated and overdiagnosed.

Geriatric Specialists Essential

Good medical care for the elderly requires an interested and responsive medical profession, including a cadre of physicians, geriatric consultants, and clinical

gerontologists versed in the diseases of aging, the age-related changes that occur in the absence of disease and the use of allied health professionals and community resources. Such specialists are necessary to identify gaps in knowledge about aging, gather the clinical and research information concerning time-related changes of disease in normal aging, promote and prescribe preventive therapeutic measures to keep old people healthy, and, improve their health when disease intervenes. Such geriatric specialists are essential to develop the wellness concept in old age.

One major reason for our present Alice in Geriatric Wonderland state of affairs is that too few American medical schools offer geriatric training. The excuse is ostensibly lack of money, but vested professorial interests protecting the status quo of existing well-established departments in medical schools is the more likely reason. Improvement of the quality and quantity of health care services requires more geriatric specialists and primary care physicians and health professionals to care for the aged. Departments of geriatrics and gerontology must be established in medical schools so that medical students, interns and residents, as well as other health workers may be trained properly. Effective training of people to care for the aged cannot take place without interested and active medical school involvement.

Toward this end, high level national planning among government officials, medical school educators, voluntary health leaders, practicing physicians and others is essential to establish and finance departments of geriatrics and gerontology in medical schools, improve the climate in training for the care of the elderly, coordinate services and facilities for the aged—well and sick—and lower costs by eliminating duplication and overutilization.

Quality medical service also requires empathetic conversation and interpersonal interaction among the patient, physician and other specialized professionals and technicians delivering medical care to the aged. Today, the more traditional health system of a close, long-term relationship with a family doctor which existed in the past is now unfortunately being replaced in this age of specialty by less satisfactory short-term encounters with specialists and other professionals. One major cause is existing hospital and medical school administrative policies which escalate costs and lower the quality of medical care. One such detrimental policy promulgated by too many medical schools and hospital centers is limitation of staff privileges to full-time faculty and physicians already on their staffs. Such institutions accept new private practitioners grudgingly, if at all. As a result, primary physicians caring for the elderly in the community must turn them over to hospital-based physicians for care when they need hospitalization. Elderly patients going to emergency rooms for acute care are frequently not referred back to their own doctor if hospitalized; and, if treated and sent home, the results of their tests are not readily available to the doctor in the community. In hospital institutions with closed staffs, a patient may be admitted through the emergency room and treated by the resident or house staff or an unknown attending doctor unacquainted with the patient, who must repeat tests perhaps already performed by the patient's own physician. Repetition of these tests in elderly patients who often have four to five chronic disorders, skyrockets the medical expenses. Upon discharge, the patient may return to his family doctor, who then faces the problem of obtaining information from the hospital record department where records may remain incomplete for several months. Open medical and surgical hospital staffs are preferable so that qualified physicians in the community may admit their patients to good hospitals, share in the educational programs and participate in the health and medical care of their hospitalized patients.

Even the British health system, which originally propagated this sharp schism between community practitioners and hospital staff, has "seen the light" and taken steps to reintegrate community practitioners into the hospital system.

Improvement in Financing of Programs

(3) Improvement in financing health care programs requires the upgrading of current financing of health coverage and services. Although Medicare has increased utilization of health services by older people, it does not pay for preventive or health maintenance services, and in many instances, services for which Medicare and Medicaid will pay, are not available in the community.

Wiser financing of home health services and alternatives to institutional care such as Meals-on-Wheels, transportation, adult day care centers, home health

aides and homemaker programs within the health care delivery system is essential to help older people remain at home (Home Health Services in the United States, 1973).

Other useful services that assist the elderly to stay out of institutions could include: (1) household handymen to clean house and perform repairs and seasonal tasks, such as changing screens, moving furniture, cleaning porches or yards, (2) geriatric aides to supply companionship, light housekeeping and limited bedside care, (3) home aides to provide escort services, run errands and shop for the infirm elderly, (4) outreach aides to locate older people in the community, visiting them, ascertaining their needs and making appropriate referrals to agencies and followup care.

Innovative programs like the pilot projects for the blind in this country have been started by some associations for the blind but they are so new that many people concerned with these problems know too little about them.

Improvement of universal access to comprehensive services requires reform of the regulations concerning the delivery of services, a viable manpower policy, proper instruments to carry it out and a workable financing mechanism that permits every American to secure comprehensive health services free from catastrophic financial barriers, and providers to deliver such services efficiently and economically.

