BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

TUESDAY, MARCH 6, 1973

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

The subcommittee met, pursuant to recess, at 9:45 a.m., in room 6226, Dirksen Building, Hon. Edmund S. Muskie (chairman) presiding.

Present: Senators Muskie, Fong, and Percy.

Also present: William E. Oriol, staff director; Kenneth Dameron, Jr., professional staff member; John Guy Miller, minority staff director; Robert M. M. Seto, minority counsel; Patricia Oriol, chief clerk; Gerald Strickler, printing assistant; and Pamela Phillips, clerk.

Senator MUSKIE. We begin this morning's hearings with a new and distinguished colleague from the Midwest, who won an unexpected victory, a very welcome one, if I may be that partisan, so Senator Clark, we are delighted to have you here this morning, and to take your statement, and to invite you to sit here for the rest of the morning if you have the time and listen to our other witnesses.

STATEMENT BY SENATOR DICK CLARK OF IOWA

Senator CLARK. Thank you very much, Mr. Chairman.

I welcome the opportunity to appear before this subcommittee and to testify on this most important matter because I represent a State that has the second highest proportion of elderly in its population among States in the Union. Almost 12½ percent of our citizens are over 65 years of age; one out of every eight would be adversely affected by these proposals.

The administration's proposals to change costs of Medicare by increasing out-of-pocket payments for beneficiaries will affect over 355,000 aged and disabled persons in my State of Iowa.

Recently I have ascertained from the Kansas City branch of the Social Security Administration, vital statistics concerning the out-of-pocket raises which will occur if the proposed changes are enacted.

The additional costs to my constituents, had such a plan been in effect during calendar year 1972, would have been around $13 million for part A of the Medicare program, and approximately $6 million for part B of the program.

Taken together, this is a per person average raise of approximately $70 a year. I suspect the additional costs would be considerably higher in the coming years, given the spiraling costs of hospital care, physicians' fees and related medical care.

Administration's Proposals Opposed

Mr. Chairman, I strongly oppose the administration's proposals to raise the out-of-pocket payments of our older and disabled Americans, considering their needs and ability to pay.

The idea of an insurance beneficiaries' program such as Medicare is to spread the liability for any specific claim over as broad a base of the population as possible.

By shifting the cost of the Medicare program to the elderly and disabled, we do not achieve the stated purpose of insurance, but rather we shift the burden of the liability to a narrower segment of the population.

A segment of the population that is, on the whole, significantly poorer than is its younger counterparts.

The administration feels that it can better utilize medical, hospital, and related health care by making the consumer, in this case the aged and disabled, more conscious of costs by raising deductibles and copayments under Medicare.

However, this idea of a user tax is absurd, considering that the patient does not determine what health facilities or medical care will be used.

This utilization factor is strictly in the hands of the physician. It is the doctor who decides what facilities must be used and what measures need to be taken to insure proper medical care, and certainly is not the decision of the patient.

Mr. Weinberger seemed to me to be implying otherwise in his testimony before this subcommittee yesterday. This user tax is by no means a viable method to "increase incentives for appropriate use of services" as detailed in President Nixon's budget message of January 29, 1973; rather it will cause many of our older citizens who need health care to stay away from the doctor for fear of excessive costs. This becomes particularly important when we remember that one out of every four Americans who are over 65 live below the poverty level.

By making our disadvantaged and aged citizens pay from $700 to $900 million more in out-of-pocket payments it is difficult to understand how the cause of good health care is advanced.

1971 White House Conference Recommendation

In the recommendations placed before the President and the Congress by the 1971 White House Conference on Aging, it was proposed that:

> * * * The complete range of health care services for the elderly must be provided by expanding the legislation and financing of Medicare and should include elimination of deductibles, coinsurance, and copayments * * *.

It is time that we consider this type of recommendation rather than take a giant step backward by doing just the opposite—raising deductibles, coinsurance and copayment, as the administration proposes.

The opinions of the older Americans have been made very clear. Medicare benefits need to expand in scope and depth in order that so many of our parents and grandparents can live a life that is not threatened by financial disaster caused by needed medical and hospital care and related health care.

The administration's proposed Medicare payment cutbacks do not achieve this goal.

Thank you, Mr. Chairman.

Senator MUSKIE. Thank you very much, Senator, for your excellent statement.

I think it zeroes in on the issues surfaced yesterday with Secretary Weinberger.

I could not agree with you more, that to use this method for the purpose of improving utilization is simply to push the wrong button, and I must say Secretary Weinberger, at the conclusion of 2½ hours of testimony and questioning and responding, still had not defined in great precision how that is intended to be achieved.

