BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

NINETY-THIRD CONGRESS

FIRST SESSION

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SATURDAY, AUGUST 4, 1973

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Coeur d'Alene, Idaho.

The subcommittee met, pursuant to notice, at 10 a.m., at North Idaho College, Hon. Frank Church, presiding.

Present: Senator Church.

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

OPENING STATEMENT BY SENATOR FRANK CHURCH, PRESIDING

Senator CHURCH. The hearing will please come to order. My statement will be brief because we have many witnesses and because I am here for grassroots information, not for speechmaking.

I think it is important for the Senate Special Committee on Aging to get out in the field for firsthand facts. If we sit in Washington and listen to statistical abstracts about the problems of older Americans, I'm afraid we will receive a limited, and perhaps distorted, picture.

As an example of what can happen when public servants grow remote from the realities of life, I refer you to the message which accompanied this January's national budget proposals.

The administration, I think you know, wanted to raise the coinsurance and deductibles under Medicare. The claim was that raising the cost of Medicare would make the elderly more cost-conscious, and reduce the utilization of the program.

Well, I raised a storm over that proposal. I could not see how the elderly could be more cost-conscious than they now are, especially since Medicare covers only 42 percent of all health care costs for older Americans.

And especially since, as well, the out-of-pocket health care payments of the elderly are today actually more than they were before Medicare took effect.

Other Members of the Congress protested, as well. The result is that the administration proposal has gone nowhere.

What bothered me, however, was not just the specific proposal, but the reasoning that went with it. I'd like to read to you a paragraph from the budget justification which expresses a very disturbing viewpoint:

"Other cost-sharing reforms include a substitute for the present

annual deductible in the supplementary medical insurance program by one which keeps pace with the beneficiary's ability to pay for medical care, as measured by the increase in cash benefits, and an increase in the supplementary medical coinsurance rate."

In other words, an increase in your Social Security paychecks should always be accompanied by increases in the costs of Medicare.

As the leader of the Senate drive for last year's 20 percent across-the-board Social Security increase, I condemn a strategy designed to take away with one hand what Congress has provided with the other.

Such thinking should be resisted, and I can assure you that I will continue to do so.

Improvements Needed in Medicare

Instead of cutting Medicare back, we should improve it. To that end, I have introduced legislation for just that purpose:

One bill would provide Medicare coverage of essential out-of-hospital prescription drugs, and I think that this has top priority.

I have introduced legislation to train more nurse practitioners in programs similar to the pioneering efforts here in Idaho.

I want to increase the Medicare lifetime reserve for hospitalization from 60 to 120 days.

I have already been successful in removing arbitrary statutory limits for skilled nursing homes and intermediate care facilities.

And I will soon introduce legislation intended to encourage use of home health services under Medicare.*

I will welcome any comments witnesses may have on these proposals, but our fundamental purpose today is to determine what difficulties older Americans are encountering when they try to obtain health care.

Sometimes the greatest barrier to such care is unavailability of trained personnel, a scarcity sometimes made more intense by great distances such as we have here in Idaho. In our State, for example, 4 counties are without physicians, 9 without dentists, 10 without hospitals, and 14 without long-term care facilities. Idaho has 17 counties that have no nurses at all, and only 39 psychologists for the entire State.

Fortunately, Idaho has also pioneered in new techniques to make the most of what we have, and we will hear about some of those innovations today. I am especially interested in the home health care programs underway in Panhandle Health District No. 1 and in Lewiston.

In-home services are so important, in fact, that the subcommittee on health of the elderly recently devoted 2 full days to that subject in Washington. In this barriers to health care series, three additional days of hearings in Washington have also been conducted. The subcommittee has also taken testimony in Maine and in Illinois.

Today it is Idaho's turn. As chairman of the full committee, I welcome this opportunity to hear directly from fellow residents of my home State.

So that is why we are here this morning. We will now turn to our first panel of witnesses: Mr. William Youmans, the Regional Planner

*Senator Church's bill, S. 2695 was introduced on Nov. 13, 1973. The text of his introductory statement, together with a related statement made by Muskie, appear in Appendix 3 (p. 671) of this transcript.

on Aging for the Planning and Service Area No. 1; Mr. Hugo Wiebusch, who is the Branch Manager, Social Security Administration here; and Mr. Larry M. Belmont, who is the Director, Panhandle Health District No. 1. They constitute the first panel and I am going to ask them to present the testimony in such order as they prefer. Mr. Youmans, are you going to be the first to speak?

Mr. YOUMANS. Yes, sir.

Senator CHURCH. We will hear then first from Mr. William Youmans and then we will go to the other panel members.

STATEMENT OF WILLIAM F. YOUMANS, REGIONAL PLANNER ON AGING, STATE PLANNING REGION NO. 1, COEUR D'ALENE, IDAHO

Mr. YOUMANS. Thank you, Senator Church and ladies and gentlemen.

The present Older Americans Act, title III senior citizens programs operating within the five northern Idaho counties; that is, State planning region No. 1, accommodates the 55 years and older segment of the population. They account for 17,846 or 21.4 percent of the regional population of 83,211, according to the Bureau of Census figures of 1970. On a county basis the 55 years and older persons relate percentagewise to their total population as follows: Benewah has 1,425 55 years plus or 22.9 percent. Bonner has 3,734 or 24.0 percent. Boundary has 1,467 or 23.0 percent. Kootenai has 7,695 or 21.8 percent. And Shoshone has 3,525 or 17.9 percent.

It was the Older Americans Act of 1965, as amended in 1967, that enabled the States to proceed with important and varying aging programs. Idaho in turn addressed itself to the Older Americans Act through the establishment of the Idaho Office on Aging in April of 1968. By July 1. the Idaho Office on Aging had nine title III senior citizens—55 years plus—projects funded throughout the State and including Kootenai County in State planning region No. 1.

Other title III senior citizen projects were subsequently identified to counties within State planning region No. 1—that is, Benewah, Bonner, and Shoshone—over varying periods. The activity level of the senior citizen programs within the panhandle region centered upon the utilization of leisure and free time.

By July of 1972 the senior citizen programs took on new dimensions with the awarding of three 1-year areawide model project program grants in the State, including one for State planning region No. 1.

The areawide model project program seeks through comprehensive planning to enable existing community resources and services to become more responsive to the special needs of the elderly in areas of high priority. It has a target population which includes a high percentage of low income and minority group elderly. It also has an area task force, members of which include older persons and representatives of major public and private agencies with programs for the elderly. The task force participates in both planning and implementation of projects.

The critical needs of the regional elderly currently being studied by the task force subcommittees in State planning region No. 1 involve information, referral and outreach transportation, nutrition, and health.

Thank you.

Senator CHURCH. Thank you very much. Let's just proceed through the panel and then I will have some questions.

STATEMENT OF HUGO M. WIEBUSCH, BRANCH MANAGER OF THE COEUR D'ALENE SOCIAL SECURITY OFFICE

Mr. WIEBUSCH. The Social Security branch office is located at 310 Lakeside Avenue in Coeur d'Alene. Our service area consists of the five northernmost counties of Idaho, a total area of 7,667 squares miles, and the Canadian area immediately north of Idaho, between the Nelson Mountains on the west and the Alberta Provincial line on the east.

The total estimated population of northern Idaho is 87,000 persons, and Canada is 83,000 persons.

In addition to the branch office location, we have five contact stations which are manned by a Social Security representative on a scheduled basis: Sandpoint, once per week; Bonners Ferry, twice per month; St. Maries, twice per month; Kellogg, twice per month; and Wallace, twice per month.

As of December 31, 1971, we were serving 14,251 beneficiaries, of which 13,567 were actually receiving monthly cash benefits in the amount of $1,572,000 per month. This is an average of $115 per beneficiary per month.

As of December 31, 1972, we were serving 15,188 beneficiaries, of which 14,507 were actually receiving monthly cash benefits in the amount of $2,037,000 per month. This is an average of $140 per beneficiary per month.

We expect that beginning July 1, 1974, when the 5.9 percent increase goes into effect we will be paying monthly cash benefits in the amount of $2,390,000 or an average of $149 per beneficiary per month.

We estimate that 9,464 of our beneficiaries are eligible for and covered by the hospital insurance portion of Medicare and that 9,274 have elected coverage by the medical insurance part of Medicare.

Thank you.

Senator CHURCH. Thank you very much.

STATEMENT OF LARRY M. BELMONT, DIRECTOR OF THE PANHANDLE HEALTH DISTRICT, AND CHAIRMAN OF THE LEGISLATIVE COMMITTEE OF THE IDAHO HOME HEALTH ASSOCIATION

Mr. BELMONT. I am Larry M. Belmont, Director of the Panhandle Health District, a local five-county health department, and I am also chairman of the legislative committee of the Idaho Home Health Association.

I should like to begin with a quote from Shakespeare:

> "the weight of this . . . (sad) . . . Time we must obey;
> speak what we feel, not what we ought to say.
> The oldest hath borne most;
> we that are young shall never see so much, nor live so long."
>
> (King Lear H.V. SC 111)

Statistically speaking, in the Panhandle Health District, we have 77 physicians per 100,000 persons versus a national average of about 148 physicians per 100,000 individuals. We have one hospital bed per 230 people versus a national average of one per about 125 people.

The Kootenai Memorial Hospital, here in Coeur d'Alene, is the third largest in the State and it has supported our home care program and our recent grant proposal. The Kootenai/Benewah County Medical Society has assisted our in-home service program and our recent home care week.

With this type of local support, we have an excellent opportunity to better coordinate elements of our medical care system through in-home service. In-home service can overcome many barriers to care for the elderly. For example, Shanas' study "Aging in Three Industrial Societies" points out that home health services reaches only about 2.4 percent of the population requiring such attention. This indicates a real need to expand this program. But, another study (NDSS report B-4, fiscal year 1968) indicates that expansion of home health is almost impossible because only .3 percent of all fiscal year 1968 Medicaid expenditures were devoted to home health services whereas 37 percent were applied to hospital care and 32 percent to nursing home care.

Changes in Coverage Suggested

With that in mind, many of us at the local level, as well as the Idaho Home Health Association, would like to offer you our support in the following:

(1) We must change the present limited concept of in-home services to a broader conceptual model that includes the total community.

(2) We must improve the financial aspect of in-home service of Medicaid and Medicare coverage.

(3) We must make the in-home service a national health priority as soon as possible.

In summary, because we don't have as many physicians, hospital beds, and other health resources as the national average indicates; and because of the limitation of Medicare and Medicaid; but with the aid of supportive health providers, we can strengthen home care to become a catalytic community health service.

Actions of the Panhandle Health District

We developed, printed and distributed two brochures describing home care services. These were placed in all the physicians' offices, dentists' offices, other health providers' offices throughout north Idaho.

We developed a home care week in the State of Idaho which was recommended by the Home Health Advisory Committee of the Panhandle Health District. It was conducted on a statewide basis. Gov. Cecil D. Andrus proclaimed the week of April 8, 1973, as Idaho Home Health Week.

We developed a home care grant proposal which would coordinate community resources. It was submitted to RMP and SSA. SSA felt it did not adequately address the issue of clearly cutting home care costs. RMP saw the value of total coordination of services; but, as you know, RMP's funding situation is still unclear. The proposal, however, is

still functional and will be implemented to a limited degree by the Panhandle Health District.

We stimulated occasional news articles on the subject of home care and the home care program of the Panhandle Health District.

We have combined two home health agencies, the Visiting Nurses' Association and the Panhandle Health District in order to provide more effective administration of the program.

We have expanded the program from a small, rural, one-county program to a broad, five-county, rural home care program.

We have sent several of our nurses to special training programs and rehabilitative programs to make them more proficient home health providers.

The Idaho Home Health Association has developed legislation which we did not submit last year because we felt this was not appropriate.

DOWNWARD TREND COUNTERED

These efforts have reversed our downward trend from 1969, which has averaged about a 30 percent decrease in the program each year. In calendar year 1972, we had an 8 percent increase in visits over 1971 which indicated, to a degree, that some of our efforts and concerns are paying off. However, we need some national support and recognition for the in-home service program in order to help our local efforts pay off.

Specific problems encountered by the Panhandle Health District in home care services:

(1) Our national medical care system is too institutionally oriented.

(2) We don't recognize in-home services as a service key in acute care. We must broaden our concern with preventative care, maintenance care, and health supervision in the home.

(3) The requirement that a patient be in the hospital for 3 days before going on home care is unnecessary and restrictive.

(4) The limit of 100 home visits is also restrictive and short-sighted.

(5) Retroactive denials are very unreasonable and detrimental to any kind of program.

(6) Resources should be available to experiment in the administrative research to improve home care. Also, there needs to be experimentation in how to pull resources of home care together into a coordinated package at the community level.

(7) There is entirely too much red tape in dealing with the Cost of Living Council, the Blue Cross intermediary, Medicare and Medicaid, agencies of the Social Security Administration.

(8) There is a very narrow funding mechanism. Title XVIII and title XIX payments must be broadened. Insurance carriers should face up to their responsibilities in home care.

(9) There is a lack of good training opportunities in the management of home care programs and home health operations.

(10) There is little support and recognition of home care from the Federal, State and intermediary agencies.

Senator CHURCH. Thank you very much, Mr. Belmont. Now I want to ask a few questions. First of all, I think in your statement, Mr. Youmans, you indicated that there were 21.4 percent of the population of the five northernmost counties of Idaho who now fall within the elderly category. I think that tends to highlight the fact that a constantly larger proportion of our population is in this older group.

Life Expectancy Higher Today

I was reading a little early history the other day and at the time of the American Revolution there were some wise old people. In fact, some of them played a very prominent part, as you remember, in the Revolutionary period and had a good deal to do with the drafting of the Declaration of Independence and later the Constitution.

But the percentage of people who grew old was very much smaller than the percentage of people who grow old today. Longevity in those days was about 42 years as compared to close to 70 or 71 years life expectancy in the United States today.

So this is a trend that we can expect to continue. There is every indication that the one-fifth of the people who are now in this elderly category will grow to one-fourth of the people and eventually, perhaps before the turn of the century, to nearly one-third of the people.

That is why it is so important that we begin to develop an adequate program to meet the needs of the elderly. I think we have made some progress in the Social Security area in the last few years, but we still have much to do. And in the medical care field I think it has been very clear that further improvements in the program are necessary.

Mr. Wiebusch, in your statement, I don't quite understand how Canada's figures enter into the work of the Coeur d'Alene District Office. Can you explain that to me?

Mr. Wiebusch. As a bordering State, or as the office bordering Canada, we are responsible for servicing the beneficiaries that are in this area.

Senator Church. You are serving beneficiaries that are U.S. citizens who are living in Canada; is that correct?

Mr. Wiebusch. That is correct.

Senator Church. And who are entitled to their benefits under our Social Security program?

Mr. Wiebusch. That is correct.

Senator Church. Good. And I am glad to know that because I serve on the Foreign Relations Committee and I didn't know we had gotten into a foreign aid program on Canada. And I thought we had better check that out. [Laughter.]

Now I would like to turn to your statement, Mr. Belmont, on the need for in-home services. This is a subject of very special interest for my committee, owing to the fact that most of our present programs, including the Medicare program—and as you pointed out, it is also true of the Medicaid program—are based primarily upon a rather rigid requirement for institutionalization before the benefits may be realized.

Patients Happier at Home

So in Medicare you can get a good chunk of your hospital bill paid but you have to go to the hospital in order to get the benefit. And we were just beginning to realize that there are many illnesses that can be better treated at home that don't really require the specialized services and the very expensive services of a hospital. The person will be happier in a home; that is, in his own familiar surroundings, with

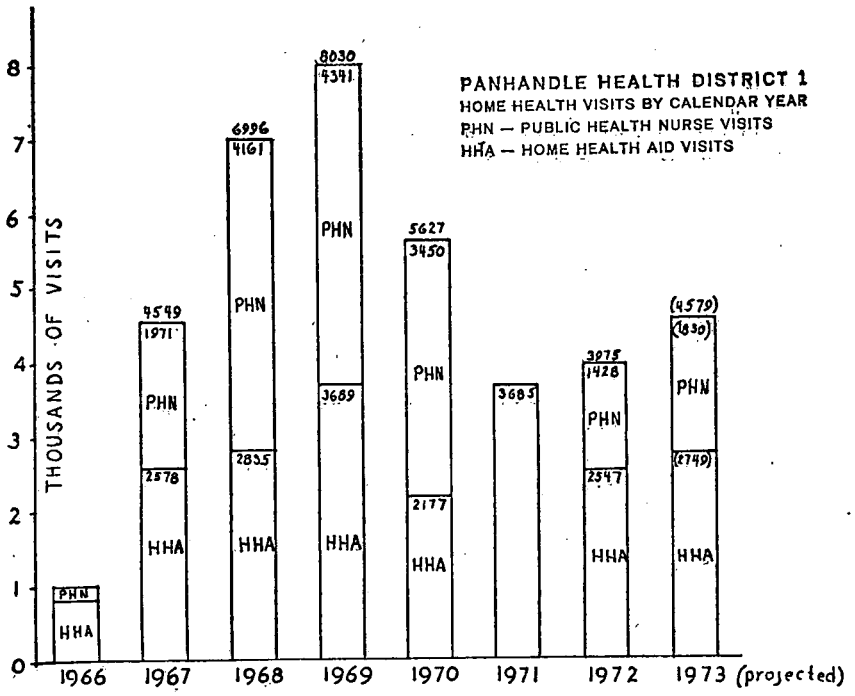
his family close by. It will be a good deal less expensive to give him that kind of care with the costs that are involved than to institutionalize that patient and put him in the hospital or put him in a nursing home.

I think that one of the most urgent needs is to make the Medicare program more flexible and begin to extend these home care services and I think your figures tend to bear that out. I hadn't seen a breakdown of this kind. But when you say that only three-tenths of 1 percent of the Medicaid expenditures in 1968 went to home health services, while 37 percent applied to hospital care and 32 percent to nursing home care, I think that underscores how much emphasis has been placed upon institutionalization as a triggering device for the Medicare and the Medicaid programs.

So this is really a very important new direction. I wonder if you could tell me just how you are trying here to expand the home care services?

Mr. BELMONT. First of all, we have what I think is a very active board of health and advisory committee. One of the things that has helped us greatly is some grassroot input to this decisionmaking, which stimulated interest at the local level as to what some of the problems are and solutions are.

I would like to submit a chart for the record.



These are the number of our visits when Medicare and home care started. And this was in 1966. As you know, the trend is definitely up. And, as you well know, the trend line is down immediately starting after 1969.

Fortunately, we feel because of our advisory committee and some of the things we have done through the brochures and things of this nature we have been able to reverse this downward trend line slightly by 8 percent. That is significant to us when the national trend is still downward.

In my statement we have a list of many things we have done with our own home health week which was supported by the medical society and other groups.*

Senator CHURCH. I think a word of explanation as to why this trend is so markedly downward is in order because this is part of the battle that the committee on the aged is fighting right now.

The money that is available for home care has been cut back drastically in the administration of this program by increasing the stringent definitions of what will qualify for home care. And these definitions have been imposed in order to reduce the cost of the program.

SELF-DEFEATING ECONOMY

Now I don't quarrel with good economy in the management of these programs, but this kind of economy it seems to me is self-defeating because if you force patients to leave their homes and enter the hospitals in order to get the benefits of the program or if you force patients to leave their homes and enter nursing homes, you are actually increasing the total cost of the program. You are not effecting real economy.

This is the banner we are now waving, to try and turn this around and get the administrators to adopt more liberal definitions for home care so that money will be available. And we think that this will mean that a lot of patients who are not so sick that they have to be hospitalized or so affected that they have to have the constant attention of a nursing home could stay in their own homes and be better taken care of and at a much less overall cost. We think the testimony from the field will be helpful in trying to turn this around again in the right direction.

Do you have any questions?

Mr. ORIOL. Not at this time.

Senator CHURCH. Very well, gentlemen, thank you for your testimony. We will go on with panel No. 2. Mrs. Ruby Elliott, who is chairman of the board of directors of the American Association of Retired Persons. She is accompanied by the Reverend Elmer West and Mr. William Keye.

I think we should be very proud of Mrs. Elliott as chairman of the board of the American Association of Retired Persons. She is heading up the largest organization in the country today that is devoted to the needs of the elderly. And just how large is the membership now, Mrs. Elliott?

Mrs. ELLIOTT. Our membership at the present time, Senator, is 5.16 million older members.

* See p. 609.

Senator CHURCH. You see, it is by far the largest organization of elderly people in the country. And the chairman is here today and we are very proud of her. I want to welcome Reverend West and William Keye to the panel this morning.

Ruby, why don't you just commence with your testimony and proceed as you had planned and I will withhold my questions until you have finished your statement.

STATEMENT OF RUBY ELLIOTT, CHAIRMAN OF THE BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY REV. ELMER WEST AND WILLIAM KEYE, COEUR D'ALENE, IDAHO; PETER HUGHES, ROBERT CAREY, AND THOMAS ELWOOD, WASHINGTON, D.C.

Mrs. ELLIOTT. Thank you, Senator Church. We welcome this opportunity to present our views on major issues pertaining to health care. Grave deficiencies exist in this country with respect to the availability of health care as well as with the quality of care provided for people of all ages. Such inadequacies are compounded in the case of the elderly.

Although persons aged 65 and older constituted only 10 percent of the population of the United States, they accounted for 27 percent of the money spent for personal health care in fiscal year 1972. The average medical bill for an aged person reached nearly $1,000 compared with $358 for a person 19 to 64 years of age, and $147 for those under 19 years of age. The average out-of-pocket payments for the elderly amounted to $276.

These high costs occur at a time in life when people are least able to afford them. Older persons who are forced to live on a fixed income have financial means which prove to be woefully inadequate in the face of such expenses. Medicare was instituted to help meet the costs of health care for the aged, but serious insufficiencies still exist. Medicare's portion of the health bill dropped from 46 percent in 1969 to 42 percent in 1971 and 1972. In 1969, Medicare paid for nearly 18 percent of the nursing home bill. By 1972, its share of the bill had dropped to only 7 percent. In 1969, Medicare's share of expenditures for physicians' services was 61 percent. By 1972, this dropped to 56 percent. The portion of the hospital bill met by Medicare in 1969 was 66 percent. This declined to 62 percent in 1972.

NEEDED SERVICES NOT COVERED

A related consideration is the failure of Medicare to pay anything at all towards other badly needed services. Routine physical checkups, eyeglasses, and eye exams for the purpose of prescribing, fitting, or changing eyeglasses are not covered. Hearing aids and examinations for hearing aids are not covered nor are expenses for orthopedic shoes and routine foot care. Items and services in connection with the care, treatment, filling, removal, replacement of teeth, or structures directly supporting the teeth also fail to be covered.

Our associations strongly advocate the enactment of legislation to guarantee payment for services like those just mentioned which are not currently provided in the continuum of health care. Costly health

needs such as out-of-hospital prescription medications, preventive health services, and long-term institutional care must be brought under some form of coverage. Cost-sharing requirements of parts A and B of Medicare must become less of a burden to our older citizens. We also urge that action be taken to correct the limitations which presently exist with regard to the amounts of inpatient care, extended care, and home health services that individuals are eligible to receive.