The establishment of a National Institute of Gerontology, as has been presented to Congress, can favorably influence the quantity and quality of health and medical care service delivery to the elderly by providing more monies for medical research on the aging process, the diseases of old age, and the delivery of health care services.

The socioeconomic impact of increased numbers of older people and the greater incidence of disease in them have seriously strained the medical profession, the allied health professions, and a health care delivery system that is designed more for acute rather than for chronic disease. However, neither the medical profession nor any single segment of society can really be held responsible for this sorry state of affairs. Medical historians recognize that the characteristic attitudes of the medical profession are determined mainly by the attitude of society toward health and disease, and that medical practices and care in different periods of history differ according to the structure and wishes of society at the time (Sigerist, 1960). The real culprit is the inevitable lagging of major social policies behind the rapid advances in the science and art of medicine which have prolonged life.

Therefore, changes in social policies must be introduced if barriers to better health care delivery for the aged are to be broken. Fortunately, appropriate social policies do correct most of the problems (Sigerist, 1960). As Dr. Felix Post, a British psychiatrist, wrote in 1965, "Adequate care of elderly persons in distress, from whatever cause, is a matter of public conscience. Medical workers should most certainly draw the attention of their community to these problems but should be careful not to overstate their case." Planners and decisionmakers of society, including the medical profession, must enter into a crucial dialogue on the major problems of health care service delivery and call upon their counterparts in religion, philosophy, politics, economics, and other social sciences to upgrade their social thinking on these subjects and to answer some important basic questions such as the following: How far should one go to maintain life in the face of incurable disease? How much of the gross national product should go into health care? Since poverty and poor health are so closely linked, is it better to seek improved health care by attacking poverty rather then by deploying medical resources? Such answers require not only medical concern but also formulation of social policies and their expression through the political system. Now is the time for such concerted action by all to break the barriers to better health care delivery for the aged.

ITEM 5. LETTER AND ENCLOSURES FROM BARBARA ALLEN DAVIS, R.N., Ed. D., STAFF, COMMITTEE ON SKILLED NURSING CARE, AMERICAN NURSES' ASSOCIATION, INC.; TO SENATOR EDMUND S. MUSKIE, DATED AUGUST 5, 1974

DEAR SENATOR MUSKIE: ANA's committee on skilled nursing care, which was formed in response to a request from the Subcommittee on Long-Term Care, will

be holding regional hearings during the month of September. Attached is information on the hearings and the issues being addressed.

The sites and dates of these hearings are as follows:

1. Lansing, Mich., September 5, 1974
2. Newton, Mass., September 9, 1974
3. Orlando, Fla., September 11, 1974
4. Denver, Colo., September 16, 1974
5. Helena, Mont., September 18, 1974
6. San Francisco, Calif., September 24, 1974

You are invited to participate in these above sessions. Please contact me if your schedule will permit you to attend any of the hearings.

Sincerely yours,

BARBARA ALLEN DAVIS, R.N., Ed. D.

[Enclosures]

AMERICAN NURSES' ASSOCIATION COMMITTEE ON SKILLED NURSING CARE—REGIONAL HEARINGS

In October 1973, Senator F. Moss, Chairman, Subcommittee on Long-Term Care of the U.S. Special Committee on Aging, asked ANA to form an appropriate group to respond to several issues related to long-term care. ANA's committee on skilled nursing care was developed in response to this request. The skilled nursing committee is made up of representatives from ANA's structural units, and delegates from 22 national organizations concerned with health, nursing, and the aged and aging, and from consumer groups. This committee is composed of an advisory committee of the representatives from ANA structural units and three task forces. The deliberations of these groups will form the basis of a document to be submitted to the Subcommittee on Long-Term Care later this fall.

The issues and concerns being addressed by the committee on skilled nursing care are as follows:

A. CLASSIFICATIONS AND DEFINITIONS

(1) Define the level of care now known as "skilled nursing" so that such definition can be used by regulatory and reimbursement agencies. This definition must be in terms of (a) the unique needs of long-term patients, and (b) the unique contribution of nursing to meeting those needs. The definition must be in language clear enough for the public to understand it, be in measurable terms, and be reimbursable.

(2) Develop criteria for classification and grouping of patients in long-term care settings according to their needs.

(3) Recommend more efficient and less traumatic methods than the prevailing one of moving the patient to find the service.