Another argument the Secretary made on behalf of the administration was that it was necessary to shift the benefits from those who over-utilize hospitals on a short-term basis to those who necessarily were confined for hospital care for longer periods than 60 to 90 days, and yet the fact is that the $700 to $900 million figure which you used, and which he protested yesterday, he said it was only $500 million, but in any case that $500 million is not shifted from persons using hospitals on a long-term basis to short-term patients, but rather is shifted to the Treasury of the United States. Actually the cost of care for those patients who utilize from 60 to 90 days is higher under the administration's proposal than under current law. If there is any reduction, it is for patients in hospitals longer than 90 days, and they constitute only one-tenth of 1 percent of Medicare patients using hospital care, so your testimony really does focus on these key points. We are delighted to have your testimony, which I am sure could be reinforced by testimony from Senators from all the 50 States. We would be delighted if you could spend some time this morning to hear some of this other testimony.

Senator CLARK. Thank you very much, Senator.

Senator MUSKIE. Senator Williams had planned to be with us this morning, but has other commitments, and unfortunately cannot be here. Without objection, his statement will be inserted in the hearing record at this point.

PREPARED STATEMENT OF SENATOR HARRISON A. WILLIAMS OF NEW JERSEY

Mr. Chairman, I am very pleased to have the opportunity to present my views before this subcommittee on the problem of health services for the elderly. I believe there is a kind of national misunderstanding about the ability of our elderly citizens to obtain adequate health care services. It is generally assumed that the enactment of the Medicare law automatically removed the barriers between the elderly and the health care they so often need. Unfortunately for the elderly, that assumption is wrong. For one thing, there are substantial gaps in Medicare coverage. This is particularly true with respect to outpatient prescription drug costs which currently average over $70 a year for the elderly. In addition, there are the deductibles, the copayments and the premium payments which are an additional financial burden to Medicare beneficiaries.

Beyond the limitations of the Medicare program, however, there are those barriers to health care for the aged, which are inherent in the existing health care delivery system. For example, there is the growing shortage of primary care physicians, general practitioners and internists, particularly in rural areas and small towns where so many of the elderly reside. And there is the fragmentation of health care services even in areas where professional health personnel are not in short supply. Such fragmentation can have a very disturbing effect on an elderly person seeking health care.

Most physicians in this country are in practice alone or in practice with other physicians in the same specialty. Similarly, hospitals, laboratories, nursing homes, and other organizations are organized as independent businesses. Each of these specialists and institutions frequently assumes that responsibility for the patient ends when the patient leaves the premises. Even when an elderly patient is referred by a physician to another source of care, he must make all of the arrangements for himself, wait for an appointment and often travel considerable distances to receive needed services. Once there, he must repeat the nature of his health problem to each new physician because the existing health care system provides for little continuity of care. The journey through this kind of maze is difficult even for the younger patient. For those whose energies are already taxed by age and chronic illness, it can be a severe and trying ordeal.

There is a great need for strong leadership and direction from the Federal Government in the development of a national health policy to eliminate the still existing barriers to health care. This great national need exists not only for the elderly but for all Americans. To date, that kind of leadership has not been forthcoming from the Nixon administration. In its place there is substantial evidence of a lack of concern about national health needs and problems, particularly those facing the elderly.

In his first health message, the President stated that the Nation faced a growing health crisis and he pledged his administration to the task of developing a comprehensive health strategy to meet the health needs of the 1970's. Those fine words were universally applauded by all and we waited for them to be translated into positive actions.

We need wait no longer. There is now evidence that the President's health strategy is to reverse the Nation's commitment to assure the aged access to quality health care. I am referring, of course, to the recent announcement by the Department of Health, Education, and Welfare that the administration will propose legislation to modify the cost sharing provisions included in both part A and part B of Medicare. With respect to part A, the administration proposal would require Medicare beneficiaries to pay an initial deductible equal to 1 day's hospital charges plus daily amounts equal to 10 percent of the charges he incurs for each remaining day in the hospital or extended care facility. Under the existing Medicare law, when a beneficiary enters a hospital, he becomes responsible for an initial deductible of $72. He then pays nothing for hospital services until his 61st day when he must pay a daily amount equal to one-fourth the initial deductible. Should his hospital stay extend over 90 days, he must pay a daily amount equal to one-half the initial deductible beginning with the 91st day.

There is no doubt that the existing copayment requirements constitute a substantial financial burden to many Medicare beneficiaries. And the President's proposal will serve to increase that burden substantially. The administration contends that its proposal will eliminate high cost sharing at the end of a long hospital stay. The truth is that, while the proposal might be of some benefit to the small number of Medicare beneficiaries who are hospitalized for prolonged periods, the majority of beneficiaries would be faced with substantially larger out-of-pocket expenses for hospital care than they now incur. Statistics compiled by the Social Security Administration show that the majority of beneficiaries are not in the hospital for these long periods of time. The number of covered days of care per inpatient hospital claim under Medicare during the first month of 1973 averaged 11.3 days.