On behalf of our membership, I would like to take this opportunity, Senator Church, to pay tribute to the excellent work you have done to advance legislation which effectively deals with these vital issues. The amendments and resolutions which you have proposed in Congress are highly significant steps in the direction of eliminating the problems older persons experience in obtaining health services. We are especially pleased with your efforts to promote coverage of certain drugs on an out-patient basis, to increase the Medicare lifetime reserve from 60 to 120 days, and to reduce the coinsurance rate from $36 to $18 for Medicare patients who must draw upon their lifetime reserve. Our members also appreciate your announced opposition to the administration's proposals to increase out-of-pocket payments for the elderly and disabled under Medicare.

Having adequate coverage for medical services is of little consequence if such services are inaccessible to those needing them. People living in isolated rural areas and in the inner cities of our metropolitan centers cannot get the services they need because personnel or health facilities are too scarce. Other situations exist where personnel and facilities are present, but they may be so poorly located or managed that those who require the services are unable to receive them because of such nonfinancial barriers to medical care as lack of transportation or inconvenient hours. Your bill to amend the Public Health Service Act to provide for training programs which will train nurse practitioners to serve as physician's assistants in extended care facilities represents a noteworthy attempt to relieve some of the inequities characteristic of medically underserved areas.

"VIM" Program Initiated

I would like to report that our associations have not been standing idle while dedicated individuals like you have been moving on other fronts. It was noted at the 1971 White House Conference on Aging that our Nation lacked an intensive large scale educational effort which included the use of health materials and motivational techniques. As a way of responding to this perceived void, we developed a program of health education called "VIM" which stands for "Vigor In Maturity." This program has already been conducted in 102 locations around the country so far this year. It is also scheduled for presentation at 63 more sites in 1973 with additional requests for programs still coming into our national office. It is estimated that more than 20,000 older persons will participate in these sessions. The course is provided free of charge and is open to all elderly persons regardless of whether or not they belong to our associations.

Judging by the responses of those who attended the VIM program, we are led to believe that older individuals have a tremendous interest in obtaining information which will enable them to stay healthy.

This interest is being translated into action in many ways. Flowing as a logical sequence to this health education program, some of our local chapters developed health screening projects in their communities.

Again, these screening projects were available at no cost to all older people. Recognizing once again the need to furnish preventive health services to the elderly, mention should be made that of the 960 persons who appeared for vision screening at one of these programs, 32 percent had not had a vision exam in 3 or more years and 3.5 percent had never had a vision exam. These screening projects provide added witness to the observation that the elderly are indeed willing to take action to preserve or improve their health. The time has come to abandon the traditional orientation of a health care system which leans mainly toward providing treatment when illness strikes rather than toward maintenance of good health through preventive services and toward detection and treatment of illness in its early stages. We heavily endorse any activities geared to create services where the emphasis is placed on prevention.

I would like to conclude by calling attention to one aspect of health care which is often overlooked in discussions of this nature, and that is the kind of care that the elderly receive. All too often, the primary focus centers on ways to increase the numbers of personnel, facilities, and services for a given population in a certain area. Much more seems to be needed than the mere provision of remedies for numerical shortcomings.

Health Professions Prefer Young Patients

Studies have indicated that health workers often express a negative preference for elderly patients. The aged are viewed as somewhat more difficult when ill. If given a choice, many members of the health professions would prefer younger patients. It must be stressed that older patients are in many respects deprived of the essential ingredients which help to make life pleasant. It was mentioned earlier that their income needs are not being met. When they become ill, they are dependent upon the resources of the Government to pay for their care. Their illness patterns differ from other age groups. When they are released from a hospital, it is unlikely that they will have been cured. Instead, they are faced with the prospect of increased lingering disability as a result of chronic disease.

Many older persons are not able to rely upon having people close to them for comfort and support in time of illness. Their period of confinement must be faced alone because spouses, friends, and relatives may either be already deceased or unavailable for equally valid reasons. Deprived of the necessities which others take for granted, it is most regrettable that the care which they sometimes receive is dispensed in an atmosphere where they are accorded second class status because of an age factor beyond their control.

It is disquieting to realize that many health professionals receive training which is devoid of any component devoted to the special needs of the elderly. It is even more unsettling to read accounts of instances where training was provided, but negative attitudes remained unchanged. It would appear that more efforts must be expended along

lines to insure that older persons will not be denied an equitable form of care. We seek nothing less than an opportunity to maintain our dignity. It is time to come to grips with the reality that we can legislate new facilities and increased numbers of personnel, but we cannot legislate compassion. Our associations stand firmly behind any proposals that will lead to the provision of high quality compassionate care for all of the people in this country.

Indifference or Resistance to Elderly

Senator Church. Ruby, we thank you very much for your statement. When you say we cannot legislate compassion, I think that is true. But I think the very last part of your statement touches upon a problem we have to think about. And you have been a nurse yourself and you have seen a great deal of this indifference or resistance to the elderly patient. Now what can we do about that? How are we going to turn this attitude around, because I hear this said so frequently by people who know, as you do, from their own personal experience?

Mrs. Elliott. I wish I could answer that question, Senator, but it is a matter of personality and it is impossible for us to choose those who will become nurses.

Senator Church. You mentioned a bill that I have introduced that will encourage the training of nurse practitioners. And I was just thinking in connection with that training program, we might emphasize the need for approaching elderly patients with an entirely different attitude.

Mrs. Elliott. It would be different and I agree that those that can help the doctors—and I find that some of the doctors now are already doing this; those who are very busy and do nothing but just special examinations, they have nurses now who ask all the questions and the doctor has all the material in front of him to start with, it saves time for him and time for others, I think it is an excellent idea.

Senator Church. I think in Idaho, as in a number of States now like Idaho, smaller community States with smaller communities, the need for nurse practitioners is becoming very evident.

I have some statistics here that I would like to read into the record. It has to do with concentration of medical services, doctors, in the larger communities and the problem that is posed the people that live in the smaller communities of the State.

There are now four counties in Idaho that are entirely without physicians. There are nine counties in the State that are entirely without dentists. There are 10 counties without hospitals and 14 counties without any long-term care facilities. We also have 17 counties that have no nurses at all and only 39 psychologists for the entire State.

Now medical care is becoming spottier all the time as the tendency is to concentrate the facilities and the personnel in the larger communities of the State. And I hope that one of the good things that might come of legislation of this kind is to fill these gaps in so many of the smaller communities with some kind of trained personnel.

Reverend West, I think you have a statement here?

STATEMENT OF REV. ELMER WEST, COEUR D'ALENE, IDAHO

Reverend WEST. Thank you, Senator Church. This is a situation report of a lady I got acquainted with in my calling and she is a widow, living alone, on an income of $170 monthly, which consists of a World War I pension of her now deceased husband of $55, plus $115 Social Security.

I think we can get a better picture if I include her former status of earlier this spring and more recently in an apartment situation.

She was living, in the spring, in a house that she paid $65 a month rent for. It had been upped from $50 by the landlord and he was rather bothered that he could get $85 for it. So later she got an apartment. It was $65 for the house rent. The heating oil was approximately $20, depending on the weather. Electricity, lights, and she also had an additional electric heater that she could use on occasion was $8; telephone, $8, and that was a party line; garbage, $1.50 a month; water was $4.09; and the pills that were prescribed by her doctor running from $20 minimum to $25 at times; and special pain pills, $3.50. That totals to $130.09. In addition she had lawn work that had to be done in the summer and snow shoveling in the winter. If we subtract $130.09 from $170, that leaves her $39.91 to live on.

Now in the apartment situation, which she moved into more recently, she pays $60 a month rent and most of the utilities are paid. I think it is only the lights that she has to pay there. But she has a telephone and the doctor recommended a private line and that is $9.81. It cost her $15 to have the telephone installed, which will not be a recurring expense but this first month. Then the pills remain about the same, $23.50. The electricity, lights and so on, $8, which brings a total of about $116.31.

Now if you subtract that from the $170 income, it leaves her $53.61 to live on, but after the first month with the elimination of that $15 installation on the telephone she will have $68.61 to live on.

Senator CHURCH. That means that she can go to the grocery store just about twice?

Reverend WEST. Yes. And then last spring she had a bout with gallstones and a heart attack and they sent her to the hospital. The doctor's fee was $95. The hospital expense was $600, or about that. She doesn't remember exactly because she has sent that bill in to be paid by Medicare. But presumably, she will have to pay the deductible which was current to July 1, which was $60. I think since July 1 the deductible was $72.

Now on that doctor bill she has paid $30.20 out of her income. Medicare paid $24.80. The balance on the doctor bill is $40. Then the balance due on the hospital, she has to pay that $60 deductible, which will be $60.

Senator CHURCH. I think that illustrates a typical problem of many people on a limited income. I don't know how they manage to make ends meet at all. Mr. Keye, do you have a statement?

STATEMENT OF WILLIAM KEYE, AMERICAN ASSOCIATION OF RETIRED PERSONS, COEUR D'ALENE, IDAHO

Mr. KEYE. Yes. A few years ago the AARP was asked to help explain the insurance policies which they have developed in order to solve what Medicare didn't take care of. Medicare, to my way of thinking, is one of the most perfectly designed programs in this insurance field that I have ever seen. But it cannot cover all cases, naturally, and shouldn't try to cover them all.

So the AARP, as I said, designed a number of policies, quite a few in fact. And in order to help our members understand these policies, I had to first of all be certain that they understood Medicare.

So I fixed up a few charts. Now Medicare, part A, pays most of your first 60 days in the hospital, quite a bit of your next 30 days in the hospital and still it leaves the next 60. That doesn't mean within 150 days you are finished because this can reoccur again during the year. In fact, it can reoccur three or four times.

If a doctor sends you to a nursing home, Medicare pays the first 20 days of it and quite a bit of the next 80 days. Or if they send you home, Medicare stands quite a bit of the cost of the in-home service. As I said before, this doesn't mean it is only for 100 days and then you are finished. That takes care of your benefit period. You can have as many as four benefit periods in a year, although you probably will not.

It has been my observation that when you get sick or hurt, you go to the hospital for usually about a week and then you are dismissed and you go either to a nursing home or you go to your own home. And that is the kind of protection that most people need. They don't need what you would think they need from the advertisements you see in the papers about hospital costs soaring. So take out your policy and get $30, $60 or $80 a day while you are in the hospital. That thing will cover you for about 3 or 4 days. And after that you are out of the hospital but you might be in a nursing home for 2 or 3 years.

Now the doctor's fees are somewhat different. It is worked on a yearly basis. Your first payment to the doctor say is $60 for this particular trouble of sending you to the hospital, and from then on Medicare pays 80 percent of the reasonable charges and you pay the rest. Now you can get three AARP policies to cover these places where you have to pay. You can get three AARP policies to cover these places where you have to pay the hospital. And then they have policies on life, accident, and automobile insurance. And that happens to be my business and that is all I know of this.

Senator CHURCH. Thank you very much, Mr. Keye. I think there are a great many elderly people that do not know that there is private insurance available that will cover the gaps in the Medicare program. But be sure you know what you are getting when you get it. Be sure you are dealing with reliable insurance firms and you are getting the kind of protection you need.

You have touched upon one aspect, Mr. Keye, of the Medicare program that I think is more confusing to people than anything else and that is the fact that some doctors will take patients eligible for Medicare and they will take them on an assignment basis; that is to say, they will accept the fee that Medicare pays that is determined to be reasonable and in line with the general fees in the community. And in that case, of course, there is no extra bill from the doctor for the services rendered. Other doctors will not take patients upon an assignment basis and they reserve themselves the right to charge a fee that may exceed the so-called reasonable fee that Medicare provides.

So you get patients eligible for Medicare, some of whom have to pay extra fees to their doctors and others of whom do not. And they don't understand, as they compare notes, why their coverage seems to have been different, why one will have to pay an extra fee to the doctor while another will not have to pay an extra fee.

I don't know if this can be corrected in the law but I do know that it is causing a great deal of confusion about the program. And all that I can suggest to you, taking the present state of the law, is to inquire of your own physician whether or not he does accept the Medicare patient on assignment basis and, thus, accepts the fee that is furnished or whether he does not. Then at least you will know in advance what to anticipate. Wouldn't you say that would be a good idea, Mr. Keye, for elderly people to inquire before they engage a doctor, what his own practice might be so that they will be forewarned?

Mr. KEYE. I think it is a good idea when all the different policies you own on this sort of thing, you have them payable to you and let the doctor come to you too, and the same way with the hospital.

Senator CHURCH. Thank you very much.

Mrs. ELLIOTT. Senator Church, I failed to introduce our men from Washington, D.C. May I do that at this time?

Senator CHURCH. Yes, by all means.

Mrs. ELLIOTT. We have three of our men from Washington here. We have Peter Hughes, who is with legislation; Robert Carey, who is on publicity; and Thomas Elwood, who is with our VIM, our health program.

Senator CHURCH. Let's give them a nice hand of applause. [Applause.]

Mrs. ELLIOTT. Thank you, Senator.

MANY SERVICES NOT COVERED

Senator CHURCH. I have a few more comments, Ruby, that I would like to make about your testimony. One has to do with the many kinds of services that are not covered by the present Medicare program. You have mentioned routine physical checkups. You have mentioned eyeglasses, eye examinations, prescriptions, and fitting of eyeglasses. You have mentioned hearing aids. You have mentioned orthopedic shoes, routine foot care. You have mentioned dentures, dental work, replacement of teeth, and so forth, all of which are not covered by the present Medicare program. It just happens that as you get older—and I have already begun to experience it—these are the very things you begin to need; glasses, dental work, hearing aids, and I know one of the chief

complaints of many of my friends who are 70 or older is that their feet hurt. And foot care is one of those areas also excluded from the present program.

But I think worst of all in terms of cost is the number of people that have to buy prescribed drugs for chronic illnesses and given the present costs of these drugs, as in the case Reverend West mentioned, a very sizable part of this lady's limited income has to go for drugs. Medicare does not cover those drugs unless that person is in the hospital.

I do hope that the bill that I have introduced in Congress would at least cover prescription drugs for chronic illnesses and finally be written into law. I think that is one improvement that Medicare needs perhaps more than any other.

Reverend WEST. I believe you are right.

Senator CHURCH. You think that is correct?

Mrs. ELLIOTT. Yes, I certainly agree with you.

Senator CHURCH. I want to take this opportunity, since we are introducing people, to introduce the members of my committee staff on the aging who are here with me today. First of all, to my right is Bill Oriol. Bill is here. And Pat Oriol, his wife, they are both with us. Bill is the majority chief of staff for the committee for the Democratic Party. And John Guy Miller, who is his counterpart for the Republican members of my committee. Both John Guy Miller and Bill Oriol are here and I would like them both to stand. And also, Pat, you stand up here too. [Applause.]

Also I am told that Dr. Edward Fox* of Coeur d'Alene, who is president of the Idaho Medical Association is here. Dr. Fox, will you, please, stand? [Applause.]

Then there is Mildred Berry**, president of the Idaho Home Health Association. She has come all the way from Boise to be at this hearing and we would like to recognize Mrs. Berry. [Applause.]

Now if I should perchance miss anyone that should be introduced, I hope someone will send forward a note because I want to recognize everyone that is here today.

I have one other observation, Ruby, I would like to make in connection with your testimony and that is where you say:

> The time has come to abandon the traditional orientation of a health care system which leans mainly toward providing treatment when illness strikes rather than toward maintenance of good health through preventive services and toward detection and treatment of illness in its early stages. We heavily endorse any activities geared to create services where the emphasis is placed on prevention.

EMPHASIS PLACED ON TREATMENT

I couldn't agree with you more. I think we are addicted as a people to great spectaculars, space spectaculars, heart transplant spectaculars, that engage the services of most learned specialists and require tremendous resources to put together. But while we are doing these spectaculars we are very indifferent toward programs that would assist people in getting early detection of illness and in health care that is based upon the prevention of the illness before it occurs, rather than dramatic treatment of the illness in its advanced stages. And

* See appendix 1, item 5, p. 651.
** See appendix 1, item 4, p. 650.

that is reflected in our Medicare and Medicaid programs. Again, the emphasis on treatment rather than on the prevention. And it is here we have fallen down very badly.

So I agree with your statement. I think one of the kinds of improvement we are going to look for as we seek ways to strengthen the present Medicare program is in this field of preventive medicine.

Mrs. ELLIOTT. I feel that we could start even with the first grade on preventive medicine.

Senator CHURCH. I think we do fall down all the way down the line.

Mrs. ELLIOTT. I think so too.

Senator CHURCH. That is as far as preventive medicine is concerned.

Mrs. ELLIOTT. Yes, and in the home, many places.

Senator CHURCH. Well, thank you very much for your testimony. It has been very helpful.

Mrs. ELLIOTT. Thank you for the privilege of testifying.

Senator CHURCH. Our next panel includes George McCourt of Coeur d'Alene, regional organizer, National Council of Senior Citizens, another very fine organization for the elderly. He is accompanied by LeRoy Howell, who is the volunteer coordinator, Coeur d'Alene Crisis Intervention and Referral Center; and Bert Russell* from Harrison. Gentleman, if you would, come up and take your positions at the table.

It has just been called to my attention, George, that the National Council of Senior Citizens consists of about 3 million or more members in the country and it is the second largest private organization of senior citizens. And it has the distinction of having been placed on the administration's enemies' list. The New York Times just announced that the National Council for Senior Citizens has just turned up on the new enemies' list. So I guess that is some distinction and I wanted you to know it before you began your testimony. But you do represent one of the very fine reputable organizations of the elderly that has a splendid standing in Washington and throughout the country. And so don't feel too badly.

STATEMENT OF GEORGE McCOURT, REGIONAL ORGANIZER, NATIONAL COUNCIL OF SENIOR CITIZENS, COEUR D'ALENE, IDAHO

Mr. MCCOURT. Well, Senator Church, after what we have been hearing lately, maybe that's a very fine and high honor. I might say here that the National Council of Senior Citizens was born out of efforts to make Medicare into law. And I think it has carried a pretty big stick back there in Washington and other areas in efforts to help solve the problems not only of the elderly but all Americans. And some of the things I am going to have to say rather briefly—or some will be rather briefly stated and some have been enumerated previously.

One of the major problems of the elderly is worry. Worry about long-term nursing home care, worry about the bookkeeping of Medicare, coinsurance, overcharge of various tests. There is also a constant fear of each ache and pain, that develops with old age, especially among the people who live alone, and to the elderly with no preparation for retirement, and with no positive activity to participate in.

* See statement, appendix 1, item 6, p. 653.

One of the most logical factors, that should be considered, is the introduction of preventive medicine into Medicare. In health programs, such as Kaiser Permanente, total costs have been lowered as much as 10 percent. The greatest benefits however are not financial, but physical and mental. These programs urge, and in some require, an annual checkup so that any problems of health may be detected at an early stage of development. The knowledge of a minor problem that can be taken care of or that there is no problem is cheerful news, and good for the individual.

ANNUAL CHECKUP UNDER MEDICARE?

Our suggestion is that an annual checkup become available to all under Medicare at no cost to the individual. When the total facts are known, it could be a wise investment for the Medicare program.

We in Idaho are moving in the right direction by the greater use of the home for the care of the elderly, by an expanded home health service. This will cut the costs, and well trained nurses and practical nurses can render a great service to the individual, by their attitude through friendly visits. This gives the patient something else to look forward to.

Another factor for better health is being neglected in most communities to some extent. There should be greater effort in every community to provide practical, wholesome recreation. The barriers are enormous for many of our elderly. They have no cars, so fishing, hunting, and other activities are not available to millions. The average community has little or no funds to provide facilities and too many of the citizens in their defense of free enterprise have become crusaders against Government expenditures for wholesome activities.

The road to an improvement of readily available wholesome recreational activities, not only for the elderly but for all citizens, is rugged and long. Wholesome recreational activities can be the finest financial investment that any community could make. The dividends in improved health not only for the elderly but for our youth, could be a major factor in rebuilding respect for our Government, and rebuilding faith in the future. The Congress of the United States and our communications media could bring about this revival, so essential for the future well-being of this Government of ours. We need leadership.

Inflation also contributes to worry. What about tomorrow? What will the cost be? Here in Coeur d'Alene water costs have doubled in the last 2 years and it looks like they will double again within 2 years, at the present plant valuation and interest costs. To people with years of pride in their flowers and vegetable gardens, it is heartbreaking to see their lawns dry up. So many of these people on set and limited incomes, wonder who does run the Government. They have less hope because this Government that they love and have worked for is under constant attack, by some who claim that this Government of the United States of America is bad, not capable to own or control their own needed facilities.

Lack of an adequate income, too, is a barrier to health. Congress should make a new attempt to pay Social Security beneficiaries a cost-of-living increase of 10 percent, beginning January 1, 1974, instead of

5.6 percent next July. This administration has made no effort to protect the poor from unreasonable inflation and it is now up to Congress, to keep the worker and retiree from being plowed under by big business financial machinery.

The income increase of the elderly, delayed until July 1, 1974, means less food to keep them in good health now while the grocery prices advance almost daily.

Health Care Cost Controls Removed

The removal of any real controls over rising health care costs, the President will now be able to raise part B premiums by 50 cents a month, a large increase for people on low incomes, discouraged by fear of what the future may bring.

The President, at the White House Conference, promised that he would cut the cost of Medicare to the participants, and that the recommendations of the White House Conference would not gather dust or be filed away in some storeroom, but would be implemented by action. The older Americans are more than concerned about this failure to carry out a promise.

There is another problem worthy of the consideration of your committee. Low-cost housing projects have been given a setback by action of the President, but there are a few suggestions that should be a factor in improvement of the health of the residents of housing projects.

It seems that the real estate developers, and the builders are more concerned with land values, than they are with the total objective for the people who are to live in these apartments. Often located outside of town, there are no sidewalks, except a dangerous highway, and many of these people need daily walks for exercise and a change in daily living. They should be handy to stores for window shopping; there should be different churches within walking distance; there should be other activities such as parks, and some would like to attend lectures. In many cases no outdoor activities of any kind are provided.

Now we appreciate this opportunity to express our views and want to thank you for the excellent work that your committee has accomplished to benefit all the senior citizens. And thanks for all older Americans and to those who hopefully will become older Americans in the years to come. We owe you a deep debt of gratitude, Senator Church, and your Senate Special Committee on Aging.

Thank you.

Senator Church. Thank you. Mr. Howell do you have a statement you would like to make?

STATEMENT OF LeROY HOWELL, VOUNTEER COORDINATOR, COEUR D'ALENE CRISIS INTERVENTION AND REFERRAL CENTER

Mr. Howell. Most of my things have been covered. I might read this through. I just have a sketch here of what I wanted to cover.

There is payment for the cost of certain eye examinations and prescription glasses. Medicare will pay 80 percent of the initial examination and after that if they are dropped or broken or anything, then the parties themselves have to pay it.

Senator CHURCH. This is in the way of suggesting how Medicare might be improved?