B. OPTIONS FOR HEALTH CARE SERVICES

(1) Explore ways of meeting long-term care needs outside the institution so that a range of services are available from which the consumer may choose.

(2) Recommend strategies for delivery of such service with special emphasis on utilization of existing institutions and expansion of existing services.

(3) Develop design that
   (a) assure continuity and accessibility;
   (b) provide information, referral, and coordination;
   (c) include volunteer and employment roles;
   (d) have built-in evaluation and education;
   (e) are planned and implemented locally to meet specific needs.

(4) Focus on nursing and nurses' role in developing, staffing, and evaluating services and systems as outlined in Nos. (1), (2), and (3).

(5) Recommend methods of reimbursement for identified options for health care services.

C. NURSING MANPOWER AND TRAINING

(1) Reexamine the composition of the nursing care team to recommend more effective utilization of all types of nursing personnel in long-term care.

(2) Make recommendations regarding education (basic, continuing education, specialization) for training nursing personnel; such as
(a) where (community college, in-service, etc.);
(b) who (nursing educators, interdisciplinary groups, etc.);
(c) what (content, congruency for different level);
(d) preparation of teachers;
(e) evaluation of outcomes;
(f) economic feasibility.
(3) Recommend methods of reimbursement, as appropriate, for No. (2).

The witnesses who present testimony at a hearing are asked to confine their statements to these issues and concerns. The problems have been well documented and publicized. We are now searching for possible solutions and innovative approaches to solutions. Each witness is to submit two copies of a written statement prior to the hearing to the State Nurses' Association. (One copy is for ANA's committee on skilled nursing care.) On the day of the hearing the witness is to summarize the statement in an oral presentation. Any interested person or group is eligible to provide testimony. This could be individual nurses, consumers, groups concerned with aging, or with any aspect of long-term care as it relates to patients who would be receiving such care. Included would be not only geriatric patients, but also psychiatric patients as well as mentally retarded or developmentally disabled.

The purpose of the presentation of statements is to provide interested individuals and groups with the opportunity to acquaint the committee on skilled nursing care with their views. These statements will be included in the document to be submitted to Senator Moss' Subcommittee on Long-Term Care later this fall. Anyone unable to attend a hearing may submit a written statement.

American Nurses' Association Statement on Long-Term Care Provisions of H.R. 13870

The American Nurses' Association views H.R. 13870 as an attempt to arrive at compromises that would make it possible for the United States to move toward a national health insurance program. The bill does not, however, provide a scope of benefits and a payment system that would guarantee health care as a basic right of all people. A single system of benefits available to all and arrangements for universal coverage of the population would in all probability be more efficient, economical, and would guarantee health care as a right of all citizens.

The American Nurses' Association is the national professional association of registered nurses with constituent associations in each State, the Virgin Islands, and Guam. At its recent convention held in San Francisco in June the House of Delegates adopted a resolution on national health insurance.

LONG-TERM CARE CENTERS

The proposals in H.R. 13870 for long-term care centers appear to be worthwhile arrangements for consideration in the development of a national health insurance program. Long-term care centers meeting Federal standards should assist communities to meet the health needs of the aged and others with long-term disabilities in the most appropriate and economical manner.

The American Nurses' Association would support the provisions of H.R. 13870 enunciating standards for community long-term care centers with the understanding that the participation of professional nurses in the development and implementation of policies is recognized as essential, and consumers are appropriately represented on governing boards.

UTILIZATION REVIEW

We would assume that provisions of H.R. 13870 dealing with utilization review would be of special concern to the two subcommittees of the Special Committee on Aging of the U.S. Senate. The health care needs of the aged range over a wide variety of therapeutic, health maintenance and protective services, and therefore, deserve the attention all health care disciplines.

ANA does not see the term medical care as being synonymous with health care. All health care disciplines contribute to the prevention of illness and the maintenance of health, to care and treatment of illness and disability, from the perspective of their own body of knowledge and skills. Health care is not limited to

services performed by physicians; nor is it limited to services that are initiated, and performed upon the determination, and under the direction of physicians.

Nursing care services are an essential component of health care. The judgments of professional nurses are essential to making determinations about the most efficient and therapeutic use of available health facilities and services so as to provide health care of an acceptable quality. Therefore, we recommend that in part E, Miscellaneous Provisions—"Utilization Review" (2) be amended to provide that review be made by a staff committee composed of two or more physicians with participation of other professional personnel including two or more registered professional nurses; or a group outside the institution similarly composed and which is established by the local medical society and the district nurses association.