The administration's other contention is that the modifications in the hospital insurance provisions would serve as a check on the utilization of hospital services by making beneficiaries more conscious of the cost of hospital care. Again, I cannot accept the Nixon argument. In the absence of financial barriers to hospital care, the patient has little or no say about whether he is admitted to a hospital, how long he will stay or what services he will receive. These decisions are all made by is physician, presumably for sound medical reasons.

The President is also recommending that the deductible under the supplementary medical insurance program be increased from $60 to $85 and that the coinsurance requirement be raised from 20 to 25 percent. The Medicare beneficiary's cost sharing responsibilties under the supplementary medical insurance program already constitutes a staggering burden: premium payments which have risen almost yearly, a deductible which was just raised by the Congress from $50 to $60 last year, partly at the President's request; and a coinsurance payment that often can exceed 20 percent of his physician's bill because of the administrative regulations regarding refunding of these costs.

I am certain that the members of this subcommittee share my outrage about the likely effects that this proposal will have on the health status of the aged. I know that you also share my belief that the administration's inaction in the area of health must be countered by a commitment in the Congress to develop a comprehensive national health policy. That national health policy must provide for alternative mechanisms for health care delivery, increase needed health resources—particularly health manpower, and deploy those resources we now have in a more rational manner. You will receive my strongest support in this vital effort which is so desperately needed by our older citizens.

Senator MUSKIE. Senator Bible, due to prior commitments, could not be with us today. Without objection, his statement will be inserted in the hearing record at this point.

PREPARED STATEMENT OF SENATOR ALAN BIBLE OF NEVADA

Mr. Chairman, I am opposed to the President's proposal that the Government renege on the promise made in 1965 to help the aged meet their cost for medical care. Medicare covers less than half of the high costs incurred by our senior citizens. As inflation boosts these costs higher, the President proposes to put an even greater share of medical costs onto the Medicare beneficiary.

I strongly object to this proposal to shift more of the cost of Medicare onto the Nation's senior citizens. Twenty million older Americans, who already are under financial stress, should not be required to assume this new burden.

Implementation of the administration's proposal would put decent health care beyond the financial reach of many of the 11.6 million who will apply for benefits next year. It would add to their financial burden by some $893 million over the next fiscal year. For 5 million elderly citizens, the costs of hospital services alone would jump by $690 million in the first year.

I was astounded when I compared the cost of hospitalization to a Medicare beneficiary under the existing coverage and under the reduced coverage proposed by the President. The comparative costs to the beneficiary using an assumed average daily hospital charge of $72 are illustrated in the following table:

Days in hospital	Patient expense today	Proposed patient expense
1	$72	$72
5	72	101
10	72	137
11	72	144
20	72	209
40	72	353
60	72	497
61	90	504
80	432	641
90	612	713
91	648	720
100	972	785
120	1,332	929
150	2,412	1,145

Most people spend less than 10 days in the hospital, and they would be hit hard by the President's proposed changes in coverage. The average beneficiary spends 11.3 days in the hospital. His out-of-pocket costs would double from $72 to $144. Only 1 percent of the beneficiaries spend more than 60 days in the hospital. Very few beneficiaries, staying more than 95 days in the hospital, would profit from the coverage proposed by the administration.

This tabulation also shows the desperate plight of the unfortunate few who are hospitalized the longest. For most older Americans, paying out more than $2,400 for a 5-month stay in the hospital would constitute economic disaster. Medicare as it stands today, or as it would be changed by the President, is not an adequate response to this kind of problem. Special attention must be given to affording our senior citizens some form of effective protection against the financial catastrophy long-term illness can bring.

The administration rationalizes its proposal for changing the coverage of Medicare on two bases: Giving beneficiaries a greater awareness of costs of medical services and decreasing Federal expenditures. Has the President really lost touch with older Americans? Does he really think older citizens do not know what they pay to protect their health or that costs for medical services have soared in the last 4 years? Does the President really feel that those of our society who are least able to pay should bear the costs of reducing Federal expenditures? I submit that this proposal by the administration to help achieve fiscal responsibility flies in the face of its social responsibility.

Furthermore, if Federal expenditures are to be cut by reducing Medicare benefits, then either the Social Security tax to finance Medicare should be reduced, or the monthly charges imposed on Medicare participants should be reduced. Perhaps both should be reduced. The President's proposal smacks to me of impoundment, another insidious attempt to deny funds for the purpose for which they are intended.

Of course, I agree with the President that Federal spending must be cut back. And I will support cuts in programs that are no longer needed or no longer effective. But I cannot understand how the President justifies seeking an increase in foreign aid and military spending while trying to cut a billion dollars from Medicare benefits. Increasing the burden on the old and the sick is not the way to correct our budgetary problems.