Mr. HOWELL. Yes. And also as Ruby has spoken, about the hearing tests, aids, and batteries. Many of the older people are missing half the things that are said around them because they are trying to save batteries, which are very expensive. And we need some help for the elderly on the aids and batteries.

Essential dental work, new dentures, relining dentures, whatever. And Medicare will not pay for it. We need some help on those because many of the senior citizens are getting to the point where their hands and fingers are not quite as sure as they used to be. They drop them in the sink, on the floor, or whatever, and they are broken. They are without them and they cannot digest their food properly without their teeth. So we need some help here, that is, in repairs and relining and so forth. This all comes under another category that I will speak about a little later.

Will Medicare pay for the buildup of shoes needed by a disabled Medicare recipient? In some instances the buildup must include a steel plate which attaches to leg braces, and it has to be built into the shoe itself. Medicare will not pay for these. They will pay for the shoes but any remodeling of that shoe has to be paid for by the Medicare recipients themselves. Some of these bills run as high as $65 and $70 to have a shoe fitted so that the leg brace may be attached to it so they can walk. This could come under Medicare.

PRECAUTIONARY MEASURES IN HOMES

Some other things, as a precautionary measure, are safety bars for bathrooms for the people at home. A lot of the people at home might be able to help themselves more, take baths and things, if they had some safety bars or something they could get hold of to get in and out of their bathtubs or even help the party that is helping them to take their baths. That could help a whole lot in this way.

And it comes down to the other category, which is transportation. People that have to have eye examinations, eye tests, they have to go to the doctor's—whatever comes up in any of these categories all involve transportation.

Now there is one party that I took care of a couple of weeks ago and neither one of them could see. One of them was 86 years old and the other one 78 or 79. Their eyes were not good enough to see to drive. They didn't have any money to hire a taxi to take them to the optometrist. So in this case we could ask our own community, you people out there that are not able to drive, to please call and turn your name in so that if someone needs transportation you can have it. And it just takes a few minutes and that is one thing we can do in our own community, is to have voluntary drivers on our transportation program for the senior citizens. We need a lot of those.

Another thing I wonder if it could be done is a larger tax relief for the needy, older people, older citizens, trying to maintain their own home. The taxes are going higher and higher all the time. They can be exempt from taxes at the age of 65.

Now some people are in better shape and are able to pay their taxes and taxes are able to be paid under different circumstances. But

the elderly people that want to save their homes, they worked all their life for their little bit of a place they have, they have some problems. They want to keep their homes. They don't want to have to turn it back to the State in order to get any help. So if they could have a little tax relief or be exempt from taxes, it would help them a whole lot in their low-income situation.

Another thing that might help—and I hope I am not heading on a subject here that is too controversial—is more frequent and thorough investigation of our nursing homes for the elderly people. In some cases—and one thing I want to bring out and would like to get information on, and that is that I understand some of the nursing homes are taking Social Security checks from the senior citizens and the senior citizens themselves have nothing left out of this check. They don't even have a receipt left out of the check. This is to pay for their care in the nursing home. And I was under the impression that a Social Security check, senior citizen in a nursing home, that they had to leave them $12 of cash for them to use to buy essentials, that they want to buy themselves. This could be looked into and checked out a little bit.

Being on the Coeur d'Alene Crisis Planning and Intervention Referral Service, I have talked to a lot of people—senior citizens—I would say about 4 or 5 percent of our calls have been senior citizens that are at home at night and are lonely and have nobody to talk to and they call us about their problems. They have called us about hearing aids and they have called us about glasses. They have called us about their dentures, they lost their dentures and they couldn't eat without them. They didn't know how to get their dentures repaired or what to do with them. I have been in contact there quite a bit with senior citizens.

I am also on the RCVP, which is retired citizens volunteer program. We would like to have more of you people and your friends sign up with us so we can furnish transportation for the senior citizens so they can go to the doctor or to the grocery store or to the hospital.

Thank you very much.

Voluntary "Hotline" Service

Senator Church. Thank you very much, Mr. Howell. I should explain to the folks that Mr. Howell is the volunteer coordinator for the Hotline in this community. Would you like to explain how that Hotline works?

Mr. Howell. We are an answering service that is entirely voluntary. There isn't a paid person in our group. We have right now 26 to 28 volunteer members that stay by the phone at night from 6:30 to midnight taking any kind of calls from drugs, loneliness, family problems, mental health problems, people traveling through the town that need a bed for the night. And those that need a bed for the night need a meal. They need legal aid—we could go on and on. We talk to anybody about any problems that they have, anything that they want to talk about, even with the senior citizens that are lonely and living alone that can't go to sleep at night. We invite them to call and many of them have called. We sit and talk to them for hours if they need it. We quiet them down and quiet their nerves and make them more settled for themselves so they can go to sleep.

I guess that just about covers our Hotline. We work in drugs. We work in mental health. And we work with the aged people. We work with the young people, young unmarried mothers, anyone that has a problem that they can't understand, they get uptight about it, we will try to talk to them and bring them down off their key, down to a level position and get them to think for themselves. And we try to get them referrals to different agencies in Kootenai County, which we have many, many referrals to make people that can help them and take the stress and strain off of their minds about these things.

Senator CHURCH. Roy, can you give us the number, the telephone number of that Hotline?

Mr. HOWELL. Our telephone number is 664–3114. It is the same telephone number that is used by the Community Action Center during the day. But at 6 o'clock at night there is no one else to take the call except the Hotline volunteers. We even refer calls for community action, whatever. People have called in and asked about community action. We have them call back the next day when the community action people are on duty. But we take any of the calls for anybody.

Senator CHURCH. I thought it would be important for you to know about the Hotline because you never know when you might want to use it. We asked Mr. Howell to please stay on this panel because he has had the experience, that is, he and others who have worked with the Hotline, to hear from so many elderly people and to learn what the problems and what the present deficiencies are in the Medicare program. So your suggestions really come from a great many people, do they not?

Mr. HOWELL. Yes, they do.

Senator CHURCH. And you pool them together based upon these conversations that you have had with the elderly people in this community.

Mr. HOWELL. I might add, Senator Church, that we are on a strict confidential basis and anything that is said over the phones goes no further than that person themselves or the person that works with them. Sometimes we have two people that work together, but it goes no further than that. And there are a lot of people that feel more freely to come out with their problems and talk sincerely about their problems to someone that they can't see rather than to face someone and try to talk about their serious problems. This is what we are there for.

Senator CHURCH. Thank you very much. I wanted to mention in passing that we had a third panelist, Mr. Bert Russell from Harrison. Bert came in yesterday and submitted a statement.* He could not be with us today because he has a very dry field of wheat and he has to tend to it before it burns up. So he wanted to be excused on that account.

George, in your statement you make one recommendation that I would like to emphasize and that is the possibility of enlarging the Medicare coverage to take care of one annual medical examination. I think that is in line with the testimony of Mrs. Ruby Elliott, in the beginning to give more emphasis to preventive medicine. And I think it is badly needed. It is a very good suggestion.

* See appendix 1, item 6, p. 653.

Social Security Cost-of-Living Adjustment

The other reference you made in your testimony, George, I think, needs a little explanation and that has to do with the scheduled 5.6 increase in Social Security benefits and it does not take effect until next July.

In the face of such rapidly rising costs in food and in the general level of living expenditures, many people ask me why we must wait until next July for a cost-of-living adjustment that will be too small by the time the paychecks are actually issued even to make up for the rising cost of living in the interval. And it is a good question because we tried to make Social Security bear fruit at the time Congress enacted the 20-percent increase that I proposed last year.

Part of that amendment set up this cost-of-living adjustment in the hopes that every year any increase in the cost of living will be passed on under the escalator clause to beneficiaries receiving their Social Security checks. And they wouldn't have to wait for Congress to catch up with rising living costs by enacting special legislation.

The trouble is that when that provision was written in, in order to get it we had to agree to a—in order to get the votes and to receive administration support and write it into law with the President's signature—we had to first set the date for the actual implementation of this provision in January 1975. That was when it was going into effect. And since then the worsening inflation, particularly in the place that hurts the worst for elderly people with lower incomes, the spiraling cost of food has come on. And so we have managed in the Congress to move the date up from January 1, 1975, to June 1974. But I would hope that we could do better in view of the seriousness of the inflation and modify the law again this year so that the triggering date for the adjustment would be January of 1974, this coming January. And from then on this adjustment could be made on an annual basis without the long wait. And that, after all, is what we are trying to get away from, the long wait. So I will be trying to move forward still another change to advance that date to January of this coming year. I can't promise that I can accomplish this but I am going to make the effort.*

I think that I have no further questions, gentlemen, and I want to thank you very much for your remarks.

Mr. McCourt. Thank you, Senator Church, for this opportunity.

Senator Church. Our next panel consists of Edna Evans, the home health coordinator for the Panhandle Health District No. 1. I understand Mrs. Evans will be accompanied by Claude Garber and William Garland, both of Coeur d'Alene.

Ladies and gentlemen, I would like to introduce a person who I am very partial toward. She has just come in the room. She makes it a practice to visit the nursing homes as we move from county to county while I am at the county courthouse conducting conferences. So she really knows more about the nursing homes of this State than anyone else I know. She keeps me well apprised of the problems that we do face in the nursing homes, and she has a very great interest in this as well as all other matters that relate to the elderly. She has just come in and would you, please, stand up? This is my wife Bethine. [Applause.]

*P.L. 93–233, enacted in December 1973 authorizes a 2-step, 11 percent across-the-board Social Security increase during 1974.

Before we move ahead to the next panel, Dr. Robert West, who is the president of the Kootenai-Benewah County Medical Society is here. Dr. West, would you stand and be recognized, please? Well, I been have informed that he had to leave.

Mr. Bryan B. Bundy,* the assistant to the State director of the National Retired Teachers Association, and let's give him a hand. [Applause.]

Mrs. Evans, do you have a statement you would like to present at this time?

STATEMENT OF EDNA EVANS, HOME HEALTH COORDINATOR, PANHANDLE HEALTH DISTRICT NO. 1, ACCOMPANIED BY WILLIAM GARLAND AND CLAUDE GARBER

Mrs. EVANS. Mr. Chairman, I am very glad to hear about the proposed legislation to encourage the use of home health services under Medicare as well as coverage of hospitals and prescription drugs. Our program started in 1966 and grew quite rapidly in our three northern counties, but especially in Kootenai County. Home care provides an entirely different service from extended care facilities or hospital care. It is an intermittent nursing service and to provide supervision of family and patient and to teach the family of the patient's care in the home; nutrition teaching is also another factor.

Home care should provide services for the chronically ill and handicapped people in their own home. This is where we get into a long-term maintenance, health supervision and teaching and preventative as well as rehabilitative services. We try to encourage patients rehabilitation and activity to their maximum ability.

Due to new interpretation of the Medicare laws by the Bureau of Health Insurance, new limitations were imposed and care was made much more restrictive, thus cutting off many people who could benefit by our care and causing extra expense for those who felt a maintenance service would avoid a definite regression in their chronic conditions.

You already have the chart** which Mr. Belmont showed you. You have to remember that as we grow older, and we all will, we tend to have more than one illness or diagnosis. In fact, just this week I encountered a patient with six to eight or more chronic problems. We have one patient who has an income of about $170 with a drug bill of over $50 a month. The patient lives alone 40 miles from Coeur d'Alene, and because of the distance, the patient must have a phone. I did not break down her expenses, as did Reverend West, but it probably would read about the same way.

CHRONIC PROBLEMS NOT ALWAYS COVERED

Frequently we get patients with four to five or more diagnoses, and if hospitalized for one of these diagnoses and then sent home to home care, we should be treating the reason for hospitalization in order to have Medicare coverage. This condition perhaps was resolved in the hospital, but the other chronic problems appear now to be more dis-

*See appendix 1, item S, p. 656.
** See p. 612.

abling. This should be covered under Medicare but usually is not. Actually, Medicare is geared for short term post-hospital care which does not meet the need of the chronically ill or handicapped person.

However, we have some bright spots where relatively short term intensive rehabilitation regime returns patients to the maximum of their ability to self care or family care.

Another phase whch should be looked into is that the cost of operating a rural agency is going to be high and some special incentive should be provided to help these agencies operate. For example, to give nursing care to 4 patients required a total of 109 miles and 6 hours. We have many small rural counties with a high population of elderly on limited incomes with no public transportation and no doctor available to any health facility. In fact, in one area I am the only link to the health care system. We are the link between the patient and the physician, especially in the rural areas. We not only need to be technically competent but competent in physical assessments and to improve our reports to the physicians.

I was just handed a note that I should mention the fact that we are developing a training program at Spirit Lake for both the youth and elderly.

I feel that home care is a most vital program to this area and to the health care system. A patient is usually happier in his own home setting and may very well go on to lead a more productive life. Besides, it is less expensive and it gives the family and the patient more incentive for doing for himself.

At this time I would like to introduce two other gentlemen who are with me. One is Mr. Garland, who is 75 years young, and Mr. Garber, who is 83 years young. Mr. Garber has been with our program—we started care in October of 1966; and in June 1970, he was no longer covered by Medicare but he still required our services. And he took care of his own expenses to his ability. Mr. Garland is another story. He was admitted to our care in April and with some intensive care we could discharge him to self-care in 6 weeks. But I would like to ask these gentlemen some questions.

Mr. Garland's wife came to see me in the office and she had picked up one of our brochures. And she was a little reluctant on taking her husband home because she wasn't quite sure the type of services needed were available.

Mr. Garland, would you like to tell these fine people how you and your wife felt about taking you home?

Returns to Work—Every Day

Mr. Garland. Well, my wife was a little scared about it and I didn't know much about it. But anyway, this service we got was wonderful help that meant everything to me. I had always been active and I couldn't—well, I couldn't hardly get down to the point where I could see any future. And these people came up and helped me and I got on my feet and now I work every day. I feel good. That's all I can say. [Applause.]

Mrs. Evans. How did we help you?

Mr. GARLAND. Anyway, they exercised me and they talked to me and gave me good advice. And, well, they just acted like real people. And I appreciate it.

Senator CHURCH. Are you working in your garden again now, Mr. Garland?

Mr. GARLAND. Man, I work about 12 hours a day. You will have to come out and see it.

Senator CHURCH. I would like to. I really would.

Mrs. EVANS. Mr. Garber, could you tell us what our aide does for you when she comes to see you?

Mr. GARBER. Pardon me, would you repeat the question, please?

Mrs. EVANS. Could you tell us what our aide does for you when she comes to see you at your home? What does she do to help you?

Mr. GARBER. She gives me a bath twice a week. Lots of people wonder why a fellow has to have help getting a bath. One reason is, my wife is 83 years old and she just isn't able to help me in and out of the tub. Now I can do everything except to get out of the tub. I just can't do that. So I really appreciate that is done for me.

Mrs. EVANS. What do you suppose you would have done if our services had not been available?

Mr. GARBER. I don't know. I have often wondered about that. I even thought about providing in some way a shower, which would be a rather major alteration because the bathroom is not very big. I don't know how we would do it. We would have to figure some way to hire somebody.

Mrs. EVANS. Now, Mr. Garland, how do you feel that we could deliver our services to more people?

IMPORTANCE OF FIRST-DAY CARE

Mr. GARLAND. Well, I honestly think that these services should start a day or two ahead of the time a patient comes home. You could go out to their home and see that there is a proper place for them. And the ride home, that means a lot. You either go up or you go down that first day, I know. I was pretty down, so that's all I can say.

Mrs. EVANS. That's all I have.

Senator CHURCH. Well, here are two cases that show the need for extending and improving this aspect of care in a private home—the home care aspect.

We have a letter here from Mrs. Ida B. Condie, a lady who is 93 years old. I am going to get out and see her. And she, too, has received service from the home care nurses. She has written about her own experience, and I am going to include her letter in the record. But she completes her letter with a poem and I just would like to read it to you. This is the first time that I have seen it. Mr. Oriol just handed me the letter and I have just finished reading it.* It concludes with this poem, which is a tribute to the nurses who have helped this lady so much. She writes:

* See appendix 1, item 13, p. 664, for full text of letter.

"To my faithful nurses, I say—
Did you know?
It's your very sweet smile,
And your very sweet way
The good thing you do
And the kind words you say
It's the love in your hearts
And the love in mine too
That makes me so thankful for
Dear nurses like you
So keep on smiling and
Know by what a smile is meant—
It's worth a million dollars
And it doesn't cost a cent."

She is 93 years old. [Applause.]

Mrs. Evans, I have one question I would like to put to you based on what was testified to this morning. Can you furnish the committee with any estimate of how many more people in need of services of this kind there might be that could and should be reached if we had a medical program of home care in this community?

Mrs. EVANS. I would have no way of knowing those figures. But if we can locate them, we will do that.

Senator CHURCH. How many do you now serve?

Mrs. EVANS. In Kootenai County in June we had 52 patients and 50 percent of those were covered by Medicare.

Senator CHURCH. This chart* that was furnished the committee going back to 1966 shows the availability of financial help through the Medicare program for these services?

Mrs. EVANS. Yes.

CUTBACK IN FUNDS CAUSES DROPOFF

Senator CHURCH. I would like to read the principal trend figures in the chart. It shows that in 1966 the program consisted of about a thousand home visits.

In 1967 there were approximately 4,500 home visits. In 1968 it went to 7,000. In 1969 to 8,000.

Since then, because of the cutback in funds for this aspect of Medicare, it has fallen off to 5,500 visits in 1970, 4,000 in 1971, 2,000 in 1972 and now it is about 1,800, at the rate of about 1,800 currently.

Mrs. EVANS. Are you speaking of 1972?

Senator CHURCH. Yes, you have them broken in two halves, the first half and the second half. So the current level for the second half of 1972 is running about 1,800; is that correct?

Mrs. EVANS. Yes.

Senator CHURCH. Meanwhile, the institutional costs have continued to go upward very dramatically and these, of course, constitute the great bulk of costs of the Medicare program. So I really think we have to reverse this trend and enlarge upon the home care aspect of the program from every standpoint that makes sense.

* See chart, p. 612.

Mrs. EVANS. I agree.

Senator CHURCH. Thank you so much for your testimony. Our next panel is from Lewiston and they got up at 5 o'clock this morning and have come a long distance to be here today.

The panel consists of Eunice Erickson, program director, Banana Belt Senior Citizens, Inc.; and Sister Helen Frances, administrator, St. Joseph's Hospital in Lewiston; and others that have come with them and are here in the audience, would you all stand. Let's give them a nice hand. [Applause.] You can tell who they are because they are wearing the Banana Belt stickers on their lapels. You may proceed with your testimony.

STATEMENT OF EUNICE ERICKSON, PROGRAM DIRECTOR, BANANA BELT SENIOR CITIZENS, INC.

Mrs. ERICKSON. Thank you, Senator Church. The delegation from north central Idaho and southeastern Washington is pleased that you are conducting hearings on barriers to health care for older Americans at this particular time.

You have requested the grassroots point of view. Time does not permit us to explore the many facets of health maintenance programs nor the scope of preventive measures that could save senior citizens hours of suffering, maintain vigorous mental faculties and permit use of talent, training, and skills in their local areas. At the same time, we do not have an estimate of the dollar saving to the community that such measures would insure. But, we do know that the cost of institutional and/or other care has skyrocketed. The State of Idaho pays at least $11 per day or more than $4,000 per year for institutionalizing a senior citizen in a nursing home. I wonder how much of this money can be saved.

Medicare, along with its companion, Medicaid, was supposed to provide medical care at a cost within the reach of all senior citizens. We note your efforts and those of your committee, Mr. Chairman, to improve Medicare, and we are grateful for your concern. However, the truth is that many senior citizens are not taking advantage of such health maintenance programs as are available because they simply can't afford them.

We have provided for your information and for the record, the results of a well senior citizen screening and referral clinic,* sponsored in our area through the senior program of the Community Action Agency, Inc., using local initiative funds from OEO plus many man hours from the local medical community and lay people. Of 120 persons screened, 60 were referred to their own physicians.

One of the problems now confronting those people who were referred to their own physician for followup is: How do I pay the bill? Remember we have a yearly deductible that you must pay and many of these people have not gone for any kind of a checkup because they had not paid that amount of money and didn't have it available.

* See appendix 1, item 7, p. 655.

Barriers to Health Care Listed

Jeff Wilson,* VISTA, serving in our area of health, lists three barriers to health care:

(1) Lack of an active preventive or health maintenance program at the local level. There are no clinics set up to encourage checkups through local health service programs and such checkups are expensive.

(2) The high cost of medical care. Medicare is inadequate as has been repeated many times this morning. Insurance companies are developing more and bigger plans for supplemental coverage which further reduces the senior citizens resources for life necessities in order to pay the premium. There must be money to be made in insurance.

(3) (a) There is a shortage of physicians who will take new patients. Many physicians are limiting their practices now rather than trying to "cover the whole waterfront" so they can provide a better quality of care.

(b) A shortage in some of the areas covered by the five northern counties of Idaho where no medical aid is available for many miles. We do now have in our area the first nurse practitioner serving an isolated area and we are very grateful for that.

(c) Fees that are above the "reasonable" amount that is stipulated by Medicare and other insurance charged by the doctors in our area.

Another barrier which I have had pointed out to me by many senior citizens is the problem of paperwork. The filing of properly completed forms with adequate support documents imposes undue hardships. This applies especially to people who have fourth or fifth grade educations and have not learned to read the legal material that goes with the documents. Another thing, the long wait between filing and reimbursement by Medicare and/or other insurances deters many seniors from making use of available moneys. Some of them say: "What is the use, I have to wait too long."

Of course, there is also the price increase explosion. I shudder to think what some of these prices will go to.

Several members of our delegation have prepared brief statements regarding barriers as they see them. They are too long to read but I would like to just cite you two of them.

This is a written statement by Dr. Edward C. Berry, president, North Central Idaho Retired Teachers and by C. Wamsley, president, Retired Teachers Organization of Asotin County, Wash.: Their statement goes this way:

> This comment is to call attention to the following items related to medical (Medicare) and problems in receiving health care.
>
> Medicare patients' appointment times are not honored in many of the clinics or doctors offices. The "so-called non-government patients" are given priority and many of the older citizens are forced to spend hours in the clinic waiting rooms to see their physician. This situation is distressing to older citizens and many men, in particular, will refuse to submit to this discrimination. These Medicare individuals are not receiving adequate medical care. This condition is often the result of the clinical staff and nurses, but it is a reflection of the physicians attitude toward the Medicare program.
>
> The cost of prescription drugs is beyond a reasonable price to many of the senior citizens and is not adequately compensated by the Medicare program at this time.

*See appendix 1, item 7, p. 655, for prepared statement.

And then from Emma Jones, who lives in Moscow, Idaho, we have this letter. She asks these questions:

Question 1.

Why doesn't Medicare pay the full 80 percent of the doctor? So many or practically all of my doctor bills have had an overcharge by the doctor making my part of the payment in most cases at least 30 or 33 percent. Why are the doctors allowed to charge so much more than Medicare will allow?

Question 2.

I have a notice which I attach which explains this question.