The American Nurses' Association is recommending that serious consideration be given to amending Professional Standards Review legislation to provide for full participation of nursing and other health care disciplines in a system of peer review where each discipline would have the right and carry the responsibility to monitor its own practitioners.

NURSES AS PROVIDERS OF HEALTH CARE

If the program of national health insurance is to insure that all people, especially the aged and others needing long-term care, have access to comprehensive health services, provisions must be made to permit payments for certain health care services in addition to those that are provided by physicians, or those that are arranged and directed by physicians. The payment mechanism should be such as to facilitate effective and efficient use of the knowledge and skills of qualified professional nurses as providers of primary care services.

> ". . . Primary care . . . has two dimensions: (a) a person's first contact in any given episode of illness with the health care system that leads to a decision of what must be done to help resolve his problem; and (b) the responsibility for the continuum of care, i.e., maintenance of health, evaluation and management of symptoms, and appropriate referrals." [1]

Health insurance should guarantee access to the health care system through the services of health care practitioners that are available and appropriate for the client's health needs. It is recommended that part E, Miscellaneous Provisions—Definitions, "Medical and Other Health Services" in H.R. 13890 be expanded to include the services of qualified nurse practitioners who are certified by the American Nurses' Association. Also, the definition of covered benefits should permit payment for primary care services rendered by nursing service agencies, or by professional nurses who are practicing their profession in structured health care agencies meeting acceptable professional standards.

HOME CARE SERVICES

Benefits in national health insurance available to persons of all ages should be such as to promote the utilization of home care as an alternative to institutional care. There should be reimbursement for services provided persons confined to their homes and in need of skilled nursing care on an intermittent basis. Reimbursement for home care services should not be contingent upon prior hospitalization, or prior confinement in a nursing care facility. Rather, home care should be financed and interpreted so that it becomes an acceptable means of meeting health care needs of people. Widespread use of home health services fostered by appropriate application of health insurance benefits would serve to improve utilization of available resources; and help contain health care costs.

STANDARDS FOR NURSING SERVICES . . . IN-PATIENT FACILITIES

Nursing care is a critical component of services provided by hospitals and the critical component of services provided by nursing facilities.

We urge that no institution be considered a hospital for purposes of implementing national health insurance legislation unless there is an organized nursing service under the direction of a registered professional nurse, and unless all nursing care is rendered and/or supervised by registered professional nurses 24 hours

---

[1] Extending the Scope of Nursing Practice . . . a report of the Secretary's Committee to Study Extended Roles for Nurses . . . Department of Health, Education, and Welfare, November 1971.

of each day.[2] Trends in hospital utilization are such that most patients are in need of nursing care provided by professional practitioners throughout their stay. It is recommended that the phrase "and has a licensed practical nurse" be deleted from (5) in the definition of "hospital" in part E, section 2051. Also private duty services by a registered professional nurse should be a benefit of health insurance when required by the nursing needs of the patient.

Further it is recommended that in every "skilled nursing facility" there shall be a registered professional nurse responsible for directing nursing care services and for execution of policies established to govern skilled nursing care and related health care services. Further, that (6) in that section be amended to read: provides 24-hour nursing service . . . and has at least one registered professional nurse on duty 24 hours a day, 7 days a week.

NATIONAL HEALTH INSURANCE ADVISORY COUNCIL

The American Nurses' Association supports the concept of a National Health Insurance Benefits Advisory Council as one means of providing advice on general policy to the administration. We recommend that section 2061 be changed so as to insure appropriate representation on the council from the health professions, health care administration and facilities, and consumers. We recommend that several more than "at least six persons" be "representatives of the general public". Appointments in this category should reflect a wide range of consumers of health care services. Further that section 2061 be changed to insure appointment of persons who are representative of organizations and associations of professional personnel in the field of health; *not* only in the field of medicine as is now written in H.R. 13870.

DATA SYSTEMS

ANA would recommend that section 1415, General Policies and Priorities, be expanded to provide clear policy direction that would insure that data systems necessary for effective management of the national health insurance program would protect the rights and the privacy of individuals. Such policy direction written into law would be particularly significant in those arrangements established for standards review, utilization review, and transfer of individuals within the health care system.

---

[2] Standards for Organized Nursing Services and The Position, Role and Qualifications of the Administrator of Nursing Services.

○