Our senior citizens deserve better treatment from the country they worked to improve and the Government they supported financially for so many years The small, fixed incomes of older Americans cannot be stretched to cover all of the escalating costs for the necessities of life—food, shelter, and health. The Congress should not allow the insult that the administration proposes by cutting Medicare benefits to be added to the injury already sustained by escalation of costs of living.

Senator MUSKIE. Our second witness this morning is Mr. Melvin A. Glasser, director, social security department, United Automobile Workers, Detroit, Mich.

Mr. Glasser, it is a pleasure to welcome you this morning, and I would say we need your testimony.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, UNITED AUTOMOBILE WORKERS, DETROIT, MICH.

Mr. GLASSER. Mr. Chairman, I appreciate this opportunity to testify. My name is Melvin A. Glasser, and I am director of the social security department of the international union, UAW.

The UAW has some 400,000 retirees and dependents who are covered by Medicare. Our active worker membership of over 1,400,000 workers also have a deep interest in the Medicare program: Their taxes are paying for Medicare; they have close identification with their fellow workers no longer in the work force; most of them have parents and relatives covered by the program. Finally, they recognize that at some future date; they too will be Medicare recipients.

Prior to the passage of Medicare, the UAW was active in legislative efforts to translate legislation into law. Since 1966, our union has studied the administration of Medicare, followed various proposals to strengthen it, and appeared before this and other committees of the Congress to share our experience and our views.

I am grateful for the invitation from you to testify today, Mr. Chairman. The administration's proposal to alter the Medicare program have grave import for the more than 21 million elderly Americans who look to it as the major means of making it possible to pay for urgently needed health services.

1.7 Million Disability Beneficiaries

The proposed cutbacks also dim the prospect of health care protection for 1.7 million disability beneficiaries who will become Medicare eligible in mid-1973, and for persons covered by Social Security and their families who require treatment for chronic kidney disease.

When Medicare began in 1966, it held great promise for the elderly citizens of our Nation. In the first annual report on Medicare, then Secretary of Health, Education, and Welfare, Wilbur Cohen, stated:

> For the first time in their lives, many have access to the full health resources of their communities * * *. And many have received surgical or corrective therapy that, without Medicare, would have been delayed or not undertaken at all.

Despite the onset of problems and deficiencies, HEW Secretary Richardson, in the fourth annual report on Medicare, issued in 1972, indicated that:

> Skeptical as many people were of Medicare at the beginning and critical as others now are of certain aspects of the program, there is general agreement in all quarters of the country that Medicare has proved to be a good and beneficial program.

This confidence was underlined by administration proposals for national health insurance introduced before the 92d Congress: the Medicare program for the elderly was to remain intact, and many of the patient cost sharing, administrative, and regulatory features of Medicare were incorporated in the proposed new programs.

Medicare has been of inestimable value to the elderly, who now enjoy basic health care protection against the costs of illness and infirmity. The addition to the program, effectively July 1973, of Medicare coverage for disabled beneficiaries is a positive step which the UAW advocated in testimony before the House Ways and Means Committee in the fall of 1969.

The burden of my testimony today is to demonstrate that Medicare performance has not lived up to its promise because it has not dealt with the basic problems of health care disorganization in this country. Furthermore, the administration's proposed cutbacks in Medicare coverages, because they do not deal with the causes of inflation in health care costs, will not solve the problems, and will cause added hardship to the elderly.

After years of discussion and debate it is generally recognized by most students of the health care system that there are several basic problems which underlie its dysfunctional nature and the accompanying, almost uncontrolled inflation which has characterized it in the last 10 years. These problems are: Shortages and maldistribution of physicians and other health personnel; inadequate or feeble cost controls; limited and often nonexistent quality controls; disorganization of services with concomitant fragmentation in their delivery; and the interrelatedness of these four factors.

The problems we face in Medicare today are a reflection of the core causes of the health care crisis in this country. In Medicare the problems are made more complex by insurance industry oriented statutory specifications which do not permit organizational change in health services and encourage extravagance and further distortions and fragmentation of medical care delivery. Further, the practice under this

program have enlarged and intensified the administrative, delivery, and cost problems throughout the entire private health care sector.

Four assumptions which underlie Medicare have proved to be of dubious validity.

Actual Costs Outstripped Estimates

First is the early assumption that dollars alone would enhance the health status of the elderly.

The actual costs of Medicare outstripped earlier estimates by a considerable margin. The Office of the Actuary of the Social Security Administration reports that hospital insurance disbursements increased 179 percent between fiscal years 1967 and 1973, while surgical-medical disbursements rose 280 percent during this same period of time.

In fiscal 1974, Medicare will be the Federal Government's largest health activity and will account for 43 percent of Federal health outlays.