The notice is this:

"To all our Patients:

"Because of the tremendous increase in volume of insurance forms, the increased costs of billing and secretarial help; we have found it necessary to institute a small charge for completion of insurance forms. This will include all forms except North Idaho Medical Service Bureau.

"We feel that the information contained on our statements is complete enough to satisfy the majority of the insurance companies' requirements, and if a statement is submitted with a signed form the companies will probably honor this."

It is signed R. D. Brooks, M.D., and W. P. Marineau, M.D.

Then Mrs. Jones goes on:

I myself don't mind furnishing the stamp but I do object to them charging for filling in for their service charge on the Medicare paper. Most of we older people are not financially fixed to pay for all of these services in these high priced days and prices still going up.

Mr. Bryan Bundy, who is from our area and is very active has already submitted his statement* to the committee which does deal with the very problems of the medical profession having a problem with senior citizens or seniors having a problem with the medical profession. It does work both ways.

We have not touched in our record, in our report, on the dental care, nutrition, sight and hearing problems, that go unattended; not because the barriers do not exist but that time is too short in these hearing proceedings to cover these barriers.

Mr. Chairman, we appreciate the opportunity you have extended us to bring our views before your committee.

Thank you.

Senator CHURCH. Thank you very much. The written statements that you have alluded to will be placed in the appropriate part of the record.

Sister Helen Frances, do you have something you would like to say?

STATEMENT OF SISTER HELEN FRANCES, ADMINISTRATOR, ST. JOSEPH'S HOSPITAL, LEWISTON, IDAHO, AND PRESIDENT, IDAHO HOSPITAL ASSOCIATION

Sister FRANCES. Thank you ladies and gentlemen and Senator Church. I would like to add that I am not only the administrator of St. Joseph's Hospital, I am also president of the Idaho Hospital Association and have been instrumental in organizing two health center councils that we needed to coordinate health care services in north central Idaho.

The Lewis-Clark Valley Comprehensive Health Planning was organized under us, as well as the North Central Idaho Comprehensive

* See appendix 1, item 8, p. 656.

Health Planning, designated State agency, which received Federal approval for funding but it has not been funded as yet.

In regionalization of health care, funding for a new hospital facility at St. Joseph's revolved around financial matters in hospital accounting, which placed stress on increased internal controls and usage of departmental and capital expenditures budget. Medicare-Medicaid programs have made it a rule that hospital systems must be voluntary as well as administrative.

Quality care is a criteria of management at St. Joseph's and in carrying out the high standards set up by the Joint Commission on Accreditation of Hospitals. St. Joseph's is a community hospital and all employees have an obligation to serve the community needs. On a long range basis the new facility was planned to fulfill these needs but Federal cutbacks have indicated some of these objectives cannot be fulfilled.

Medical care has improved greatly in this century because of the growth of medical and allied sciences. Taking care of the sick elderly, who now comprise a large percentage of the average St. Joseph's Hospital's patient load, is a very expensive matter, requiring large amounts of labor and much complex equipment. Care cannot be mechanized like the production of cans, and so forth. It cannot be an assembly line operation such as an automobile factory. Productivity in the hospital at the bedside cannot be adequately measured because of the types of care rendered.

New Equipment Helpful

New equipment such as the cardiac pacemaker has aided in surgical procedures and in medical care. Complete total hip and knee procedures, unheard of 5 years ago, now replace worn out and painful hips and knees. Through our free arthritis clinics held at St. Joseph's by a group of medical staff physicians in conjunction with the arthritis clinic and dread disease funds, and medical consultants from Seattle, many arthritic sufferers are afforded some relief. This necessitates the use of physical therapy services. We will be unable to plan this service in the planned projected new construction, expansion program because of cutbacks in Hill-Burton 1973 funding, both grant ($1,300,000) and loan interest subsidy. Therefore, this service will not be expanded. The cutback or denial of funds has become a dilemma. In order to look ahead within budgetary constraints and economic controls, a determination has to be made relative to what methods are necessary to link the old with the new for greater integrated patient care. Our decision to build goes back 10 years but we had to pay off a debt on our new west wing, and for 5 years we have been endeavoring to comply the Department of Health's statement, which is now known as the Department of Environmental Community Services. We had nonconforming beds that should be replaced.

The successful control of many infectious diseases of childhood and young adulthood have allowed more persons to reach maturity through preventative medicine. The improved methods of the medical and allied sciences have been factors in increasing our aged population.

In planning for the future of Lewiston and surrounding areas, the total care of the aged, it is important to use the past as a guide, not as a hitching post. We must render all necessary services. We must provide social and economic, as well as spiritual, restorative, and respiratory services. This is a crucial service as among the elderly are many pulmonary invalids, subject to pneumonia and other chest diseases usually chronic, such as emphysema, pulmonary fibrosis, bronchial asthma.

Cardioviscular diseases causing limitation of activity such as heart blocks, requiring a pacemaker implant, arthritis, rheumatism, orthopedic impairments, hypertension, with or without cardiac involvement, mental and nervous disorders and impairment of vision. Paralysis following a stroke is a leading cause of limitation resulting in disability—physical therapy is treatment of choice for these aged. Speaking of mental or emotional disorders, loneliness is a disease, therefore, occupational therapy is needed not only for the aged but for all other ages. Diversity of activity is needed for rehabilitation. There is not a provision for this in our planned new facility because of cutbacks.

Unless the concept of prevention of deformities is uppermost in the mind of everyone involved with patient care, good medical care will fall short of its potential. Early prevention and rehabilitative methods in restoration potentials and in accepting and utilizing remaining functions rather than allowing his condition to become static or hopeless is of prime importance. According to the needs of the services planning for home service requirements on discharge should begin on admission.

I agree that the Medicare insurance program should be improved upon.

Government Reimbursement Decreasing

Government reimbursement is continually decreasing in its relation to reasonable costs in rendering the service to the aged. Not only our own, but the hospitals generally who have committed needed resources for needed expansion, find it almost impossible to pay costs of financing these needed expansion projects because of reduced reimbursement.

Our patient accounting is 35 percent Medicare, 20 percent Medicaid, and 45 percent all other, private or other programs for reimbursement, many of which are also limited. In all of these programs of care, the important factor of financing the costs becomes apparent. Forced to carry multiple and ever-growing responsibilities, the hospital is unable to plan for construction for expanded services. The emphasis is in the fact that Medicare and Medicaid reimbursements continues to limit the financial ability of hospitals to offer much of the medical services to the aged because the aged feel that they are unable to pay for medical services, since their own financial resources do not permit them enough to live a dignified life, commensurate with their need to exist.

I am grateful for this opportunity to appear in a public hearing as we are concerned with the means for fulfillment of a much needed expansion program. This has and will radically change the health needs and expectations of our people in our area. It requires imagi-

native thinking, courageous and enthusiastic action to define our health problems for the aging, set practical goals aimed at their resolution, and plan dedicated and intelligent strategy to overcome them.

I wish to thank you for permitting me to be here. And I want to thank Senator Church. And I ask God's blessing on his continued effort in improving health care in the State of Idaho and the entire region. He is one individual, one Senator, who has an understanding heart, not only for the aged, but from birth to the life beyond. Thank you very much.

Senator CHURCH. Thank you, Sister Frances. One of the earliest and perhaps one of the most successful Federal programs has been the Hill-Burton Act. And I think many of you have heard of the Hill-Burton funds. They are grant-in-aid funds made available through the Government to enable local communities to enlarge and modernize their hospitals to secure necessary medical care.

This program has been really indispensable. And I think without it, very few hospitals in the country could have expanded and modernized in the face of rising costs. I know many small communities would never have been able to provide adequate hospital facilities at all.

This year the administration proposed ending the program on the argument that we have enough hospitals and space and there was no further need to continue the program.

HOSPITAL SPACE VARIES THROUGHOUT COUNTRY

Well, one of our witnesses this morning pointed out that the availability of adequate hospital space is not even throughout the country. It varies from place to place. And it was in the testimony of Larry Belmont. He spoke of the situation up here in the panhandle of Idaho. He said in the panhandle district we have 77 physicians per 100,000 persons versus the national average of about 148 physicians per 100,000 persons. That is about half of the national average.

And we have one hospital bed for 230 people versus a national average of one for about 125 people. There again, the hospital bed average in the panhandle is about half that of the national average.

This demonstrates that it really isn't possible to say on the basis of the national average that a given program is really needed or not needed. You have to apply the program to the particular situation that exists from community to community and from State to State.

Now in Lewiston, I know your hospital has been very much in need of expanding its facilities. You have mentioned that in your testimony. And I would like to know whether in your case it would be feasible to go forward with expansion plans without the help of Hill-Burton money?

Sister FRANCES. We are progressing in that direction, Senator Church, without the grant, but it has been necessary that we have to cut back on some of the services.

Senator CHURCH. In other words, you are having to cut back on your expansion because of money not being available.

Sister FRANCES. That is correct. We are moving 61 nonconforming beds into the facility. This we must do because if you would visit our hospital, you would know there are only two toilets for 21 patients

and that is not to be. In our new facility we are providing all private facilities with a removable showerhead.

The gentleman that spoke ahead of me made me think of this. This would be of tremendous assistance to us. Right now we wheel the patient under the shower. But this would give them an added encouragement to take their own shower with a nurse standing by.

Many other facilities of this nature are being offered, but not in the areas where it is needed; like the preventive, respiratory type. And this still remains in the east wing but they cannot be expanded.

Senator CHURCH. Now you have carefully planned, I know, to try and meet the future needs of the community. And you have blueprinted your program for the future. How much have you had to cut back on this program because of the nonavailability of Hill-Burton money?

CONSTRUCTION COSTS PROHIBITIVE

Sister FRANCES. I think we have cut it back to $1,300,000 for the year 1973, as the fiscal year funds are not available to us, although they have been committed to us. I know Senator Kennedy is also interested in this area, so we are going on the assumption that we have the 1971–1972 committed, subject to the hospital's borrowing $4½ million. And the total cost of the project is $7.2 million which is quite an increase when you look back 10 years and the west wing cost $1.5 million. Construction costs today are so prohibitive along with the labor costs, that is 1½ percent increase per month.

Senator CHURCH. You are counting on getting that money?

Sister FRANCES. Yes.

Senator CHURCH. Counting on it being released in time for you to have it to figure into your program?

Sister FRANCES. Yes.

Senator CHURCH. If you didn't have it, this program would not be feasible, would it?

Sister FRANCES. Right, Senator.

Senator CHURCH. I see our time is running out on us and we have one more panel here. And I think I will defer the second question in the interest of time. I want to thank you both very much for coming.

Sister FRANCES. Thank you, Senator Church.

STATEMENT OF LOUISE MARTIN, DIRECTOR, ELDERLY MEDICAL PROGRAM, NEZ PERCE RESERVATION, LAPWAI, IDAHO; ACCOMPANIED BY WIL OVERGAARD, DEPUTY DIRECTOR, IDAHO OFFICE ON AGING, BOISE

Senator CHURCH. The last panel this morning consists of Mrs. Louise Martin from Lapwai, who is the director of the elderly medical program in the Nez Perce Reservation. And I am going to have you give us the Indian words because I don't believe I could quite get through them. And I hope you will give us the Indian name of that program, please.

She is accompanied by Mr. Wil Overgaard, deputy director, Idaho Office on Aging, who comes up from Boise and is here today and will introduce Mrs. Martin.

STATEMENT OF WIL OVERGAARD

Mr. OVERGAARD. Mrs. Martin has asked that I give you the name and it is Noon-Ta-Kehse-Nim-Ne-Mee-Poom, which in English language of the Nez Perce means Our Elderly Wise Ones Senior Citizens Program.

Mrs. Martin is the project director for this program. This program was initiated 2 years ago. It was developed by the people on the Nez Perce Reservation. It is their program and it was developed by them. And then our office had the job of putting it in the form necessary for it to be funded. But the project is operated and managed by the Nez Perce Tribe. The project director, Mrs. Martin and her companion, Mrs. Elsie Maynard, are the principal catalysts for this project on the Nez Perce Reservation.

STATEMENT OF LOUISE MARTIN

Mrs. MARTIN. Senator Church, the older residents of the Nez Perce Reservation have some health problems which are common to all the senior citizens in the United States and some which are found only among them because of the Nez Perce traditions, the rural character of the reservation, and because they receive the majority of their medical care through the Indian Health Service.

Although the health status of the older Nez Perce people has been constantly improving for many years now, the Nez Perce people, the Indian Health Services and others in the health field are working to continue the upward trend.

Of course, not all the health problems nor the barriers to overcoming these problems have been solved. It is the purpose of this report to point out some of the general health problems of the older Nez Perce people and the barriers which sometimes prevent an improvement in health for some individuals.

Because these problems and the barriers to their solution are listed here does not mean that they have never been solved or that methods to overcome the barriers have not been developed. The nature of health work and human nature being what they are require that these problems be identified and solved over and over again for each new individual.

One problem among the elderly which appears quite often is poor or inadequate nutrition. This problem is especially important because a person's diet habits can either create more health problems or help to control certain kinds of health problems depending upon the kind of eating habits he has. Health workers feel that the following statements are some of the barriers which prevent older people from developing a nutritious diet.

People living alone feel it doesn't make much sense to cook a meal for just one person. In some cases the person does not know how to prepare certain foods. There is frequently a lack of personal funds to purchase adequate food. There is frequently a lack of transportation to obtain food. There are inadequate home visits by health workers to check on how older people are doing. Traditional high quality foods such as roots, berries, fish, and venison are not available for a number of reasons.

INSUFFICIENT FUNDS FOR FOOD

The Senior Citizens Center lacks sufficient funds to provide one well balanced meal per day per person. Grandparents sometimes take care of grandchildren and this reduces further the amount of money spent on each person for food. Older people who have lived for a long time on low incomes have learned to like and eat only inexpensive foods high in carbohydrates.

The second general health problem of importance of the Nez Perce elderly is one of early diagnosis or sometimes even diagnosis of chronic disease. Some of the barriers to early diagnosis of chronic disease are seen as follows:

Elderly persons sometimes do not recognize or have knowledge of early symptoms of chronic diseases. Some symptoms come on so gradually that they are accepted as normal in old age.

Some persons have never seen a physician for a general health checkup or are not in the habit of regularly visiting a doctor.

Some elderly persons are incapable of arranging their own visit to a doctor because of senility, being uninformed about how to go about it, et cetera.

Another problem for the Nez Perce senior citizens is that of taking prescribed medications regularly and properly. Barriers to solving this problem are:

Some elderly people fail for a number of reasons to tell the doctor, nurse or druggist that they do not understand the directions for taking the medicine.

Some people just simply forget to take their medications. The patient sometimes becomes confused about taking medicines, especially if several drugs are prescribed.

Some patients become discouraged about taking their medicines if they do not improve quickly or their condition is one which cannot be cured.

Poor housekeeping, home maintenance, and general sanitation are also problems of the elderly. Important barriers to changing these conditions are:

Some persons are not physically capable of doing many kinds of housekeeping and maintenance tasks.

Some do not know how to do certain maintenance work and also they lack personal funds and transportation to obtain materials and help to do this work.

There is a lack of funds in the Indian Health Service and other Government agencies to provide enough homemakers services.

Some elderly people who live alone simply feel it makes no sense to do housekeeping and certain maintenance jobs around their home because no one is affected but themselves.

In some cases the housing is too inadequate to do proper housekeeping or maintenance work.

Also, some elderly people just don't want someone such as a homemaker in their house handling their things. They feel that they can have no real privacy.

RELATED HEALTH PROBLEMS CITED

Finally, another general health problem for these elderly is the lack of such things as glasses, hearing aids, and dentures. Some barriers to solving this problem are:

The need for such devices sometimes goes undetected as in other cases of chronic diseases.

There is a lack of Indian Health Service funds and funds from other Government agencies for obtaining these devices.

Some persons lack personal funds for even the small laboratory fees, as is charged for dentures, which are required of the patient.

Sometimes the person does not realize that these devices need to be changed as their condition changes, or that they need batteries or other maintenance.

Quite a few Indians are on Medicare and if they don't have enough money to pay the deductible costs, the Indian Health Service pays it for them.

Senator CHURCH. Thank you, Mrs. Martin. When I come to Nez Perce County, I hope to come out to Lapwai and I would like very much to visit with you then and to learn more about the special medical care program for the elderly that you have mentioned here. If you could show me around and give me a better idea of what you are doing at that time, I would appreciate it very much.

Mrs. MARTIN. Yes.

Senator CHURCH. Well, that concludes our panels this morning. You have all been very patient and it has been hot in here. I think maybe the man that has worked the hardest is Dwight K. Wells. He has had to take it down word for word. So I think we ought to give Dwight Wells a hand. [Applause.] Also I received a statement from Mr. Al Sarchiapone and that will be included in the record of the hearing.*

Is there anyone else here this morning before we conclude this hearing that would like to submit a statement or who would like to make a statement?

For the record, please, state your name and address and then proceed with your statement.

STATEMENT OF JOHN ERNSDORFF, ASSOCIATE ADMINISTRATOR, ST. JOSEPH'S HOSPITAL, LEWISTON, IDAHO

Mr. ERNSDORFF. Thank you, Senator. My name is John Ernsdorff. I am the associate administrator of St. Joseph's Hospital of Lewiston, Idaho.

The purpose of asking the permission of Senator Church to respond to a question that was submitted partly in testimony of the Hill-Burton Fund cutback as programed for St. Joseph's Hospital is what effects that cutback would have on our planning for both, let me say, built in equipment or brick and mortar, if you will, as opposed to again offering more extended services for not only the aged but for all of those who require special services like physical therapy, and so

* See appendix 1, item 2, p. 647.

forth, rehabilitative services, and home health and preventive medicine.

So, Senator, what I would really like to say is that the cutback in the Federal Hill-Burton assistance to St. Joseph's Hospital in effect and in essence would to a major—not a major degree, but to a significant degree, mean that the hospital in using its financial resources including fund raising from the community for building and equipment, to repay those would mean that our future financial resources would need to be used more for the repayment of a loan as opposed to the ability to offer these services for the aged as talked about this morning at a very reasonable cost and/or without cost, as we do need to offer more of these for the fixed income aged.

Senator CHURCH. Thank you very much, John. You remind me of my early experience as a boy when I was attending church and every Sunday we heard about the mortgage. And until we got that mortgage paid off we never did get around to the word God. So we don't want the hospital to be in that fix. [Laughter.]

Mr. ERNSDORFF. Thank you, Senator Church.

Senator CHURCH. Thank you very much. I have another request here from Faye Rebenstorf, who would like to make a statement. And I would invite her to come forward at this time. She is the Idaho Assistant State Director of the AARP.

Apparently she has left, but we will accept whatever statement she has to submit in writing and we will keep the record open for that purpose.*

That concludes our hearing this morning. I want to say how much I appreciate the fine testimony that we have received and the fine audience. I think that demonstrates the importance of this subject to elderly people. Many good suggestions have been made and we will sift through those as we conduct these hearings throughout the country. We are learning a great deal about the present deficiencies in the program. And we hope to pass legislation that will help to improve and strengthen the program.

Among the many suggestions that were made this morning, there are three that will stick in my mind. One is the desirability of including prescription drugs for chronic illnesses within the coverage of Medicare, along with many other suggestions.

The second is the desirability of emphasizing and enlarging home care services to avoid the need of hospitalization or institutionalization, or nursing homes.

Third, the importance of preventative medicine and design of a program to better accommodate physical examinations and other procedures that will help to detect and then to give early preventative care, rather than waiting until the final stage of illness requires costly institutional care.

All of this has been very helpful to us who have sat through these hearings. I thank you very much. [Applause.]

[Whereupon, the hearing was adjourned.]

* See appendix 2, p. 670.

APPENDIXES

Appendix 1

LETTERS AND STATEMENTS SUBMITTED BY INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTERS FROM LARRY M. BELMONT, DIRECTOR, PANHANDLE HEALTH DISTRICT NO. 1, TO SENATOR CHURCH, DATED AUGUST 13, 1973

DEAR SENATOR CHURCH: The Panhandle Health District appreciates very much your past assistance and interest in our home care program. We feel that your recent hearing in Coeur d'Alene brought the Federal level a little closer to the grass roots.

You also asked some specific questions about in-home service in our area. We are happy that you raised these issues for many citizens, home care patients, and public employees feel that home care is a forgotten health care concept. This is unfortunate for home care is a reasonable solution to part of the spiraling cost of medical care in the United States. It is by no means a single panacea, but when coordinated in an appropriate manner, it has important relationships to all elements of the medical care system. Home care at this time is focused primarily on care of the elderly due to title XVIII and title XIX of Social Security which is the primary sources of funding for home care. We have been working to expand this limited role to relate to other elements of the population as well as other funding mechanisms.

At present, we are not entirely dependent upon Medicare for our program. We feel this may be the main reason our program is still viable. This is important because a recent study by Caro and Morris entitled "Personal Care for the Severely Disabled" shows that there are almost as many functionally handicapped and disabled persons under the age of 65 as there are over 65. Therefore, home care is certainly relevant to the over 65 population, as well as the under 65 population. Indeed, we have developed a project that will relate to many health problems as well as many sources of reimbursement for home care. This project will pull together many elements of the medical care system, but it has not been funded by RMP to date.

This project is important to the Panhandle of Idaho because Kootenai County has one of the fastest growth rates in the state of Idaho. The Panhandle Health District's population exceeds the national average for persons over 65 and over 60 years of age. The national statistics show that 9.9 percent of the national population is 65 and older, and 14 percent is 60 years and older. All but one of the counties of the Panhandle Health District exceeds these national statistics:

In Benewah County, 17 percent of the population is over 60 and 12 percent is over 65.

In Bonner County, 18 percent is over 60 and 13 percent is over 65.

In Boundary County, 17 percent is over 60 and 12 percent is over 65.

In Kootenai County, 16 percent of the population is over 60 and 12 percent is over 65.

Using 1970 data, 16 percent or about 13,300 of the total health district's population is older than 60 and 11 percent is older than age 65. Both figures exceed the national average. This indicates to us immediately that there is a very important need for home health services in this area just for the elderly.

The National Health Survey defines "limitation of activity" as a "measure of long-term disability resulting from chronic conditions." It is the "inability to carry on the major activity for one's age and sex group such as working or keeping house or going to school." In 1969 and 1970, it was estimated that about 12 percent of civilian noninstitutionalized population of the United States had reported some limit to their activity as a result of a chronic disease or impairment. If we applied that statistic to the population in the Panhandle Health District, we would find 10,440 people with some limitation due to a chronic disease, disability or impairment who could benefit from in-home service.

Even so, many of us feel that we must change the present concept of home health. It must be realized by all health providers, federal, state and local agencies regulating health services, that supportive and/or maintenance care of individuals with long-term chronic disabilities is not an inappropriate health concept, but an important element of medical care.

In summary, the number of people who can benefit from home care would vary from our present patient load of 130 to 13,000. This, of course, will eventually depend upon what in-home service is allowed to become.

If there is anything the Panhandle Health District can do to help in-home service become more relevant to the medical-care system in America, please call upon us at any time.