In view of this appalling escalation, it should come as no surprise to us that the fires of Medicare inflation, which have burned 10 percent of the U.S. population, have also singed the rest of us. In March 1972, the Social Security Bulletin demonstrated that during the post-Medicare period of 1967 to 1971, the medical care price component of the consumer price index increased at twice the rate reported in the 1960 to 1967 pre-Medicare era: 6.6 percent versus 3.2 percent.

Second, the idea that quality control could be effected through existing health system mechanisms.

It was initially expected that control over quality of hospital and physician services would be limited principally to self-regulation by those who would provide the services—the physicians, the hospitals, and the nursing homes. There is ample evidence to indicate this has proved to be an unsound assumption.

Operations by Noncertified Surgeons

As but one illustration, the Archives of Surgery states that almost half the operations performed in the United States are performed by noncertified surgeons.

The very necessity of much of the surgery performed today in our country is called into question by the report of Dr. John Bunker that we have twice as many surgeons in proportion to population in our country than has England and Wales, and that U.S. surgeons perform twice as many operations as in the United Kingdom.

Medical fiscal agents have shown little interest in the quantity or appropriateness of surgery.

The elderly are admittedly difficult patients. They are time consuming. Many physicians will not take elderly patients. The economics of solo, fee-for-service practice makes it more rewarding to deal with younger people who often take less time to be seen and with whom there are fewer communications problems.

Accordingly, from our own experience in the UAW, we know that the elderly are seen in a large number of instances by older physi-

cians, by semiretired physicians, and by physicians who on the whole are less qualified than the very well-trained doctors who constitute the majority of the American profession. In the absence of requirements for continuing education, the elderly not infrequently receive health supervision of dubious quality.

The use of fiscal paying agents in Medicare contributes to poor quality. For example, the Comptroller General of the United States, after examining the operations of seven paying agents in five States, reported in 1971:

> The paying agents independently developed their systems for detecting possible unnecessary services. As a result the systems are based on widely varying methods. For example, one agent questions the need for more than 4 office visits a month; another does not question the need for visits unless they exceed 10 a month.

In the long run, the best health care is the most comprehensive health care and becomes the least expensive health care. This is a quality factor not sufficiently recognized in the Medicare program. Its benefits are not comprehensive enough, and the overall quality suffers as a result.

"Assignment" Under Medicare Program

Third, the assumption that the payment of reasonable and customary fees to physicians would assure their full participation and would protect patients from overcharges.

Initially, some 60 percent of the Nation's practicing physicians accepted "assignment" under the Medicare program. It was thought that more would do so because many physicians, alerted by their State and medical societies, in fact raised their fees substantially before Medicare started. But actually, the figure on assignment has decreased to the present level of about 49 percent. The elderly person whose doctor refuses assignment must now pay out-of-pocket the difference between the doctor's charges and what the fiscal intermediary decides is a fair reimbursement.

A 1971 study by the Michigan department of social services of increases in physician incomes attributable directly to Medicare and Medicaid concludes: "Such a result clearly qualifies as 'income redistribution' but, needless to say, it is woefully misdirected."

Prior to Medicare, our union was able to maintain in most jurisdictions of the country where we have members the continuation of a fee schedule for physician services. There were inequities in the schedules, but basically they operated well. The impact of the billions of Medicare dollars, accompanied by billions of Medicaid dollars, paying on a reasonable and customary basis forced us reluctantly to agree to give up fee schedules and conform with the public program practices. In the very first year of the switch, this represented a 30 percent increase in our insurance premium costs.

What I am trying to say is that reasonable and customary payment is a problem for the elderly, but that, in addition, it creates a problem for the entire society.

Senator Muskie. Maybe we should have chosen a fight rather than to switch.

Mr. Glasser. You may be right.

Protecting Basic Incomes

Fourth, the assumption that Medicare would safeguard the income status of the elderly by paying for their medical expenses and thus protecting their basic incomes.

Two million older persons receive old age assistance today. This figure has remained relatively stable for the past several years. The median income of persons age 65 and over was only $2,044 in the spring of 1972. In 1970, nearly one-fifth of all persons age 65 and over were below the poverty level, while among the unrelated elderly, about 40 percent of the males and 61 percent of the females had incomes below the poverty level. When, therefore, we talk about cost sharing with the elderly, we are talking about a group who are basically poor people.

Medicare has not improved their economic status. According to HEW, the average out-of-pocket payment for personal health care by the elderly in 1971 was only $9.57 less than it had been in 1966, before Medicare. And in fiscal 1971, Medicare met only 42 percent of the personal health expenditures of the aged, a slight decrease from the previous year.

The primary reasons for this disappointing economic record is inflation of health care costs. Another major cause is lack of comprehensive benefits. Prescription drugs are an example. The 1968 task force on prescription drugs reported per capita costs for the elderly for this one program were more than three times those of persons under age 65. Yet only 16 percent of the elderly had private insurance for prescription drugs in 1971.