Sincerely,

LARRY M. BELMONT, *Director.*

AUGUST 10, 1973.

DEAR SENATOR CHURCH: Here are two letters from our patients who live well out from Coeur d'Alene.

They tell the story of home care better than any of us bureaucrats.

Sincerely,

LARRY M. BELMONT, *Director.*

(Enclosures.)

RATHDRUM, IDAHO.

DEAR SENATOR CHURCH: I would like to let you know how much I appreciate what you are trying to do for the aging.

I am a widow and live alone, and my health is very poor, and it gives me a great deal of pleasure and satisfaction to know that we have the home health care program. I live at Twin Lakes, Idaho, across the lake, and it is hard to get to especially in the winter, you have to walk in, but bless the nurses, they come with smiling faces, which I am so grateful for, just to know someone is checking on you, means so much.

Do hope you will be able to do something about the out of hospital prescription drugs, as mine run between $30 and $50 a month, which is quite a sum out of my small income, plus a large tank of oxygen that I have to take three times a day

I am a native of Idaho, was born in Old Town Pollack down on Salmon River.

Good luck to you in all you are working so hard for.

Sincerely,

INAZ A. WHITEHEAD.

BAYVIEW, IDAHO.

I feel it my duty to write this letter in regard to the home services of the north Idaho medical program sponsored by Medicare.

Last October my wife Ona Mosher had a stroke which left her partly paralyzed.

The health unit sent two nurses out to our home twice a week for 6 months. One nurse came on Monday, then one came on Thursday. Each one gave her a bath and helped her with therapy treatment in some way or other.

Then about the first of March my wife had another light stroke. So the nurses are coming to see her once a week now. If the health unit had not sent these nurses and paid for them my wife wouldn't have had this care as my income isn't enough to pay for such treatment. So we are both thankful for this service.

Sincerely,

Mr. and Mrs. J. N. MOSHER.

ITEM 2. LETTER AND ENCLOSURE FROM ALDO P. SARCHIAPONE, FRUITLAND, IDAHO, TO SENATOR CHURCH, DATED AUGUST 3, 1973

DEAR SENATOR CHURCH: I wish to submit the attached exhibit, a study of the elderly men and women throughout the world, for the record at your meeting of the Special Committee on Aging in Coeur d'Alene, August 4, 1973.

The study was made in the last year or two under the fellowship grant of Alicia Patterson, by Mr. Nada Skerly, a noted researcher and writer and now a recently appointed member of the Newsday staff.

I sincerely hope Mr. Skerly's findings will be of some interest and help to you and your committee when next you meet to consider new Social Security legislation . . . hopefully, for the many millions of poor but neglected men and women in the 50 to 60 year-old group, as well as for those in the 60, or over, group.

Best wishes for a most successful meeting.

Sincerely,

ALDO P. SARCHIAPONE.

[Enclosure.]

RETIREMENT YEARS ARE HAPPIER IN SOME COUNTRIES

[Mr. Nada Skerly, now a member of the Newsday staff, spent the better part of a year recently studying the problem of the aged around the world, on an Alicia Patterson fellowship. Here is what Mr. Skerly said about his findings in a newspaper reprint in 1972:]

You complain for years about the low pay, long hours, dumb boss and grouchy coworker. You say you can hardly wait to sleep late, paint the house, putter in the yard and maybe take a trip South.

But soon after you've retired, you wonder how you can afford it, financially and psychologically. Inflation, taxes and medical bills eat into savings. You worry about maintaining the house and the grounds and how long you'll be able to drive. Worse, you agonize over becoming a burden to children or family, and that nasty alternative of nursing home looms as a possibility.

Modern medicine has extended the lifespan, but have we managed to add life to years? To make the so-called golden retirement years more than a tarnished myth?

Dr. Ian Goldfarb, a New York geriatician and psychiatrist, says. "It doesn't pay to get old in this conutry, with some qualifications, unless you've got money. It's better to be rich and sick than poor and healthy."

Social Security analyst Paul Fisher of Washington, D.C., agrees. "Elsewhere in the world," he says, "retirement is a right and pension moneys are provided. In the United States, it is a right to die fast."

A 1-year study of the aged around the world, sponsored by the Alicia Patterson fund confirmed that. The social welfare mecca of Scandinavia, for example, offers cradle-to-grave security with numerous fringe benefits in between. The Danes boast that they solved the problem of the elderly with legislation back in 1891.

In Denmark, the aged—rich and poor—get good pensions (for which they paid during working years) plus a number of free services. The handicapped (including victims of arthritis and stroke) get household renovations; spring-seat wheelchairs; cleaning, food, laundry, and nursing help. City fathers pay for holidays abroad and adult education seminars. They also provide transportation to doctors' offices, recreation centers, podiatrists, and hairdressers. They reason that looking well and socializing is part of feeling great.

At Tranehaven, a dazzling $2.6 million geriatric health spa outside Copenhagen, individuals with minor problems get thorough physical and emotional checkups. There also are cheerful attendants, tea parties and Saturday night dances. In a few weeks or months, when they are ready to leave, they know how to tackle life anew. The community pays the tab and the back rent. The only drawback is that children feel the government is doing it all and so they withdraw emotional support as well.

Other industrialized societies, like Italy and Japan, lack social-welfare programs for older persons. But family ties are strong and individuals are recognized for their personal worth, not their productive output.

Poland is an exception. A worker there experiences the same plight that his U.S. counterpart does. Once out of work he also is out of life's mainstream. There is a place in the worker society only as long as one is productive. After that, the children are expected to take over support. Communist party officials say that theirs is a young, developing government and the investment is in youth. There is no return on the aged.

In the United States, your status hinges on your job, on being a former bricklayer, executive or whatever. You also bear the tag "senior citizen," as though you weren't a citizen before.

Elsewhere in the world, there is no special epithet for the elderly because everyone knows aging begins the day you were born. The retirement period is just another phase of life. Here in the United States, aging means 60-plus, wrinkles, rocking chair, depression, and a prelude to dying.

By comparison, in Italy, Austria, and Japan, it's good to be old. In fact, preferable. Retirees there are happy to be done with the pressures and insecurities of youth and to relish positions of respect and reverence. It's a time for new wine and old friendships.

In Vienna, a geronotocracy where the aged represent 36 percent of the population, 45-year-olds actually gray their hair for credibility. Youth imitates age by affecting pompous old-world manners and dress.

Age commands authority—and promotions. The older a woman becomes, the more often her hand is kissed. And even a laborer's wife grown old gets a courtly nod from the butcher and a sweeping "good day, most gracious lady." This is one city where traffic stops. Not for a curvaceous blond, but for a sauntering old gentleman with a cane and a Stetson who wants to cross the street—against the light.

Italy is a world unto itself with mamma taking a front seat, both in the family and in her son's Fiat. Older parents still are consulted on such major choices as a new mate or a job.

Even in Japan, a country sometimes falsely accused of being Americanized, "senior citizen" would translate into "most honorable superior." The older you get, the deeper the bows from subordinates (who include wife, son and underlings). Job status depends on seniority rather than on ability, and ambition is frowned upon. Retirement at 55, however, doesn't mean going home to your wife and carping about her tea-making. Your contacts arrange a second career and subordinates from your first job take you out for drinks regularly.

Despite Japan's industrialization blitz, tradition and social values haven't been tossed out. Extra money goes to an aging father rather than to a second car or for "things." The selflessness reflects a sense of obligation to parents for their "sacrifices." The trouble with the United States, says a Japanese, a former Yale scholar, is that self sufficiency and independence are fostered and one winds up old, independent and alone.

The Japanese, as well as eastern societies, have a more fatalistic life outlook and anticipate less with age. We expect life to keep getting better. "There's a hitch, though," says a retired Navy man's wife. "You're geared to expect and maintain a certain standard of life, but it seems to fall apart when you retire. In this land of plenty, there's something wrong about that."

For obvious reasons, we are different from other societies and have reason to be proud of the positive qualities that keep us going. Through wars, depression, disasters (natural and personal), older persons have proven resilient, resourceful, independent and scrappy. Above all humorous, although it sometimes gets buried under feelings of uselessness and inadequacy.

After schooling the children and working for decades, there is no reason why one can't branch out and explore whims and talents and have the proper financial and psychological climate in which to do it. In this age of women's liberation, maybe it's time to think about aged liberation as well.

[The forgoing study of the elderly was also published in the Idaho Daily Statesman, April 24, 1972.]

ITEM 3. LETTER FROM HAZEL CORBEILL, KELLOGG, IDAHO, TO SENATOR CHURCH, DATED AUGUST 8, 1973

DEAR SENATOR CHURCH: I was unable to attend your special meeting with the senior citizens in Coeur d'Alene on August 3, but, being anxious to express my views, have decided to communicate this way.

I am increasingly and painfully aware of the rising cost of everything for anyone on a fixed income and especially aware of the inadequacies of Medicare in some instances.

There is certainly no justice in the proposed increase in the cost of Medicare based on the theory that the increase in Social Security should justify the same. The skyrocketing cost of food is no secret and that is naturally more distressing to those on a fixed income. Aside from that, just a quick look at other cost rises is alarming.

My husband and I operated a small flower shop here for 27 years. We knew we had only one possible way of adding to our Social Security for our retirement and that was money in the bank, but accumulating a savings account was a slow and hard-fought battle. Every time another strike hit one of these mines in this district, the small businessman suffered, in loss of business, in loss of accounts that were not paid by persons who moved away, and also by the need to deplete savings to pay rent, utilities, etc., on the business premises. However, we did get enough in the bank that I could count on approximately $120 per month income to add to the Social Security. My husband's health became so bad we were forced to close out the business and I could not look for other work because I had to care for him. Fine.

We retired in 1970. At that time, water cost us $2.50 per month; the minimum amount is now $8.75 for 600 cubic feet, and it is really difficult to run a household on that minimum, especially in summer. We did get on the senior citizens low rate on our property taxes, but it was $65 in 1970 and will be over $70 this year. There will soon be a regular charge on sewer service, the amount not yet determined. The cost of the TV cable service has increased from $3.50 per month to $4 per month. In the winter of 1970–71 our fuel bill (oil furnace) ranged from $27 to $34 per month; in the winter of 1972–73 the bill varied from $32 to $47 per month and will no doubt be much larger this year. If I am not mistaken, the telephone rate also went up 50 cents per month also since 1970, or it may have been just prior to that. And if anyone needs a telephone it is the older folks.

In 1971, when my husband was almost 70 years of age, he suffered a coronary occlusion plus, at the same time, bleeding ulcers. He was in cardiac unit for 10 days and intensive care most of 6 weeks. We appreciated Medicare then, believe me. But have learned of its shortcomings since.

After my husband was released from the hospital in 1971 (November) I cared for him at home. He was comfortable and contented, could walk in the house or to visit closest neighbors, but was increasingly confused and unsure of himself. Then, this spring, he had a series of small strokes, and in March a massive one. Finally, after being back and forth from the hospital to our home, he had a final 3 weeks in the hospital and was moved from there to the Shoshone Convalescent Center. That's when I learned that Medicare is sorely lacking.

This man cannot talk, cannot comprehend anything said to him, rarely knows me when I go to see him, has no control of bowels or bladder, cannot feed himself, and, partly because of paralysis and partly because of brain damage, cannot direct the movement of arms or legs at all and must be cared for like a baby. I cannot do it at home. The hospital cannot keep him there. So it must be a rest home type of care, and Medicare does not cover this situation. Also, as you know, Medicaid, in Idaho, is for those who are quite indigent or have minor children, etc.

I write this case history, not in the hope of obtaining redress for our case but rather to direct attention to the fact that there must be countless others who, like us, have striven to be hardworking, honest, independent citizens all their lives. Then, when they do retire, they uncomplainingly try to live decently, but within their budget and with always a thought that there should be a little extra laid by for a rainy day.

So here is the situation: I have to dip into those meager savings every month to cover the rest home bill. He may pass into that final sleep today . . . or he may live in this condition for 10 years. Each month the savings become less, each month that $125 dwindles and will soon be nonexistent. We have sold our car. I am cutting corners, just as any other wife in my situation would be doing. If my husband dies soon, I will continue to be independent, but if the savings are exhausted before he passes on, it means that both he and I will be on welfare.

Which brings up this thought: How many widows in this country are on welfare today because all the savings were exhausted in caring for the husband's terminal illness? I am 64 years old now, in excellent health, but scarcely an age

to try to cope with the labor market. I see a very real need for rest home coverage in Medicare, and I do not mean only such rest homes as have a full staff of doctors on duty either. I mean places like this one where the care is wonderful, the staff well trained, and it is practically adjoining the doctor's clinic and expert medical attention can be had almost immediately.

I urge rest home care based on physical need rather than financial need.

Speaking of doctors . . . I maintain they are still striving to create dissension with Medicare. For example: Every doctor's bill I have received is approximately one-third more than the Medicare allowable charge. Even when the doctor just walks into the room and glances at the chart, and even if the patient is asleep when this happens, and even if there are two or three other patients in that room receiving the same kind of attention, the doctor bills $10 for that call, the Medicare allowable charge is $6.

I hope that this letter may be of some assistance to you in the fight I know you have been waging in our behalf.

Thank you.

Sincerely,

HAZEL CORBEILL.

ITEM 4. LETTER FROM MILDRED BERRY, RN, PHN, PRESIDENT, IDAHO ASSOCIATION OF HOME HEALTH AGENCIES, TO SENATOR CHURCH, DATED AUGUST 23, 1973

DEAR SENATOR CHURCH: This statement on home health services is provided for inclusion in the report on "Barriers to Health Care for Older Americans". On behalf of the Idaho Association of Home Care Agencies we would like to express our concern regarding this issue.

Due to the geographical area of Idaho, it is strongly felt that the home care program is not only desirable but essential. Many areas do not have sufficient facilities to provide the care and in many instances care in a facility is not needed or desired by the patient or family. We would hope that care for the patient could be at home with intermittent professional services as well as supportive services such as homemaker and home health aide. When the individual is seen at home the cost is less than to institutionalize.

At the present time the at-home benefits are maximum but to establish them and proceed with the present funding system has brought hardship on both the patient and the agency providing care.

The legislation introduced for training of suitable personnel (nurse practioner) would certainly assist the patient where limited physician and nurse services exist. As pointed out in the hearing August 4, in Coeur d'Alene, many patients need care but it is nearly prohibitive for the physician and even the agency personnel to make home calls. When the nurse makes a home call now, it is to serve as the "extended arm of the physician" and to detect possible problems early and report to the physician and/or refer to the appropriate resource for the patient. More expertise in this already existing function for patients at home certainly would benefit the patient and extend an even better service. Costs of further training has essentially been borne by the agencies. Unfortunately, no monetary return is present to provide better service. (Medicare does not honor nurse practioner, etc.)

Transportation for the patient to see his physician even one time per month or one time per year is virtually nonexistant. Driving to and from the physician's office seems routine but the elderly no longer drive and many have no relatives and friends are of the same age group and having the same problems. Voluntary agencies are excellent but are usually able to service a small circumference. The agency may be the only group whereby services to the patient are given in the home.

Preventive health care, annual checkups and providing care on a limited basis may essentially reduce not only the patient's costs but hospital and skilled nursing facilities costs as well. If the initial contact for the patient is due to illness, when the "well-er" condition is gained, the Medicare program no longer provides funds for the patient. If no services can be rendered the patient returns to his illness stage again and perhaps even becomes hospitalized and/or needs twenty-four hour care. It would seem that the patient is chastised for being healthy.

Use of a yearly physical may ward off more serious conditions or even prevent some illness. If intermittent care is needed, it should be available before more concentrated services are necessary.

Often needed medications are prescribed but monies to buy them by the patient are not available.

The under use of home health services has been documented numerous times. Medicare has paid for good quality care but mostly of institutional type. The cost of home services are considerably less but there has been no change to provide funds for these services.

To give proper care there must be made available the proper supplies, medicines and equipment or total comprehensive care is severely lacking.

We would like to thank you for this opportunity to state our concerns and hope you will consider these points in an effort to provide better care and fewer barriers for the older American.

MILDRED BERRY, RN, PHN, *President.*

ITEM 5. POSITION PAPER OF THE IDAHO MEDICAL ASSOCIATION WITH REFERENCE TO HEALTH CARE OF OLDER AMERICANS; SUBMITTED BY E. R. W. FOX, M.D., PRESIDENT, IDAHO MEDICAL ASSOCIATION

The problem: (1) Availability of care, (2) cost of care, (3) quality of care, and (4) quantity of care.

1. AVAILABILITY OF CARE

The Idaho Medical Association rejects the premise that "50,000 more doctors are needed" to serve the health care needs of the American people. The physician population is increasing at a rate of two to three times faster than the total population. We are aware that some counties in Idaho, with a population of perhaps four people per square mile, have no physician.

There are very few settled areas of the State that are not within reasonable travel distance of medical attention. As more doctors come to Idaho, it is reasonable to expect that this situation will change.

2. COST OF CARE

The rapid rise of expenditures for Medicare and Medicaid has alarmed the public and has focused the attention of our legislators on ways and means to control cost. Unfortunately, a preoccupation with cost can have an adverse effect on quality.

Furthermore, we physicians have resented the implication that the cost of "health care" is synonymous with the cost of "doctor care." Statistics from the U.S. Department of Labor reveal that the medical profession has kept its fee increases far below the inflationary level seen in practically every other segment of our economy.

Long before the passage of Public Law 92-603, physicians recognized their share of the responsibility for controlling health care costs, and have instituted numerous measures designed to assist in limiting, by voluntary means the cost of care, both in and out of the hospital, as well as for all patients regardless of whether their payment was to be through private or commercial carriers or by Government funds.

The methodology was not universally the same, but various means of medical care evaluation were introduced, utilization review committees were set up, and length of hospital stays were carefully monitored. In addition, here in Idaho, we have physician-sponsored medical service bureaus, with active review boards whose members effectively survey the work of their colleagues.

3. QUALITY OF CARE

The quality of service rendered has always been the primary concern of practicing physicians. This has been the result of training, the spirit of competitiveness, and the sense of personal pride of physicians who are engaged in provding direct patient care.

The medical profession has expressed concern lest the thrust toward cost control might result in impairment of the quality of medical care. So far, this has

not happened. You are aware that in Idaho the length of stay in hospitals is far below the national average. And the quality of care most certainly has not suffered.

Idaho physicians, individually and collectively, voluntarily engage in continuing medical education, constantly upgrading their ability to render the highest quality of patient care.

4. Quantity of Care

During the Coeur d'Alene hearings, no one really complained about the quality of health care, but everyone, including Senator Frank Church, kept repeating that we need a greater quantity of care: more doctors, more nurses, more medical assistants, a longer stay in the hospital, more free drugs, dentures, eyeglasses, more of everything.

This may get votes, but the Idaho public has a right to expect its legislators to exercise some wisdom and prudence.

The voters have the right to expect their legislators to study the health programs of countries where medical care has been nationalized and the public has a right to expect our leaders to avoid the pitfalls that have befallen the Governments that succumbed to the siren song of "free" medical care.

A few of these are: Serious overutilization of office and hospital care, reduplication of prescription items, assembly line care of patients, unhappy, striking doctors and nurses, "feldshers" and "mid-educated" doctors, emigration of doctors, waiting lines for patients, waiting lists for surgery.

These are the facts of life in countries that have nationalized health care. These are conditions the American people would not tolerate.

Let us not promise more and more luxuries. Let us instead practice fiscal responsibility, at the same time preserving the genuine values of the finest system of medical care in the world.

The Solution

We contend that the physician is a small part of the problem, yet certainly he can be a major factor in the solution. But the responsibilities for searching for solutions to our health care problems must be shared by the institutions, the public, the Congress.

Some of the steps physicians are already taking include the following:

(1) We are encouraging patients to "get well quickly."

(2) We are trying to educate the families of elderly patients to believe that hospitals, with room rates at $70 to $80 a day, are for acute medical care.

(3) We are setting up time tables for estimated length of hospital stay for all categories of medical and surgical cases.

(4) We have review committees to evaluate the need for continued care.

(5) We encourage patients and their famiiles to use home care and ambulatory care whenever possible. Home is still the best place for the ailing patient.

Institutions

(1) Hospitals should accept the philosophy that they are primarily for acute care, and cooperate with the physician, the patient, and the family to that end.

(2) The financial structure of "for-profit" nursing homes should be under close surveillance.

(3) Allowances for care in a nursing home for less than skilled nursing care should be liberalized. It makes sense to move a patient out of an $80 hospital bed to a $20 extended care facility bed, as an intermediate step to return to their home.

(4) Some consideration should be given to relaxing Medicare-Medicaid restrictions on payment for so-called "shelter care." The ambulatory but homeless elderly person deserves the healthy, happy home that can in many areas be given to him at $10 a day or less.

(5) Home care in familiar surroundings is, of course, the best for the patient. Home health care can be cautiously expanded.

The Public

(1) The media, Congress and health writers should stop raising the expectations of the public. Unfortunately, there is a limit to what we as providers can provide, and to how much we as taxpayers can spend.

(2) In the same way, the public must be convinced that the care of the aged is, first of all, our problem here at home. Society must never allow Government to usurp the responsibilities that belong to the family.

(3) The public must be made to realize, as they apparently have in auto insurance, in health insurance, in fire insurance, that first dollar coverage is never worth the exorbitant premium.

CONGRESS

(1) Our lawmakers should welcome the input of physicians and physician organizations. Doctors are, for the most part, public spirited citizens. And the polls show that they do influence voters' thinking.

(2) Congress, in its deliberations on health care, should guard and preserve the fundamental characteristics of American medicine; the person-to-person, patient-doctor relationship. Nationalized or federalized medicine is poor medicine, in which the patient is no longer dealt with as a person.

(3) If national health insurance is inevitable, as we are being led to believe, then our legislators should see to it that certain qualities of our present practice of medicine are retained, and that certain basic needs are met such as:

(a) Coinsurance or deductible clauses should be maintained. We have learned, as have our neighbors to the north, that people appreciate least, and over-use most, the services they get for "free."

(b) Catastrophic illness, though comparatively rare, still can be a tremendous setback. This coverage, available for the price of a pack of cigarettes a day, can be a boon to the patient and his family.

(c) Most people believe that government is often wasteful and a poor substitute for private management in business enterprises. They believe that health insurance, whether national or individual, should be underwritten by the American insurance industry.

(d) Extension of ambulatory coverage would greatly decrease costs. Now patients insist upon being hospitalized because "If I am in the hospital, it will be covered by insurance (or Medicare)".

(e) The insurance must allow freedom of choice, both as to physicians and hospitals. The American public insists on the "voluntary" approach. The spirit of independence is our cherished heritage.

In summary, preserve those attributes of American medicine that distinguish it from the nationalized medicine of socialist and communist countries.

Encourage family practice, and the family practitioner.

Most every older American has a physician whom he calls "my doctor"—a most prized possession.

And, over the years, the confidential patient-doctor relationship, with its protected privileged communication, served to keep medical care a personal thing.

Let us not legislate away this valued privilege of the American public!

Respectfully submitted,

E. R. W. Fox, M.D., *President.*

ITEM 6. PREPARED STATEMENT OF BERT RUSSELL, CHAIRMAN, HARRISON CHAPTER, NATIONAL COUNCIL OF SENIOR CITIZENS

TRANSPORTATION

GENTLEMEN: Directly following the needs of the elderly for medical attention in States where small towns and rural conditions predominate, like Idaho, is the need for transportation. In this respect Idaho is typical of many western States and of the midwest where small towns are ghosting into unimportance and offering little or no medical and other services.

On the face of it, it would seem that the problem of transportation for the elderly in such areas would be a dwindling one but this is not so for the reason that a reverse direction of people from the cities to the land is taking place as more and more elderly and those approaching the elderly status are seeking spots for retirement. With our urban population pressure to escape from pollution ridden cities, the problems of transportation of the elderly for medical and other services in rural and small town areas will increase.

My statement herewith is based on personal observation and general knowledge unsupported by graphs and figures. I believe, however, that the detailing of conditions and needs in one small area, like that of the Harrison-Medimont-Rose Lake area, can shed light on conditions existing elsewhere.

The farm population in this area has an average estimated age of 58 years. Age and physical condition leaves people no longer able to get driver's licenses. Residents are then left in a position of putting the bum on friends or relatives when they need to see a doctor in St. Maries, 24 miles away; or Coeur d'Alene, 28 miles; or Kellogg, 36 miles. Having always made their own way against competition and weather, these people are fiercely independent and will sit tight until their condition is critical.

The same holds true as well for retirees coming out of the cities. They, too, tend to be isolated and independent.

Our experience shows that such people will not use volunteer transportation, even when it is offered on a well advertised basis unless a senior citizen organization is formed, social closeness established and personal friendships, and even then the service will be asked for only in case of great need and accepted with an inevitable insistence on paying.

Of course there is an alternative to sitting out in the brush or a small community. The elderly one can sell his home, leave friends, neighborhood organizations, garden plot and the security of familiar surroundings and move to a center like St. Maries, Coeur d'Alene or Kellogg which offers medical services.

This change is made at considerable financial loss since city property costs far more than rural or small town and the fear of becoming another one of these alone and friendless "city people" makes the elderly reject this course until their condition becomes desperate.

We have witnessed the selling out and the moving of couples to a large center when one of them is in swiftly declining health. After the one dies, the other, now committed by ownership of a small house to living in the city, will return again and again like a lost soul to the community and friends and organizations where he has lived much of his life, seeming to feel that he belongs nowhere. In a year or two he becomes uncertain and forgetful and his health, though excellent in the beginning, starts to decline.

Public transportation could have allowed him and others like him to remain among his friends and living the healthful routine for which his life has fitted him. But in this area, as in many others, there is no public transportation outside of the mailman's bus, and this follows a schedule exactly counter to the needs of the elderly.

For example, our mailman who will carry passengers, freight, beer and prescriptions, leaves St. Maries, which has doctors and hospital, about 10 a.m., 6 days a week, proceeds to Harrison, population 250, and having no doctor or nurse, at 11:30 a.m. peddling mail along the way. From Harrison, another mailman makes a spur run some 20 miles along the summer home shore around Lake Coeur d'Alene. But our mailman from St. Maries goes up the Coeur d'Alene river to Medimont, population 30, and beyond, delivering mail and returns to Harrison at 4 p.m. He then leaves Harrison and arrives back in St. Maries at 5 p.m.

An elderly person in need of medical attention can climb into this mailman's bus anywhere along the route, make the round with him for the day and arrive in St. Maries at 5 p.m., at a time when the doctors have gone home for the day. He can stay overnight, see a doctor the following afternoon (the doctors are generally occupied with hospital calls and surgery during the mornings), stay overnight again and return home with the mailman next day. Having spent at least two half days on the mail bus, two nights and one day in St. Maries, he should be even sicker than when he started and if his income is small, like most people on Social Security, he will most certainly be broke.

We need cheap public transportation which goes in a reverse direction from the outlying area into the main center, leaving in the morning and returning in late afternoon, so that sick people can reach and return from doctors with a minimum of misery.

For really critical cases we need an ambulance with volunteer but trained personnel.

For off hours emergency visits to doctor and hospital we have volunteer cars and drivers but the volunteer cars should be reimbursed on a mileage basis—not so much because the owners of such cars are unwilling to donate their services but because public knowledge that such owners are being reimbursed would make a vast difference in how often their help would be requested.

P.S. I have concentrated here on transportation needs only in connection with medical services. To maintain mental health and reduce isolation, a public bus

system is needed also to bring people together at various meeting places like the Medimont Grange Hall or meetings and potlucks of the Harrison Chapter of the National Council of Senior Citizens.

Another prime need is a public bus system to bring the elderly into town for shopping.

Very truly yours,

BERT RUSSELL, *Chairman.*

ITEM 7. PREPARED STATEMENT OF JEFFREY KENT WILSON, VISTA

One of the issues the Banana Belt Senior Citizens have had to deal with is the lack of a health care system with an emphasis placed upon preventive medicine. As a result of this there is no provision made for providing senior citizens with a reasonable means of access to preventive health care services. This constitutes a barrier to health care for the senior citizens in our area. A senior citizen living on a Social Security income of $200 per month cannot afford to pay the fees needed for an annual physical checkup. Thus even though senior citizens are a high risk group for pathological abnormalities, many times the low income senior citizen will procrastinate going to a physician until a crisis situation develops.

In an attempt to help our senior citizens avoid costly delays in their health care, we are attempting to provide health screening clinics for the senior citizens in our area.

The first such clinic was held in our area June 9, 1973, and provided the following services free of charge:

(1) Examination of the chest and lungs by a physician.
(2) Blood pressure and pulse reading.
(3) Height and weight measurements.
(4) Multiphasic blood screen (panel of 12 blood tests).
(5) Hemoglobin and white blood cell count.
(6) Urinalysis.
(7) Pap smear.

One hundred fifteen citizens participated in this clinic of which 60 were subsequently referred for further consultation with their personal physician. The breakdowns and the referrals are given on the sheets attached to this report.*

The $1,300 (provided thru OEO local initiative funds $1,018 and participant contributions of $240) financing of this clinic went into paying for basic fixed laboratory costs and supplies. Staffing for the clinic was entirely volunteer drawn from local physicians, nurses, and lay volunteers in the community.

Thus at a local level we are attempting in the aforementioned manner to deal with a barrier to health care which has not been provided for on a national level.

In following up on the patients who have been referred to their personal physician we have encountered two subsequent barriers to their health care. The first of these is that even with Medicare patients have trouble paying their doctor bills. Many people who have been referred to their physician are reluctant to go in part because of the financial burden it will place upon them. The administration's proposed increase in out of pocket payments by older Americans under Medicare can only serve to compound a problem which already exists. A second barrier is that of finding a physician. Many of the physicians in our area have been forced to stop accepting new patients because their practices are getting so large that they cannot effectively deal with the ever increasing demand placed upon them. A senior citizen who has no personal physician (13 percent of the people attending our initial clinic had no personal physician) may have great difficulty finding a physician who is accepting new patients. No directory is available to senior citizens stating which physicians are accepting new patients. As a result many people may get discouraged because they have called six or seven physicians, none of whom can accept new patients.

Thus at the community level we are encountering three barriers to health care of our senior citizens. A lack of provision for preventive services, inadequate coverage of medical bills by Medicare, and a shortage of physicians available to our senior citizens.

*Retained in committee files.

ITEM 8. PREPARED STATEMENT OF BRYAN B. BUNDY, IDAHO STATE DIRECTOR, NATIONAL RETIRED TEACHERS ASSOCIATION

SOME AREAS OF INADEQUATE HEALTH CARE FOR OLDER AMERICANS

A type of nonservice which concerns senior citizens, and which serves to reduce the effectiveness and health care, is the reluctance on the part of certain hospitals and some doctors, to assist with the completion of Medicare forms and supplementary hospital and medical insurance forms following hospitalization and/or treatment at a doctors office. In some cases, it seems, hospitals and doctors have resisted providing the information and documentation of treatments and charges so that the patient himself could complete the necessary forms. A case in point involved an older couple in Northern Idaho. The husband was hospitalized. During his convalescence and while he was still incapacitated, his wife attempted to complete reporting forms for Medicare and for the patients supplementary NRTA insurance. Both the hospital and the attending physician refused to cooperate. She asked for proper documentation of treatments and charges but met with further resistance. At the time of our conversation, and several weeks after beginning her efforts, the foot dragging was still in progress and she had not yet secured all of the necessary information from either the hospital or doctor. In addition she was being subjected to pressure from both for payment of their accounts.

A second, and somewhat different problem, is the reluctance of some doctors to certify older patients for nursing home care following hospitalization. The following case is typical: An 86-year-old woman suffered minor brain hemorrhages which became progressively worse until her mind and memory, also certain other vital bodily functions, were impaired. She was hospitalized. After several days of treatment her doctor certified her as fit to return to her own home. Her daughter objected knowing that she could not be trusted alone.

"Then you take care of her," the physician replied. The patient was taken to the daughter's home. Her condition was such that 24-hour care was necessary. Two weeks later she suffered a relapse. The daughter was physically worn out. The patient was again hospitalized, was again released after treatment, this time to a nursing home, but only with the doctor's reluctant permission. The nursing home cooperated to the fullest extent and placed her in the Medicare section for care and treatment for the duration of her stay. She suffered a second relapse and was sent to the hospital for the third time where she subsequently died. During the entire case. which extended over a period of many weeks, both the hospital and the nursing home cooperated in excellent manner.

The doctor however:

(1) Refused to certify the patient to the nursing home following the first hospitalization as set forth above.

(2) Was indifferent, even rude to both patient and daughter.

(3) Was slow to answer calls to the nursing home and sometimes did not respond at all.

(4) Refused to complete reporting forms and resisted providing documentation of treatments and charges.

(5) Charged exhorbitant fees.

It pleases me to report that the two hospitals which serve our area, St. Josephs, Lewiston, Idaho and Tri-State, Clarkston, Washington, appear to serve older citizens well in reporting information essential to Medicare. Most doctors in this area are likewise cooperative.

ITEM 9. PREPARED STATEMENT OF ROY O. HARRIS, JR., DIRECTOR OF ADULT SERVICES, IDAHO DEPARTMENT OF ENVIRONMENTAL AND COMMUNITY SERVICES

Mr. CHAIRMAN: First I would like to comment on the excellent work of the U.S. Senate Special Committee on Aging. The work and efforts of this committee has done more to spotlight the needs of older persons and to develop significant legislative actions to elevate and upgrade the services and resources available to older persons than any other force in America today. The dedication, willingness to spend long hours, and selfless efforts of your chairman, Senator Frank Church, and his colleagues, has always filled me with the greatest respect and admiration.

Likewise, the selfless willingness to devote long hours and the production of tremendous volumes of work behind the scenes by the staff members of the committee under the capable leadership of Mr. William Oriol, staff director, has resulted in significant advances for the needs of older persons to be more adequately met than ever before in the history of our great country.

Although there have been significant strides ahead in recent years in the development of acceptable and adequate health care for all older Americans, barriers yet remain which must be given attention if older persons are to be insured that their health care needs will be satisfactorily met in the time to come. Much has been said and written regarding this subject in the recent past which has been documented and is readily available in the reports of hearings before this subcommittee as well as others. I do not intend, therefore, to repeat what has already been said and documented by others, but would like, however, to briefly indicate three areas which I consider to be barriers to health care for older Americans.

Medicare and Medicaid legislation (titles XVIII and XIX of the Social Security Act) in recent years have been expressions of the intent of Congress that all individuals in America who need medical care will receive that care they need. Congressional intent, however, has been distorted by administrative and bureaucratic actions to develop policies and procedures which have thrown up barriers to the achievement of the intent of Congress. This has resulted in significant lacks and gaps in health care rather than increasing the availability of health care for older persons. Although Medicare and Medicaid legislation has increased the potential for older persons to receive health care, the cost to the consumer has likewise increased. Out-of-pocket expenses being paid by older Americans for health services are higher now than ever before in the history of our Nation. Legislation is needed which would decrease the cost to the consumer of medical services. Specifically in regard to Medicare (title XVIII of the SSA), legislation should provide for decreases in and eventual discontinuance of the consumer's necessity to pay deductive and coinsurance premiums and for other expenses not covered in the Medicare program. There is a need to look toward expanding the coverage of Medicare and Medicaid to include payments for the costs of dental needs, prescription drugs, the purchase of eyeglasses, and other prosthetic appliances. The most significant need of older persons in the State of Idaho is the availability of in-home services that will meet needs of individuals in their own homes for as long as possible, rather than individuals being admitted to institutions for the delivery of services which are significantly more costly than the provision of the same kinds of services in their own homes. Medicare and Medicaid legislation needs to be extended to allow for the payment of in-home services, which would include expanding the definition of home-health services to include homemaker and other personal services.

The medical delivery system in America, and specifically in Idaho, has numerous constraints which prevent the older person from easily securing medical services. Idaho is predominantly a rural state and there are transportation problems which provide significant constraints to the older person in getting to the medical delivery system. Many of the small rural areas within the state do not have medical services, and elderly individuals, as well as others, are forced to travel to larger population centers to receive needed medical services. Often there are long waiting periods in doctor's offices and outpatient departments of hospitals which older persons particularly find most difficult to tolerate. The complicated procedures necessary to secure payments for medical services have resulted in many older Americans having to pay for medical services out of their own pocket because they had completed some form incorrectly or had not filed the appropriate forms at the correct time. The complicated red tape and paper work is too much for the older person to readily be able to accomplish in order to receive payments for medical services provided.

The medical delivery system should include increased use of paraprofessional individuals in the delivery of services, increased development of small community clinics, health maintenance organizations, and other prepaid group medical practice programs, and there should be increased coverage in programs such as Medicare to pay for additional needs not currently met in these programs.

In summary, I have identified three significant barriers to health care for older Americans as well as having briefly alluded to a number of others. These include (1) the inability of older persons to pay for needed medical services, and the need, therefore, to provide for increases in availability of medical services without increases in costs to the individuals being served, (2) revisions to the traditional medical delivery system which currently provides many constraints to

older persons, thus preventing them from being able to avail themselves of the services that are available, and (3) the need for expanded services to older persons in their own homes rather than their either having to secure services outside their homes or not receive the services that are needed. Additional constraints involving administrative attempts to circumvent the intent of Congress have resulted in older persons not receiving the services they need. It is hopeful that Congress in the time to come will not only continue to expand the availability of medical services needed by older persons, but will also be able to develop the methods whereby the intent of Congress is carried out rather than circumvented.

ITEM 10. LETTER AND PREPARED STATEMENT FROM LAURA G. LARSON, COORDINATOR, NURSING AND ALLIED HEALTH, MOUNTAIN STATES REGIONAL MEDICAL PROGRAM, TO SENATOR CHURCH, DATED AUGUST 15, 1973

DEAR SENATOR CHURCH: Thank you for the opportunity to submit written testimony for inclusion in the proceedings of the recent hearings on "Barriers to Health Care for Older Americans" in Coeur d'Alene.

The enclosed statement represents a summary of our experiences with family nurse practitioners who are providing the most practical means of bolstering the health services, particularly for the elderly. I strongly believe that these nurse practitioners represent a real breakthrough in the present health care dilemma, in view of their acceptance by the general public as well as the health professionals.

Upon request, I shall be glad to furnish additional information and documentation, either written or verbal.

Sincerely,

LAURA G. LARSON, *Coordinator,*
Nursing and Allied Health.

[Enclosure.]

STATEMENT OF LAURA G. LARSON, RN, MA

I have a deep and abiding concern for the elderly and have served in many capacities over the years both as a volunteer and professionally in programs for the aging. My master's degree from Columbia University is in the clinical area of long-term illness. For the past 7 years, I have been nurse coordinator for the Mountain States Regional Medical Program.

While seeking solutions to health care problems, particularly in rural areas, we have actively promoted the concept of a family nurse practitioner, a nurse with special training, to augment the physicians' services. An unexpected development was the extension of services to older patients, who eagerly accepted the family nurse practitioner.

The late Dr. John T. Edwards, a family physician in Council and Cambridge, Idaho, who helped pioneer the family nurse practitioner, testified to their effectiveness in a letter written a year ago to the Senate Committee on Aging:

". . . It seems that it is almost impossible to obtain house calls or to have very much followup of patients who are in the nursing homes. The nurse practitioners that we have are ideal solutions to this problem. They make house calls, and they visit nursing homes. They take the time to establish a rapport with the elderly patients and our experience has been that they are even better accepted by the elderly persons than the average physician. . . ."

In view of our successes in encouraging the use of family nurse practitioners during the past 3 years, I contend that the full and effective utilization of educationally prepared family (or geriatric) nurse practitioners will exert a positive force upon the entire health system.

To extend improved services to the elderly, Congress should take immediate steps to expand Medicare responsibility to provide payments for services of these specially trained family nurse practitioners in whatever setting they may be functioning—in the patient's home, in extended care facilities, in offices, and in clinics.

Reimbursement by Medicare for such services should be provided for the educationally prepared registered nurse who has completed the necessary formal training including the acquisition of the additional medical skills necessary to function in the expanded role of a family nurse practitioner.

By virtue of the time-honored acceptance by the physicians and other allied health personnel, and the respect and confidence of patients and the general public, a registered nurse holds the greatest potential for this expanded role. Nurses are available in virtually all communities, large and small, throughout the nation. He or she frequently lives with their families in areas having limited health services, sometimes lacking an available physician.

Specially trained family nurse practitioners should be able to function wherever health services are needed and provided—in home health agencies, hospitals, nursing homes, community clinics, or physicians' offices. Working in conjunction with physicians, they can help improve the health care, both qualitatively and quantitatively, for senior citizens.

The American Nurses Association commission on nursing outlined the functions of a nurse practitioner in December 1971. Some of the major responsibilities included were:

Obtaining a health history, assessing health-illness status, entering a person into the health care system, sustaining and supporting persons who are impaired, infirm, ill, and during programs of diagnostic therapy; managing a medical care regimen for acute and chronically ill patients within established standing orders, aiding and restoring persons to wellness and maximum function, teaching and counseling persons about health and illness; counseling and supporting persons with regard to the aging process, aiding people and their survivors during the dying process, and supervising assistants to nurses.

The demand for these specially qualified family nurse practitioners will soon exceed the supply. Registered nurses in increasing numbers are applying for admission to the limited training programs now available.

Since the first two family nurse practitioners in Idaho were trained, we have financially assisted registered nurses, both male and female, to obtain family nurse practitioner training. A total of 21 are employed in community clinics, nursing homes, in physicians' offices, or are fulfilling their preceptorships with physicians. Ten additional nurses are currently enrolled in such a program.

Financial assistance to provide additional training slots for nurse applicants is a paramount need, as more communities and physicians are recognizing that the opportunity to expand health services in their area lies with family nurse practitioners.

At a patient level there is a desperate need for coordination of all health services to eliminate duplication and avoid the confusion which elderly persons face when seeking health care today. One central agency, such as a nonprofit Visiting Nurse Association, a local public health department or community hospital, is needed to coordinate and arrange for all in-home services. A small community can neither afford nor needs two home health agencies.

Taking care of patients in their homes is the most advantageous—psychologically, physically, and financially. But while costs have soared, the number of certified home health agencies has been drastically reduced, as documented by the Trager report prepared for the Senate Special Committee on Aging (2,350 in 1970 to 2,221 at the end of 1972). The total amounts spent by Medicare for home health services in 1971 was $49.5 million, almost half of the 1969 expediture of $78.8 million. And a continuing downward trend in home health services is indicated. However, the profit motive must be removed from these kinds of services if we are to provide adequate health care for the elderly.

Funds could well be utilized for the training of additional family nurse practitioners. A FNP who serves a patient at home can offer health maintenance and management of the stabilized chronically ill, thereby postponing or obviating a stay in a nursing home or hospital. Payment to in-patient institutions for chronically ill patients, with no provision for ongoing maintenance care, continue to keep Medicare costs at a high level.

Many of the physicians in Idaho and the surrounding states who are employing family nurse practitioners view this as an opportunity to extend and improve health services far beyond their present limitations of time and energy. Their sincere desire to improve the care of their elderly patients is exemplified by a physician in Nampa, Idaho, who has assigned a family nurse practitioner to assume full responsibility for the health maintenance of his geriatric patients both in their residences and in their nursing homes, with the physician providing all necessary backup services. Under present regulations, the physician is not permitted to collect for these FNP services under Medicare.

By making trained family nurse practitioners available through home health agencies, health departments, and nursing homes, the patient services which presently are limited under Medicare to the administration of physicians, would

be extended immeasurably. Such a plan of care would also encourage the more effective utilization of the physicians.

Over the years, we have made many promises to our elderly citizens to improve their lot—through Medicare, the Older Americans Act and other well intended legislation. Some of those promises have indeed been improvements. Let us not stop now! Today we have an opportunity for positive action to expand and improve health care for the elderly. Trained family nurse practitioners in adequate numbers, with their services reimbursed through Medicare, could well be the breakthrough in the "health system" which citizens and Members of Congress alike have been seeking.

ITEM 11. PREPARED STATEMENT OF MARGOT TREGONING, DEPUTY ADMINISTRATOR, REGION I, DEPARTMENT OF ENVIRONMENTAL AND COMMUNITY SERVICES, STATE OF IDAHO

SERVICES TO ADULTS

Applicants for, and recipients of financial assistance in the adult categories (OAA, APTD and AB) are eligible for medical care and a variety of social services including services to enable persons to remain in or return to their own homes.

Staff in adult services includes caseworkers and service aides. The aides are supervised by the caseworkers on a ratio of approximately four aides to one caseworker. Staff training outside of the direct case supervision is provided on a routine basis by a social worker and a nurse at the regional office. Consultation is available through a nurse consultant, a psychiatric social worker and psychiatrist as needed. Staff training is also provided through the mobile learning center of the vocational education department at North Idaho College, Coeur d'Alene.

In Region I, which comprises five counties in North Idaho (Boundary, Bonner, Kootenai, Shoshone, and Benewah) there are over 1,200 individuals who are receiving financial assistance under one of the adult programs, including medical assistance.

Data collected in Region I reflected priority of needs of disabled and elderly individuals as follows: (1) In-home care, (2) improved nutrition, (3) transportation, (4) recreation, (5) housing or repairs, (6) counseling, and (7) training and/or employment.

Although planning is underway to assist in meeting other needs, for the purpose of this report emphasis is placed on the greatest need, "in-home-care."

The staff assigned to the "in-home-care" program frequently works in homes where an individual is being served by a nurse under the home health program. This nurse carries basic responsibility for the medical component of service with a caseworker and/or service aide carrying responsibility for social services including counseling, home maintenance, personal care and chore duties. Personal care is that aspect of service which can be assumed by the service aide under general direction of a nurse, as shampooing, bathing, helping dress, etc.