Administration's Proposals for Medicare Changes

I would next like to deal with the administration's proposals for Medicare changes.

The problems which have beset America's health care system, reflected in Medicare and compounded by it, need to be seen against the backdrop I have sketchily outlined.

The administration is quite correct in its assessment that important changes are needed in Medicare. Its prescriptions for cure are not likely to succeed because they do not deal with the causes of the problems.

The principal feature of the administration's proposals is: "* * * seeking to encourage greater cost consciousness and cost awareness on the part of the medical care consumer in order to minimize over-utilization of medical services."

Most Social Security recipients already living on minimal budgets do not need any encouragement for cost consciousness. Furthermore, as testified to by Senator Clark and others, it is only physicians who write prescriptions, admit patients to hospitals and nursing homes, and discharge them from these institutions. The notion that cost consciousness on the part of the Medicare patient would change this situation cannot be supported by the facts.

In addition, it has been suggested that patients would be encouraged to shop around among hospitals and nursing homes to find the best

buys. This simply is not the way the system works. Patients almost never have a choice as to when and where they are hospitalized. They go to a hospital which has an available bed and at which their physician has privileges. We have had instances in our union of members asking their doctors to place them in less costly hospitals when they were ill. Their doctors were quite willing to do this, but indicated that they would then have to find other physicians who had privileges in the less costly hospitals.

Further, the present system simply does not provide means whereby a prospective patient may call hospitals in his community and ask for quotations on the daily room and board charges plus other expected charges he or she might have to pay for treatment of a heart attack or a stroke, or surgery for a hernia or a gall bladder removal.

One of the principal problems with the administration's proposals is that they go counter to the basic social insurance principles which underlie Medicare, and most other insurance programs. Instead of spreading the costs over the entire population, the administration's proposals transfer the costs in increasing amounts to those who become ill and require the use of services. They, therefore, pay for them at a point in their lives when they can least afford it. This is a retreat of major magnitude from social insurance.

Under the proposed changes, part A beneficiaries would shoulder the actual charges of their first day in the hospital. After the first day, the patient would continue to pay 10 percent of actual charges for each succeeding day of hospital, nursing home, or home health agency service.

As the subcommittee knows, under the present system, there is no patient copayment for initial hospital and nursing home days and no copayment whatsoever for home health agency services.

Part B enrollees, under these proposals, would find their deductible payments increased from $60 to $85—a 42 percent increase. Their copayments would rise from 20 to 25 percent.

As I have indicated, these all represent a further retreat from the social insurance principle. Part A deductible and copayments have risen 80 percent since Medicare began; by July 1973, part B will have escalated 110 percent; the part B deductible rose 20 percent this past January.

Elderly Postpone Needed Care

That the administration's proposals for increased charges are inappropriate remedies is demonstrated by the fact that rising prices have clearly not held back demand for Medicare services. There is still a great unmet need and further increases in charges in all likelihood would force even more of the elderly to postpone needed care.

During hearings last month before the Senate Committee on Labor and Public Welfare, on the confirmation of Caspar Weinberger as the new Secretary of Health, Education, and Welfare, three questions regarding patient cost sharing were put to the nominee:

(1) Were there any statistics showing the elderly overutilized the health care system relative to other groups?

(2) Were there any studies showing that increased deductibles and copayments have a positive effect in moderating utilization?

(3) Were there any studies indicating that after 100 days hospitalization there was any appreciable favorable effect from having paid 10 percent of actual charges from the second day of care as opposed to the present method of paying an amount equal to 25 percent of the first day hospital deductible for each day of hospitalization beyond 60?

Secretary Weinberger could not cite evidence at the hearing, but indicated that he thought there were studies which could be reported to the committee. To my knowledge, this report from HEW has not yet reached the committee. There is, however, some evidence on these questions.

We all know that the elderly use health services more substantially than those below age 65. However, when we turn to comparative statistics on the length of hospital stay, there is little appreciable difference between the pre- and post-Medicare periods. In 1966, persons age 65 and over averaged 13.4 days per hospital stay: In 1969, the latest period for which figures are available, the elderly averaged 14 days per hospital stay—a modest 4.4 percent increase—this despite the fact that Medicare was paying most of the hospital bills.

Blue Cross-Blue Shield Survey

In the fall of 1971, the Blue Cross and Blue Shield national associations undertook a survey of their member plans to sample opinions on deductibles, coinsurance and copayments. While member plans believed such mechanisms had an impact on utilization, the exact nature of the effect was unclear. However, the report indicated that imposition of these deterrents could act as economic barriers to needed care, resulting in underutilization of health care services.

A 1972 study reported in the Social Security Bulletin of the effects of coinsurance payments on the use of physicians' services found no conclusive answers as to whether coinsurance reduced overuse, unnecessary services, of "sniffle complaints." It did, however, demonstrate that the introduction of coinsurance led to a substantial reduction in the use of physician services and that the lowest socioeconomic group of enrollees reduced their use the most.