For example, a widowed lady of 92 years who has no family and desires to remain in her own home has been assisted for several months by a service aide. Services provided have included light housework with emphasis on adequate nutrition, transportation to physician, assistance with shopping and personal care. As physical problems have increased it was necessary to request home health services for which she qualified under the medical assistance program. A nurse will provide that aspect of care, including dispensation of medication and will give directions to the aide if needed. Time spent in this home by the aide is about 6 hours a week; the nurse will spend about 30 minutes a visit.

Another example is a widowed lady of 72 years, who is nearly blind and had several physical problems including difficulty in walking. A service aide was assigned a year ago to assist her to maintain her home and to shop. A nurse visited routinely, usually once a week, to check on medications and maintenance of control of diabetes. In this situation joint services of the nurse and service aide are clearly making it possible for this lady to remain at home where she wishes to be. She has had to be hospitalized on one occasion within the past 6 months but with help she could return home. The service aide services this lady about 4 hours a week and the nurse about 30 minutes.

At this time in-home care is being provided primarily to recipients of financial assistance. The same service can be made available for beneficiaries of

OASDI whose income does not exceed this department's economic criteria. After January 1, 1974 it is planned that in-home care will be available to those individuals who qualify for supplemental security income.

An area of need not portrayed in this report so far but which has been noted by recipients of old age, survivors, and disability insurance is that for prescription drugs. In Idaho, the recipient of financial assistance (OAA, APTD and AB) is eligible to obtain prescription drugs costing up to $20 a month. Individuals in a common living arrangement as a shelter home, are provided for more adequately under the state programs than under the Social Security program insofar as provision of prescription drugs is concerned. It is recommended that a provision be made to purchase prescription drugs under Medicare to provide greater equity and to relieve the beneficiary of OASDI of an expense which they can ill afford.

ITEM 12. INTERIM REPORT SUBMITTED BY ARLENE D. WARNER, STATE OMBUDSMAN FOR NURSING HOMES, IDAHO NURSING HOME OMBUDSMAN PROGRAM

IDAHO NURSING HOME OMBUDSMAN DEMONSTRATION PROJECT

1. Project Objectives

First year project goals were generally achieved. The ombudsman received 207 complaints and successfully resolved 54 complaints. Two related legislative proposals were passed. The advisory committee was formed and continues to function and has contributed to the interim report. Public acceptance and support for the concept of nursing home ombudsmanship were achieved by intensive developmental activities of project staff and support developed through commitment of advisory committee members who represented service agencies, providers and consumers. Twenty-six volunteers were trained as friendly visitors and complaint finders, and five months later 21 volunteers are spending two hours a week in each facility in the project area.

We have determined that some of our stated goals are difficult to measure—for example, such statements as: "to have a positive effect in improving agency function and service."

2. Project Organization and Staffing Patterns

The location of the project within State government seems most useful. In this position we are able to develop linkages and use resources not so readily available to those outside of government. The fact that the project is federally funded and state operated may well account for the responsiveness of both Federal and State agencies.

The Department of Special Services is an appropriate place for the project within state government. The ombudsman needs to be as free as possible from the political pressure brought to bear by those persons with vested interests.

While the project was initially conceived having an attorney from the Attorney General's staff as director and State ombudsman for nursing homes, project experience indicated that success of the program was not predicated on the attorney status of the director or on the direct relationship to the Attorney General's office. Rather, emphasis was placed on the intermediary role of the ombudsman versus that of advocacy litigation.

The State ombudsman, a social worker, is responsible for overall supervision of the project staff, administration, operation and coordination of the project.

The State ombudsman reports to the Director of the Department of Special Services, most often through the Deputy Director for Aging. Ultimate decision making authority is vested in the office of the Governor.

The regional ombudsman is a Methodist minister who has worked as a trainee counselor, State mainstream director, and most recently as a program technician in the area of welfare rights.

The regional ombudsman is responsible for recruitment and training of volunteers, works directly on complaint investigation and resolution, and, in coordination with the State ombudsman, is developing the plan for statewide expansion of the project.

The local ombudsman, a social worker, during the second project year will be responsible for the complaint structure operative in the original project area and

has daily supervision over volunteers. The three professional staff members function on a collegial rather than hierarchical manner.

The project secretary has a personnel rating of secretary I and is responsible for record maintenance, compilation of data and regular secretarial duties. An accountant (part time) is responsible for the fiscal operations of the project and participates in planning for future operation and/or expansion of costs and services.

Volunteer staff consists of 26 "ombudsman volunteers" who visit nursing homes weekly as "friendly visitors" whose function is the elicitation, documentation and followup of complaints.

A 3-day training session for the volunteers was held in February followed by monthly in-service training sessions plus regular individual conferences with professional staff on complaints. Volunteers have been generally well received by the nursing homes, which is an indication that their training was successful. Careful screening of potential volunteers also is a contributing factor.

Future training needs are not entirely defined, but there appears to be a continuing need in three areas: First, maintenance of familiarity with regulations governing nursing homes and the effectiveness with which those regulations are enforced. Second, greater awareness of the range of benefits and services from both public and private resources available to nursing home residents. Tied to this is the need to be knowledgeable about appeals procedures related to denial of benefits from public programs. Third, more sensitivity to and knowledge of problems of nursing home administrators and their staffs, potential solutions to those problems which are recurrent, and trends within the industry.

Currently there are 21 volunteers related to the project. Their prime function is to serve as a channel of communication between the nursing home resident and the ombudsman.

The volunteers indicate that training needs to be oriented around the everyday life experiences of the nursing home resident and the most effective way to establish a helpful relationship with persons in such circumstances. The overall training program, reported in the quarterly reports, appears to be satisfactory if not outstanding. The major weakness is in providing new volunteers with the same training opportunities as those received by persons who have been with the project since it began to use volunteers. Supervision of volunteers takes place in the monthly group meeting and in individual conferences with the ombudsman. This appears adequate.

The greatest assets of using volunteers is that there is regular and frequent contact with nursing home residents and that persons from the community involve themselves in the facility. The major liability is the time of employed staff required to recruit, train, and maintain the volunteer staff.

Continued use of volunteers in the future is one of the options being considered at this time. Whether that option will be exercised or in what precise manner is unclear at this time. Given the present staff, a statewide volunteer system such as the one now operative in the present project area would be most difficult to develop, train and maintain. We are exploring the volunteer capabilities available through the Department of Environmental and Community Services.

3. Complaint Mechanism

As the project has developed, complaints have been generated through various avenues. The first is outreach contact with nursing home residents by professional staff. The second most quantitative method for receipt of complaints is the use of volunteers developed in the second quarter to cover the total project area. The volunteer system is based on the friendly visitor model. The third avenue, which often results in complex and time-consuming investigation, is the referrals of complaints to the ombudsman by outside agencies and individuals—such as Veterans Administration, Social Security, Department of Environmental and Community Services, nursing home administrators, and relatives.

When a complaint is received, an investigation is conducted immediately, or generally in a following 2-week period. Initial investigation usually determines whether a complaint is valid or invalid. Once a complaint is determined valid, resolution is based upon the problem itself. For example, if a complaint deals with services being provided by a specific nursing home, the ombudsman may be able to effect resolution by discussion with nursing home staff or administrators. If a responsible agency is identified, then a referral is made for resolution, generally to regional head or division director. In a referral instance, if no response is forthcoming within two weeks as to the status of the referral, a

followup inquiry is made. If, again, in 2 more weeks, a positive response has still not been received, a referral will then be made to the appropriate State agency head.

Special note should be made of the use of volunteers. In some instances, as their training and familiarity with the program has developed, they have been able to resolve complaints by discussion with nursing home administrators and/or appropriate staff. Investigative contacts outside the nursing home are always handled by professional staff. When an in-house solution has occurred through a volunteer, a followup investigation is always made by a professional staff member.

Upon case closure or resolution, the complaint is then filed for followup action. Followup includes a 30- and 90-day contact with the complainant to insure that the resolution is still in effect or that extenuating problems have not developed.

The most reliable method of complaint receipt is by continuous program staff outreach with nursing home staff and residents. Each nursing home is contacted at least once every 2 weeks. However, in development of trust and support relationships, the volunteers have proven more effective. All volunteers are asked to visit once a week for a minimum of 2 hours. Although referrals from outside the nursing home—that is, agency, et cetera—are increasing, it is too soon to make a critical evaluation. A pitfall that has to be avoided is that in some instances DECS caseworkers view the ombudsman as a supplement to their staff; consequently, misinterpreting the program's designed purpose.

The present method of case investigation and resolution is generally effective with individual variations upon procedures used. As the result of a consultant evaluation of the complaint mechanism, we have developed and implemented a program manual which allows for a progress maintenance control and cross reference check on all opened and closed cases.

4. External Linkages

The most helpful linkages for the project have been higher echelon people in the service agencies and nursing home association. They are committed to the concept of ombudsmanship in nursing homes and have expressed their commitment through active participation on the advisory committee and support of the ombudsman in public statements, interoffice memos and directing their employees to cooperate with the ombudsman project. Our strongest advocate has been the Governor, who discussed the ombudsman project in his State of the State message in January.

We have found resistance among some nursing home administrators, especially those with a paternalistic attitude toward their residents. We can safely say resistance to the project has been minimal.

5. Outreach/Publicity

The project has received visibility primarily in three ways: direct media coverage, volunteer outreach, and continued attention from the Governor.

Publicity during the project year has been spotty, with major coverage occurring during the volunteer training session in February.

Effectiveness is difficult to judge, but we suspect that prolonged awareness of the project is good among nursing home residents and relatively poor among the general public.

Future plans call for the development of a comprehensive publicity campaign covering the whole State and evenly spaced over the program year. We are currently seeking the aid of the Boise Ad Club in this development.

6. Patterns of Need and Broad Issues

Major issues defined during the project year were based on specific complaints; for while the ombudsman may observe deficiencies in the quality of life in nursing homes, it is difficult to build a major issue on generalities. By remaining within the complaint structure, we deal with specifics that cannot be denied.

Major issues in order of seriousness:

(1) Placement of mentally ill and retarded in Idaho nursing homes. Project staff is working with State Mental Health Association to develop an issue paper with proposed alternatives.

(2) Adequate care of nursing home residents by their personal physicians.

(3) Pharmaceuticals and the role of counties in caring for indigent nursing home residents. Staff secured Attorney General's ruling which has forced one

county to revise its policy. We have alerted the State Nursing Home Association to the opinion.

(4) Payee problems, patients' personal effects and funds, and nursing home accounting-bookkeeping. The staff, in cooperation with DECS and the Nursing Home Association, is sponsoring a seminar dealing with this issue for service agencies, vested interest group and consumers.

(5) Small claims procedures against estates of deceased nursing home residents. Staff are developing legislative proposal dealing with this issue patterned after legislation enacted in California.

Issues to be addressed next year in order of priority are:

(1) Lack of alternatives to nursing home care available in Idaho.

(2) Lack of patient care planning, including the discharge process.

(3) A residents bill of rights.

(4) Quality of activity programs in nursing homes.

(5) Lack of available social services to nursing home residents.

(6) The sterile environment of nursing homes as fostered by the Government through restrictive licensure clauses.

7. Attitudes Toward Project

Generally, the project has been well received by consumers, providers and service agencies. We feel there has been a lack of communication and some turf consciousness on the part of regulatory agencies.

ITEM 13. LETTER AND POEM FROM IDA B. CONDIE, COEUR D'ALENE, IDAHO, TO EDNA EVANS

MEDICARE

What do we mean by Medicare?

Medi refers to medicine, and care, in this sense, means the good work and motherly love the nurses give their patients; this, in my opinion, is what every old and ailing person needs.

In this city of Coeur d'Alene, Idaho, Medicare has a perfect system for taking care of their older citizens.

I came from Malad City, 2 years ago, to be with the Reed Condie family, because I was too ill to live alone. As soon as my needs were known to the home health agency of the Panhandle Health District, I received special care from Medicare which has a corps of four wonderful nurses who are at this time: Phyllis Camp, Banita Olenslager, Elizabeth Karas, and Ann Jensen.

Now you ask, what makes a good nurse?

First, I would say, congeniality. They greet you with a smiling face that brings a streak of sunshine into your own little room.

I can't help but smile back, for I know she has some love for me, and will lend an ear, for she has the listening ability to hear and will answer all the questions that her patient has thought up since her last visit.

A nurse's job is hard and steady work. Without it, little could be accomplished. She must take the affirmative view, even when the going gets rough, and go along with enthusiasm for it generates the desire and energy to get the job done.

These nurses have the capacity to visualize the results they want and the steps required to reach those results.

A firm and friendly approach, with a bit of love, makes them encouraging and inspiring leaders.

They are blessed with mutual trust which vibrates from nurse to patient and each one has faith and confidence in a new found friend.

Their flexibility is strong and stretches like an elastic band, so she can be open to trust, respect and confidence to those who need her care.

It is through Medicare and these faithful nurses that all this wonderful work can be accomplished. My thanks to all who have and are still helping me through a long siege of illness.

To my faithful nurses, I say—

Did you know?
It's your very sweet smile,
And your very sweet way
The good things you do
And the kind words you say
It's the love in your hearts
And the love in mine, too,
That makes me so thankful for
Dear Nurses like you
So keep on smiling and
Know by what a smile is meant—
It's worth a million dollars
And it doesn't cost a cent.

ITEM 14. LETTER FROM MARGARET R. ORTON, LEWISTON, IDAHO, TO SENATOR CHURCH

Mr. Chairman: Name—Margaret R. Orton. Heart operation in Boise—May 6, 1972. Taken to St. Al Hospital by ambulance—May 1, 1972. Was in intensive care 5 days.

Transferred to St. Lukes on May 6 for operation which had to be in order for me to live. An implant Pacemaker was put in the left breast. Was in hospital 15 days as left arm was semiparalyzed. Had therapy. Was in Boise 4 months at my son's before being allowed to come to Lewiston.

Two hospitals, two doctors, nurses and with calls at doctor's office every week after being released from hospital.

My bill came to $4,000. Had no hospitalization, no other insurance of any amount to call on. So was in dire need. So through personnel of the two hospitals in Boise got me acquainted of the DPA living in Lewiston. Had papers and through that office to sign, etc. In 4 months after being home my bills were cleared.

This DPA is under Medicaid which is part Federal and part State. Am very thankful for such an organization that came to my aid. My husband being deceased for 5 years and was drawing at that time his Social Security, which was $125 a month and a veteran's check of $60. This you can see was a great help. The hospitals in Boise wanted a payment of $50 a month not including the doctor's bills or office calls, which just couldn't be gotten out to be paid and also medicine I needed. Now in the future is what I am worrying about as in 1½ years will have to have Pacemaker replaced. Now being 65 years have applied and received Medicare which will help. But from time to time do have to have medicine and that all comes out of my Social Security check which at this time has risen; but trying to hold on to my property and maintaining a car which I need and for my utilities of house barely is enough. Social Security check now is $152.60, Veterans $52.38, applied for disability $98.30.

Some month runs me close, as for home insurance and car insurance and always have worked all years before now denied that for having some extra money.

But to me to be happy and free from expense worry have gotten by; but do know so many others have less. Am thankful for another chance on life. But as for myself and other would like to see an increase especially for ones who put out so much for medicine.

This I hope will help the health issue that is before us senior citizens.

MARGARET R. ORTON.

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

Dear Senator Church: If there had been time for everyone to speak at the hearing on "Barriers to Health Care for Older Americans," in Coeur d'Alene, Idaho, on August 4, 1973, I would have said:

The following replies were received:

MRS. OLIVE L. BEAMIS, CATALDO, IDAHO

What about the "multiple sclerosis" cases? Is there anything that will help these cases?

I have to remind you of Mrs. Don Grende, Kamiah, Idaho. A recent letter from his folks tells me she is a woman struck down in her fifties and has had 7 years of suffering already. He is my nephew and is telegraph agent, there at Kamiah, Idaho. I would be so glad to know there was some hope, even for improvement with her case. What is the barrier? I am not familiar with this illness except it cripples. We need to know for none of us knows—who may be next victim struck down.

I am a member of CDA Elderly Citizens Council, and also have a gold card from NCSC, Washington, D.C. My ailments at age 76 are: light stroke and asthma condition. I am in the care of Dr. H. Bouebrake, Kellogg, Idaho.

ALVIN ANDERSON BREWER, POST FALLS, IDAHO

My list of gripes:

(1) Excessive cost of telephone service in this area. I pay $8.83 per month for local calls, with tax. I have to skimp on other items to pay.

(2) Someone to share my home or even two other pensioners. Congenial companionship, plus help in case of emergencies, sharing of telephone, electricity, heating, fuel, and water. A big saving in care of the elderly would be hiring of part-time housekeeper if necessary.

(3) More control over quality of foods, over processing and packaging, advancing prices at each step; and excessive salt and seasoning, which conflicts with diets of aged; and more natural food and fresh vegetables.

(4) Free legal advice to elderly on making will, signing deeds, transferring property to strangers, who make a business of duping the aged.

MRS. J. R. BURNSIDE, POST FALLS, IDAHO

One of the most critical barriers to health care for older Americans is the "ban on vitamins" which is being introduced and encouraged by a certain group, which I feel if passed, will do more harm not only to the elderly, but to all the American people, as it is impossible to maintain good health from the supply of nutritionally drained food on the market today. With the refining and reprocessing of food which takes all the nourishment from it, tell me, what kind of healthy human can survive on what's left—fiber and fillers? Please don't take away the only thing that is vital to maintain health.

KATIE CHARLESWORTH, COEUR D'ALENE, IDAHO

Help the older people pay for their medicine. I take heart medicine and some times I skip taking it because I don't have the money to buy more.

MR. AND MRS. N. V. DUNCKEL, POST FALLS, IDAHO

Why did Medicare go up to $60 deductible? We haven't had a raise in Social Security but we cannot blame Nixon for this. Who will pay for all these things the same people that want Medicare to pay for, such as glasses, teeth and corrective shoes? The taxpayers of course.

Why try to get a job for the retired person drawing Social Security and getting benefits from Medicare when some younger person needs that job. I know some will not work but there are others who would if they could find it.

In this country you can get a reduction on your taxes if you meet the requirements; also a rebate for money spent for State sales tax on food, etc. One speaker did not mention this when he was pleading for the elderly.

Then there is AARP which was not mentioned at all—a big saving for the elderly, especially for medicine.

MARIE EIDE, WALLACE, IDAHO

I enjoyed this meeting very much. (1) Give the same medical benefits to people on Medicare that the girls on aid to dependent children get, $20 per person per month for prescriptions. Make the prescription allowance which you are working on applicable to any type of prescriptions, not just chronic illness. (2) Increase the burial fund allowance. The amount that is allowed now is about one-fourth of the cost and this works a hardship on people.

We here are pleased with your efforts on our behalf and will work hard to keep you in Washington, D.C.

MRS. H. G. HARRIS, COEUR D'ALENE, IDAHO

That place health care for the elderly falls down in is:

(1) Don't pay for glasses.

(2) Don't pay for prescriptions.

Should provide ambulance service when a doctor ask if patient is able to walk as was the case of my husband this spring. He had a ear infection and lost his power to walk straight. I could not handle him and so I had to get an ambulance and so I did. Medicare tried every way possible to get out of paying it. I can see a question but not act like you are putting something over on them.

DORA E. HAWLEY, COEUR D'ALENE, IDAHO

Please pardon me; I am a convalescent at this home for the time being. A cripple due to the habit of so many of today, acquiring a broken hip in a surprise fall.

I am sorry I didn't get to hear your opinion on aging—it looks like I won't be home soon, if ever.

There is a chapel here, also a large dining room—so try to see us here at Sunset Terrace some time if you can, when in Idaho.

MRS. DAVID HOUSKEEPER, SANDPOINT, IDAHO

I'm not in favor having prescriptions for vitamins. I think we senior citizens know what we need, and they are not injurious to our health. They have improved both mine and my husbands health—and if we had to get prescriptions we couldn't afford to take them.

We thank you for what you have done in favor of all us senior citizens. And pray you will continue to help us.

ERMA T. HUBER, POST FALLS, IDAHO

I am in agreement with your points and bills introduced in the legislature on Medicare. I am not yet old enough for Medicare; but have visited nursing homes and places of elderly people who could use better health care. Nursing homes in Idaho are generally excellent—and give good care but costs are so high. Many elderly still holding a home or shack together, very poorly—because they don't have enough Social Security to do anything else—they fear going to hospitals because of the initial cost. With all the money handed out to the "plumbers" and "the elegant properties" and "wire tappers" a few poor American pioneers could have had a little better diet and a "happy smile" with a couple extra dollars on their checks.

My mother gets $2,236 Social Security per year. I would like to see some of the people in our Government live on that. Forgive me for sounding off.

Keep up the good work.

MRS. W. H. HUNTER, COEUR D'ALENE, IDAHO

I feel that the Medical care patients are being released from the hospitals (at the discretion of the Board who reviews the case) regardless of how unable to feed, dress or take care of their needs; especially being trusted to handle medications. Many have no one to care for them. According to the enclosed information, taken from the 1973 handbook, I see very little that one will qualify for, in extending care facilities under this very limited coverage. Thank you so much for your interest in our senior citizens welfare.

(Enclosure)

WHEN MEDICARE CAN'T PAY

Extended care benefits are intended only for people who can be released from a hospital, but who still need daily skilled nursing care or rehabilitation services. Medicare can't help pay your bills if you are in a skilled nursing facility primarily because you need help in eating, dressing, getting around, taking medicine, and meeting similar needs, even though these services are performed by skilled nurses. And Medicare can't pay for your care if you need skilled services only from time to time—for example, to change a dressing once or twice a week.

RUTH E. HUSSA, CATALDO, IDAHO

As a very mild women's liberationist, the "hotline" should be interested in the young unmarried fathers as well as the young unmarried mothers. For every unmarried mother, there is usually, though not always, an unmarried father. (He may be married to someone else.) But we fail to develop responsibility for the fatherhood as this is difficult to establish. Our double standard does not consider this important.

I am sure that we need legal counsel, which is not costly somehow, for the bookwork necessary to process insurance forms. I happen to be employed where I carry Blue Cross, but I have spent the last 6 months in writing letters, making phone calls, etc., to collect what is legally coming to me. I think the mistakes that are made there are unforgivable, and I think that an older person than I would have given up long ago. I am determined now to collect every cent, even if the collection is as costly as the payment. The cost of coverage for our family of three was $960 a year, including the employer's share. The coverage was good and prompt in the hospital, but collecting the extended major medical is something else again. So I am very interested in seeing a medical plan for everybody, and better rules to govern the insurance that we in the younger segment of senior citizens carry through our employment.

The AMA, as a closed shop has purposely kept the numbers in the profession as small as possible. I don't think that everyone can be a good doctor, but I do think that many jobs can be done by a paraprofessional, and I also feel that many people are unable to finish medical school because of financial and other pressures. The doctors literally kill themselves off in their selfishness to assume responsibility for more patients than they can handle.

People move to Canada or European countries in their retirement years for their health care. I know an elderly Canadian woman who would like to visit her relatives in Kentucky but is afraid she might get sick and have to be hospitalized here. My relative in Finland this summer said that many people of Finnish extraction were moving there, even if the cost of living is higher otherwise. A friend of mine had 11 days in intensive care for $275 after suffering a heart attack on his trip there!