The evidence would seem to indicate that the coinsurance proposals of the administration are not likely to change utilization, except in ways that would be detrimental to health.

The administration proposal for further cost sharing by transferring increasing patient payments from the part A program to the patient for hospital care, as I have already indicated, is not likely to enable the patient to select a cheaper hospital. But the administration has suggested, in addition, that the patient is less likely to be able to afford the cost of care after a great many days in the hospital. Therefore, the long-term patient, says the administration, will be better off than the short-term one. However, according to the 1972 current Medicare survey report, only 1.4 percent of Medicare beneficiaries in 1968 were hospitalized 61 days or more.

Thus, the administration proposal would increase the cost sharing burden on 98.6 percent of Medicare hospital patients in order to diminish the cost impact on 1.4 percent of those hospitalized. This

seems to be the reverse of equity. All but a very few of the 5 million elderly citizens who will be hospitalized this year would just about have their out-of-pocket costs doubled by the administration's proposal.

Higher Coinsurance and Deductibles

Higher coinsurance and deductibles will not reduce the number of hospital admissions. There is evidence from a number of studies, including a nursing home study we have conducted ourselves, that such increased cost sharing, if substantial enough, may force patients and physicians to seek alternative care. This may be desirable if in fact there were viable alternatives to hospital and nursing home care. But doctors, by and large, have been reluctant to transfer patients to nursing homes; and patients, worried by substantial evidence of poor quality of care in many Medicare nursing homes, have resisted these transfers.

The home health care services offered under Medicare are an attractive and potential highly useful alternative. The number of communities in which they are available is so few, however, that this is a relatively little used benefit.

Furthermore, the administration's proposals, while aiming at less costly alternatives, would also deter their use by introducing a 10 percent daily payment to nursing homes and home health care agencies, obviating the elimination of the deductible from Medicare part B home health care benefits, which was introduced on January 1, 1973.

In an interview with Garnett Horner of the Washington Star-News prior to his inauguration, the President called for "a new feeling of responsibility * * * of self-discipline." He called on us to rely more on our own resources than on public spending in our behalf.

This is a call for the return to the virtues of an early and less complex time in America. I believe, however, that the old-fashioned virtues also called on us to honor our elders. In an era when living generations of families are increasingly separated by geography and residence, I suggest that if we insist that the old be self-reliant, we should not undermine their financial capacity to do so by reducing the public commitment to Medicare.

It would be ironic and sad to find the consequences of the administration's cutbacks resulting in increased medical indigency and escalation in the number of elderly forced onto public welfare rolls.

Short-Range Cost Savings

The burden of what I have said thus far, Mr. Chairman, has been the administration is correct in recognizing that there are serious problems in Medicare and that they cry out for solution, but the administration's solutions are entirely fiscal in nature. They do not deal with the problems and accordingly will provide no solutions. In my view, the absence of concentration on the root problems would mean that inappropriate solutions might make some very short-range cost savings through penalizing patients. However, within 2 to 3 years, it would be necessary to come back and propose further penalties, for the problems would not have been solved.

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Constructive Alternatives

I should now like to outline several constructive alternatives which might begin to deal effectively with the problems in the Medicare program. Among them I would suggest the following:

1. Vigorous administration support for extensive development of health maintenance organizations as proposed in Senate bill 14. It is not enough to make available as the Medicare program will be doing in July, dual choice with health maintenance organizations under severe restrictions. We need a great many more such organizations, since we now have extensive evidence that prepaid group practice plans are able to provide good quality care far more readily and more economically than the present fragmented, solo practice approach.

2. Adoption of a fee schedule for paying physicians, together with making assignments by the physician mandatory. I am not proposing the introduction of cutrate medicine. Quite the contrary. The adoption of such a schedule could have a major impact on the escalation of Medicare costs.

3. Initiation of a program to bring all participating hospitals under reimbursement through approved annual budgets rather than the present cost-plus basis. Such a program has operated in Canada for a dozen years with substantial success.

4. Combine Medicare and Medicaid, with provision for modest increased contributions from general revenues to support Medicare. The integration of records, a single claims review process, and a single set of standards would make for major administrative economies and be a blessing to providers as well as to patients, who must find their way through the complex eligibility requirements of both systems.

5. Abolition of the deductibles in part B and eventually of the present coinsurance and deductibles in part A. Again, this would reduce administrative costs, aid a large number of beneficiaries, and make possible appropriate care when needed.

6. Addition of a prescribed prescription drug benefit. This is a major worry and cost item for the elderly. Very few, even of those who can afford supplementary private insurance, have coverage for prescription drugs. There are proper concerns over the costs of adding such a benefit. A number of carefully thought through alternatives are available to phase in such a benefit so that the high impact of costs on the program would be reduced in the early years.