Nix on private nursing homes. Many of them give as little as possible for as big fee as possible. One which was recommended by her doctor to my mother turned out to be just terrible, but the doctor did not know it. I found the Shoshone Nursing Home (county operated) just wonderful by comparison.

We need to educate younger people toward respect for the abilities and contributions of older people. At age 50 we are not really over the hill. Japanese people may go a little too far the other way, but I'm sure the older people there are not shunted or shut up as we tend to do with ours. Finnish also. These are the only people I've had any contact with.

We work a lifetime to accumulate security—a home, for instance—or maybe even a little for leisure or pleasure—and I mean simple things like fishing, or a trip to visit faraway relatives—and the whole thing can be wiped out by one illness. Wealthy people can leave big estates and business to their kids; we can leave doctor bills.

LUCY P. KOLBE, SPIRIT LAKE, IDAHO

As it stands, old people and low wage people would be better off on welfare when it comes to hospital and doctor bills.

Small businesses and low wage people cannot pay the prices they ask today for hospital and doctors. In my case I was in the hospital three times in 9 months. I wasn't old enough for Medicare. I had a small insurance of which didn't near cover. There was another woman went through the same surgery. She is on welfare her bill was paid in full. I still have one hospital and one doctor to pay.

It doesn't seem very fair to people that have worked all their lives.

MARGARET L. PARKER, SANDPOINT, IDAHO

It is a great worry to most of us about the cost of hospital and health care. Our small savings would soon be swept away in case of illness.

JACK INMAN, MAYOR, SPRING LAKE, IDAHO

Why should senior citizens have to wait for Social Security pay increases for months after the cost of living goes up, especially since the cost of living increase is a steadily rising thing?

(NO NAME AFFIXED)

Four years ago I cared (was hired to care part time) for an elderly lady. She had a son and daughter in Canada, her daughter was alienated from her—her son visited once a week for less than 1 hour.

(She was spunky and refused to be hospitalized—so she hired women to care for her.)

In October, it became too demanding—a young girl replaced me. December 20 she quit her job (calling the woman's son before leaving), the S.C. was able to get around—but if she fell, was unable to get up—and on December 24, she was found by her son, lying on the floor in a pool of urine, chilled to the bone. She died 11 days later in Kootcno Memorial Hospital. (She had laid there after her fall for 2 days.)

In reference to in-home care—a telephone—something she could or would not afford, could have avoided this tragedy. A telephone call at a certain time each morning by senior citizen agents, would alert trouble—flexibility to the indi-

vidual need of each specific situation and person—a common sense solution and acceptance toward the private attitude of the elderly person is human and essential.

Hang the rules—if a telephone solved the problem.

"The rules" stated under these circumstances she should spend years in nursing home (when a telephone and 5 minutes of an attendant's time could have solved the problem) and she content. "Flexibility"—the key to a "realistic, common sense" senior citizen program.

MRS. RICHARD J. PENMAN, OFFICE MANAGER, MEDICAL CLINIC OF HAYDEN LAKE, INC., HAYDEN LAKE, IDAHO

Why was there no representation of doctors? They seem to be the "ogres" of Medicare.

Can't something be done about the procedure of payment on deceased persons?

Hooray for the work being done to get preventive medicine included as this is needed so badly and these are the things that our staff spends all their time trying to explain to our older patients ! ! ! They feel it's the doctors fault that they are not paid for.

What about the computer printout of "more than the allowable charge"? This really gives us problems. Are the doctors supposed to charge our people on Medicare the rates of 2 years ago and have another fee schedule for those not receiving Medicare benefits? Our charges have to be raised too along with everything else or we couldn't stay in business.

We in this office would more than welcome a member of your staff to spend a day with us to get to the "grass roots" of problems we encounter daily and to see how time consuming they are.

MRS. FAYE REBENSTORF, COEUR D'ALENE, IDAHO

With the present food shortage, the affluent people can and do hoard. The less fortunate have to take what they can get. I propose food rationing as was done in World War II.

Medicare allowable costs are based on 1970 doctors fees. This should be updated. We know how doctor and medical costs have risen since 1970.

Food costs have risen far above the proposed increase in Social Security. I am in favor of a 10 percent increase now and another 10 percent by July 1, 1974.

MRS. W. C. SPENCE, HAYDEN LAKE, IDAHO

The doctors and hospitals have taken Medicare over. In order to get into a hospital and pay initial payment for a doctor under Medicare it costs more than most elderly were accustomed to pay in a year before Medicare started. Your $72 initial payment at hospital only lasts 60 days. Another illness in hospital costs another $72 just to get in. A doctor looked me right in the eye and charged $100 to put a cast on my arm which had already been set and X-rayed at an emergency center, then he charged extra for the plaster. Medicare didn't object to his charge but balked at paying $13 to the emergency center, where they were very kind to me. After such charges, the doctors put you on prescription drugs and the druggist takes his toll. In some cases it would be cheaper to die.

Appendix 3

PROPOSED HOME HEALTH CARE LEGISLATION

By Mr. Church:

S. 2695. A bill to amend the Public Health Service Act to provide for the making of grants to assist in the establishment and initial operation of agencies which will provide home health services. Referred to the Committee on Labor and Public Welfare.

By Mr. Muskie (for himself and Mr. Church):

S. 2690. A bill to amend title XVIII of the Social Security Act to liberalize the conditions under which post-hospital home health services may be provided under part A thereof, and home health services may be provided under part B thereof. Referred to the Committee on Finance.

Stimulating Home Health Care

Mr. Church. Mr. President, I introduce for appropriate reference legislation (S. 2695) to stimulate the expansion of home health agencies and services.

These bills are part of a twofold legislative package being introduced by the distinguished chairman of the Subcommittee on Health of the Elderly of the Committee on Aging, Senator Edmund Muskie, and myself as chairman of the committee. This legislation would open up the home health care benefit for the elderly under the medicare program and at the same time expand the services available from home care agencies.

We are just beginning to realize that there are many illnesses that can be better treated at home if they do not really require the specialized and very expensive services of a hospital. Often an older person can be happier at home in familiar surroundings than in an institution and it will be far less expensive.

Institutional costs have continued to soar upward dramatically and they constitute the great bulk of costs uder the medicare program. I think it is about time to reverse this trend and enlarge the home care aspect of the program.

Home care is nowhere more needed than in rural areas where institutional facilities are sparse and there are large proportions of elderly people. I recently chaired a field hearing at Coeur d'Alene, Idaho, as part of the "Barriers to Health Care for Older Americans" series and a witness testified that the home health agency was the only link between the patient and distant physician. This was in an area without public transportation and an elderly population with limited incomes.

Many rural areas, however, have no home health agencies or agencies that can provide only limited service. About half of the agencies certified under the medicare program offer nursing plus one other service, usually physical therapy. These agencies cannot provide the range of professional and supportive services which will encourage physicians to utilize and depend upon home care.

Now no mechanism exists for agencies to expand or for new ones to be established in communities without such services. Home health agencies do not have sufficient funds to finance the expansion of services since their fees for services performed barely cover operating costs. One agency wrote the committee of being asked to expand into two neighboring counties without any home care services. It was hesitant to do so, because of the possibility of incurring increased costs which surpass income.

Mr. President, because of the need to expand home care agencies, particularly in rural areas, my bill would provide funds for public and nonprofit agencies in areas without such agencies. It would also authorize funds to expand services in existing agencies.

In addition, the proposed legislation would provide grants to public and nonprofit private agencies and institutions for training programs for home health personnel. Professional and paraprofessional personnel would be trained to staff expanding agency services.

Under the companion legislation which Senator Muskie and I have also introduced, homemaker and home health aid services would be made more available under medicare. Therefore it is anticipated that many more aides will be required. Now we have only about one homemaker-home health aide for every 7,000 population and the aides are clustered primarily in urban areas of the eastern seaboard. Just how inadequate this supply of aides is can be judged by the fact that the White House Conference on Aging recommended a ratio of one homemaker-home health aide per 100 older persons.

Mr. President, this legislation would make it possible for home health agencies to begin to expand their services and to reverse a downward trend caused in part by a too narrow interpretation of the medicare home care benefit. Other legislation which I have cosponsored would liberalize this benefit and allow coverage for desperately needed home services. The bill I am introducing now would insure that comprehensive home care services are available not just in a few urban areas, but to all of the elderly wherever they may be.

HOME HEALTH MEDICARE AMENDMENTS OF 1973

Mr. MUSKIE. Mr. President, I introduce today the Home Health Medicare Amendments of 1973, a bill to provide increased home health benefits under the medicare program.

This legislation would clarify and expand the definition of home health care medicare benefits to meet the needs of the elderly for nursing and personal care in their own homes. It would also bring under medicare the homemaking services so necessary to maintain the independence of the patient who requires continued care, but not institutionalization. And it would increase from 100 to 200 the number of home health care visits covered by medicare.

This bill is a companion to a bill introduced today by Senator Church, the Home Health Services Act of 1973, which provides "startup" funds for home health agencies and funds for training home health personnel. Together, these bills would give new Federal emphasis to the critical needs of home health care.

In July, I conducted 2 days of hearings on home health care as chairman of the Subcommittee on Health of the Elderly. Witnesses representing such diverse groups as the Gray Panthers and the American Medical Association endorsed home care.

Yet it was also brought out at these same hearings that home health agencies are relegated to an almost insignificant provider role under medicare—receiving less than 1 percent of medicare expenditures. In fact, payments for home care under medicare declined from $115 million in fiscal 1970 to $69 million in fiscal 1972.

In addition, a paper on the current status of home health services prepared by Brahna Trager for the committee reported a decline in the number of certified home health agencies: 2,350 in 1970 compared to 2,221 in 1972 and many of these agencies are having financial trouble.

There is general agreement as to the reason for the decline in home health services under medicare. Our witnesses agreed that it is due not to the lessening in the need for such services, but to a narrowly restrictive policy applied under the medicare program.

Thomas Tierney, Director of the Bureau of Health Insurance for the Social Security Administration, admitted that beginning in 1969 the interpretation of the language of the law has become increasingly restrictive "in application and practice." Yet he also stated that "one of the greatest breakthroughs that medicare made was that it was the first program of any size that ever really recognized a home health service as a covered benefit."

Mr. Tierney asserted that the restrictive policy toward the home health benefit was caused by congressional concern about the overall high costs of the medicare program compared to original estimates.

The result of this approach was evaluated by Dr. Andrew Jessamin, speaking for the American Hospital Association. He said that SSA policy on home health benefits has become so restrictive that few patients can qualify.

He added:

> Apparently concern over opening the door too wide has kept the door so tightly shut that very little light and air could get in and few home care services could get out.

Another witness, Dr. Henry Smith, director of the Nebraska Department of Health, spoke of the "double standard" in reimbursement policy which makes it

much easier to justify institutional services than to justify alternative care under medicare reimbursement procedures. He suggested that a more affirmative attitude, among other things, would be helpful.

This reimbursement double standard was affirmed by other witnesses and the experiences of many agencies. The hospital stay seems to sanctify claims while home care is subject to the most piercing and technical scrutiny.

I have received letters from agencies all over the country detailing medicare denials and delays of reimbursement and the subsequent effects on home health agencies. A feeling of terrible frustration and concern for their elderly patients is expressed again and again in these letters.

One Indiana agency wrote:

> The abuses of Medicare on the home care level have been practically non-existent. The on again off again policies of the federal government and SSA are making orderly development of home health care services practically impossible. Board, staff and patients are confused and disgusted. Many patients go without needed care because their right to Medicare coverage of health care services has been denied them.

The restrictive policy of medicare administrators also puts an unfair burden on concerned agencies who feel obligated to provide care even though the patient cannot afford it. As one administrator, a nun, succinctly put it:

> Do we refuse to give these patients the care they need, or do we give them the care without third-party reimbursement?

When care is given without third-party reimbursement, agencies may be faced with a financial crisis. Then agencies are faced with the cruel choice of either not taking care of the elderly poor or becoming poor themselves.

This is an intolerable situation unworthy of a nation which professes to have a system of medical care for the elderly.

Therefore, it is imperative that the medicare law be amended to provide a home care benefit that truly meets the needs of the aged and provides a real alternative to institutional care. The Congress must reaffirm its intention that home care be a viable medicare benefit.

Mr. President, the legislation which I am introducing today would make the following changes in current law: First, delete the restriction that only "skilled" nursing care or physical or speech therapy may be reimbursed as home health services under medicare, and the requirement that home health treatment be related to the condition which required previous hospitalization; second, include full homemaker services in medicare coverage; and third, increase from 100 to 200 the number of home health services covered by medicare. Each of these changes remedies a barrier to the effectiveness of home health services which has been identified by witnesses testifying in hearings we have held.

The "skilled" nursing-physical-or-speech-therapy requirement has been one of the main barriers to the provision of needed home care to the elderly since it has in effect limited the home care benefit primarily to those who are acutely ill and need rehabilitation. It does not cover, and thus bars from medicare coverage, a wide range of situations when the patient's condition has stabilized or when the patient requires something less than the level of "skilled" nursing care as defined by the Social Security Administration. All nursing care performed by a nurse is skilled, but the term has come to have a very narrow meaning.

As an example of what is not covered, SSA cites the following in its intermediary letter No. 395, which defines skilled nursing care:

> A stroke patient whose condition is stabilized and has no more potential for rehabilitation may require help in getting in and out of bed, getting meals and meeting other activities of daily living. A nurse would visit this patient to evaluate his personal care needs and, subsequently, to assure that the home health aide is performing necessary duties and that the patient's social and personal care needs continue to be met.

Such a situation, I repeat, is not covered. And one of the managers of a home health agency commented on this type of denial as follows:

> In receiving Medicare denials, I have often wondered just how much rehabilitation can be done for an 88 year old person who has perhaps had a stroke or some other debilitating disability and is being cared for by a spouse of equal age. It would almost seem that the provisions of Medicare could more appropriately be applied to a 21 year old, where rehabilitation potential is naturally higher and health problems for long-term chronic disease disability are very low. Medicare, however, is specifically for our

> senior citizens. Therefore, it ought to be realistic about the health care needs and problems of geriatrics. Under the present restrictions it certainly is not fulfilling that realistic need.

In order to meet that very common and even desperate need, this bill would make a patient eligible when he needs, on an intermittent basis, nursing care or any other home health services listed in the law. These other home health services include: Physical, occupational or speech therapy; medical social services; medical supplies or the use of medical appliances; and part-time or intermittent services of a home health aide. The need for nursing care or other necessary services would make the patient eligible if directed by the doctor. Thus, a patient could need only the services of a home health aide for bathing, dressing, et cetera and would qualify if the service was approved by a doctor and carried out under appropriate supervision.

The bill also deletes the requirement that the home health care treatment must be related to the condition which required hospitalization. This requirement has resulted in the denial of many home health care claims because the condition requiring home treatment is different from the one which was originally diagnosed as a cause of hospitalization. As one witness testified:

> Frequently we get patients with four to five or more diagnoses, and if hospitalized for one of these diagnoses and then sent home to home care, we should be treating the reason for hospitalization in order to have Medicare coverage. This condition perhaps was resolved in the hospital, but the other chronic problems appear now to be more disabling. This should be covered under Medicare but usually is not.

By deleting this requirement, this bill makes no change in the requirement that home health services are only covered if they follow a medicare-covered hospitalization.

My bill would also expand medicare coverage of the important service of homemakers. Homemaker services are not now listed in the law as one of the services which may be provided by a home health agency, and the services of the home health aide are narrowly defined in terms of personal care. As a result, aged persons who live alone may be forced to remain in a hospital longer than necessary for the lack of a few simple supportive services such as cleaning or shopping. They may be forced from their own homes and communities into an institution earlier than necessary.

The testimony which I received pointed out again and again the great need for homemaking services by medicare patients. And the report to the committee by Brahna Trager stated:

> The assumption [by Medicare] that others in the home are available to provide the essential supportive services of daily living is not generally applicable to the age of living arrangements of the insured group. It is far more likely that the patient who lives alone or with an elderly spouse will be able to achieve his "personal care" services independently, than that he will be able to maintain a decent environment and get the laundry in.

Since homemaking services are so often essential to the continued independence of the ailing elderly, my amendment would include the part-time or intermittent services of a homemaker in the list of services that may be provided by a home health agency.

Finally, the Home Health Medicare Amendments I introduce today would increase the number of home health visits covered by medicare from 100 to 200. The limitation on visits to 100 under both parts A and B is a hardship to persons requiring extended home care visits. Relatively few medicare recipients need more than 100 home health visits. But those who do should not be cut off from necessary home health services, and possibly forced back into the hospital. Establishing a limit of 200 visits would grant coverage to almost all qualifying home health patients.

Mr. President, medicare is now very much oriented to post-hospital acute-illness care, and is not meeting the needs of many of our elderly. These Home Health Medicare Amendments would make medicare more responsive to the need for home care for patients with chronic and stabilized conditions.

These liberalizations are not costly in terms of the medicare program as a whole. And in the long run it is possible that they may save money by substituting home care for more expensive institutional care.

In fiscal year 1975, for instance, it is estimated that my amendments would raise home care expenditures under medicare from approximately $100 million to between $275 and $300 million. This would be about 2 percent of the total projected medicare benefit expenditures.

These actuarial estimates do not take into account any savings that could be made by the shortening of a hospital stay and the avoidance of hospitalization and nursing home admittance. And these savings could be substantial. The General Accounting Office, for example, has stated that 25 percent of the patient population are treated in facilities which are excessive to their needs.

Home care can normally be provided at a fraction of the cost of inpatient care. The exact ratio is dependent upon the level of care provided. There are no definitive national cost figures. Under the medicare hospital insurance program, however, the amount reimbursed per claim in 1972 was $844 for inpatient hospital care, $398 for skilled nursing facilities and $91 for home health care or roughly 9 to 1 and 4 to 1. These figures give only a very rough idea of cost ratios, for medicare does not necessarily cover total costs, particularly in the case of home care.

Other estimates from the National Association of Home Health Agencies state that home care is 3½ times less expensive per case than hospitalization and four to five times less expensive per day than skilled nursing home care.

Home health services not only cost less than institutional services, but from a communitywide perspective these services can lessen the pressure to build expensive new facilities. And it is from the community perspective that we must view home care—not from the narrow perspective of the cost analyst who may see the home care benefit "cost more" because of this legislation.

Dr. Charles Edwards, Assistant Secretary of Health, stated at the subcommittee hearings that in order to contain the costs of health care we must "encourage the service that will push health care away from the institution and closer to home."

I see an expanded home care benefit as a cost effective and humanitarian device that will help take care of the people in the way that they want to be taken care of and at the least possible cost. It is time to quit paying lip service to home care and make it a viable supplement and alternative to institutional health care for older Americans under medicare.

Mr. President, I urge early adoption of this legislation and ask unanimous consent that the bills be printed in the Record at this point.

The PRESIDING OFFICER. Without objection, it is so ordered.

S. 2695

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Home Health Services Act of 1973".

SEC. 2. Title VI of the Public Health Service Act (42 U.S.C. 201) is amended by redesignating Part D as Part E and inserting after Part C the following new part:

"PART D—Establishment and operation of home health agencies

"SEC. 635. (a) For the purpose of assisting in the establishment and initial operation of public and nonprofit private agencies (as defined in section 1861(o) of the Social Security Act) which will provide home health services (as defined in section 1861(m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary may in accordance with the provisions of this section, make grants to meet the initial costs of establishing and operating such agencies and expanding the services available in existing agencies, and to meet the costs of compensating professional and paraprofessional personnel during the initial operation of such agencies or the expansion of services in existing agencies.

"(b) No part of any grant made under this section shall be used for the construction of facilities, and no recipient of an initial grant under this section shall be eligible for further assistance under this section.

"(c) In making grants under this section, the Secretary shall consider the relative needs of the several States for home health services and preference shall be given to areas in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or both.

"(d) Applications for assistance under this section shall be in such form and contain such information as the Secretary shall prescribe by regulation.

"(e) Payment of grants under this section may be made in advance or by way of reimbursement, or in installments as the Secretary may determine.

"(f) There are authorized to be appropriated to carry out the purposes of this section such sums as may be necessary. Funds appropriated under this subsection for any fiscal year shall remain available until expended.".

SEC. 3. (a) Part D of title VII of the Public Health Service Act (42 U.S.C. 201) is amended by inserting after section 767 the following new section:

"GRANTS FOR TRAINING OF PERSONNEL TO PROVIDE HOME HEALTH SERVICES

"SEC. 767A. (a) From the funds appropriated to carry out this section, the Secretary is authorized to make grants to public and nonprofit private agencies and institutions to assist them in initiating, developing, and maintaining programs for the training of professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act).

"(b) Applications for grants under this section shall be in such form and contain such information as the Secretary shall by regulations prescribe.

"(c) Payment of grants under this section may be made in advance or by way of reimbursement, or in installments as the Secretary shall determine.

"(d) There are authorized to be appropriated to carry out the purposes of this section such sums as may be necessary. Funds appropriated under this section shall remain available until expended.".

(b) The caption for Part D of title VII of such Act is amended by adding at the end thereof:

"AND TRAINING OF PERSONNEL TO PROVIDE HOME HEALTH SERVICES"."

S. 2690

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1814 (a)(2)(D) of the Social Security Act is amended to read as follows:

"(D) in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed nursing care on an intermittent basis or any of the other items or services referred to in section 1861(m); and a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; or".

(b) Section 1835(a)(2)(A) of such Act is amended to read as follows:

"(A) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed nursing care on an intermittent basis or any of the other items or services referred to in section 1861(m); and a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician;".

(c) The amendments made by subsections (a) and (b) shall be effective only with respect to services provided in calendar months after the calendar month which follows the month in which this Act is enacted.

SEC. 2. (a)(1) Section 1812(a)(3) of the Social Security Act is amended by striking out "100 visits" and inserting in lieu thereof "200 visits".

(2) The first sentence of section 1812(d) of such Act is amended by striking out "100 visits" and inserting in lieu thereof "200 visits".

(b)(1) Section (a)(2)(A) of such Act is amended by striking out "100 visits" and inserting in lieu thereof "200 visits".

(2) The first sentence of section 1834(a) of such Act is amended by striking out "100 visits" and inserting in lieu thereof "200 visits".

(c) the amendments made by subsection (a) shall be applicable in the case of home health services provided under part A of title XVIII of the Social Security Act on visits which occur in one-year periods (described in section 1861(n)) of such Act which begin, in the case of any individual, after the date of enactment of this Act. The amendments made by subsection (b) shall be applicable in the case of home health services provided under part B of such title XVIII in calendar years which begin after the date of enactment of this Act.

SEC. 3. (a) Section 1861(m)(4) of the Social Security Act is amended to read as follows:

"(4) part-time or intermittent services of a home health aid and of a homemaker.".

(b) The amendment made by subsection (a) shall be applicable only in the case of services furnished in calendar months after the calendar month which follows the calendar month in which this Act is enacted.

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