7. Phase out the use of fiscal agents in the Medicare program. As early as the beginning of 1968, the Health Insurance Benefits Advisory Council, in reviewing the first year of operations, began to raise questions as to the appropriateness of using fiscal agents. These questions derive from concern as to the effectiveness of these fiscal agents in both cost and quality control. Since then, many more questions have been raised by reports of the Comptroller General on administrative practices of these fiscal agents. In 1969, the HEW Task Force on Medicaid and Related Programs, of which I was privileged to be a member, recommended that a study be undertaken of the effectiveness of the fiscal agents. There is reason to believe that there would be both cost savings and quality improvements if the Congress faced up to the issue and insisted on adherence to the time-honored principle of public administration: That public expenditures be publicly supervised.

Mr. Chairman, I began this testimony with comments that the root causes of the present problems faced by Medicare are those of inadequate supply and distribution of health personnel, poor cost controls, inadequate quality of care, fragmented distribution of services, and the interrelationship of these four factors. The theme of my testimony has been that Medicare reflects and makes even more complex these basic problems in the system.

Comprehensive Health Security Proposal

Because the administration's proposals for change in Medicare do not address themselves to these problems but would primarily add hardships and suffering to the elderly, it is my view that they are inappropriate and not likely to succeed.

I have suggested a number of changes that might help to deal with the problems we recognize exist in Medicare. Though partial and incomplete, they are more appropriate in my view than those suggested by the administration. But they are at best only half answers. The basic answer lies in the adoption by the Congress of a comprehensive health security proposal which would provide universal access to health services for all Americans, and which would make possible major changes in the delivery system and in cost and quality controls.

Such a program is within the economic means of our country. It is possible to bring about comprehensive change which would help the elderly and all Americans within the parameters of what this country is now spending for health care.

The program proposed in S. 3, the health security program now before the Congress, is in my view a realistic and constructive approach to dealing with the basic causes of the problems with which we are grappling in these hearings. I would hope that the Congress will pass this program in this session, for this is truly what the elderly need.

In President Nixon's 1971 health message to Congress, he said:

> The toughest question we face then is not how much we should spend but how we should spend it. It must be our goal not merely to finance a more expensive medical system but to organize a more efficient one.

In my view, Mr. Chairman, the administration's Medicare proposals do not meet the criterion enunciated by the President. They attempt to deal with how much we should spend. The health security program proposes to organize a more efficient system of health care for all Americans, including the Medicare beneficiaries.

Senator Muskie. Thank you very much, Mr. Glasser, for your excellent testimony.

I appreciate the cost critique of the administration's proposed cuts in Medicare, but I also appreciate your constructive suggestions that you have given us.

Now, with what you said in your testimony, with respect to the President's call for a "new feeling of responsibility, of self-discipline," yesterday Mrs. Alice Brophy of New York made the point that the Social Security system is a reflection of the fact that the working Americans in their self-reliant years, while they were working, had contributed to the Social Security fund, they are entitled therefore in

their retirement years to get the benefit of those self-reliant years with adequate programs of medical care, though the President's rhetoric is not matched as it seldom is by his actions and his recommendations.

For example, yesterday I made the point that at the same time he proposes cutting Medicare benefits by a minimum of $500 million a year, and the estimate is as high as $800 or $900 million a year, he did not propose any reduction in the Social Security tax increases of last year, and the result of that omission is to funnel the $500 million or whatever it is, not to ordinary Medicare patients, but to the U.S. Treasury.

The U.S. Treasury may be a sick patient, but it seems to me it is not laced with the health problems of senior citizens, so many of them trying to live on below-poverty-line incomes.

Mr. GLASSER. May I extend that just a bit, sir?

REGRESSIVE SOCIAL SECURITY TAXES

Our union and many others are very concerned about the regressive nature of the Social Security taxes, and we are making some proposals to alter that.

The way the system stands now, as you well know, the near poor and the workers pay a much larger percentage of their income than the more affluent, for Social Security taxes, which are the taxes basically supporting Medicare. We now have before us proposals that say to the poor, near poor, and the workers, you pay a larger portion of your taxes to finance this program, and in return we propose to take the larger proportion of the cuts to save the Government money. I suggest, sir, that is not equity.

Senator MUSKIE. The staff advises me that the $500 million applies, which is the figure Secretary Weinberger used yesterday, applies to the next 6 months, and the annual figure is closer to $1 billion.

Mr. GLASSER. That is using somewhat of a crystal ball, sir. Our estimate is it will probably be about $1.2 billion on an annual basis.

Senator MUSKIE. In your testimony, you make this statement, and I would like to refine a little more in my impression of the facts that are in accord with yours.

You say the administration's proposal would increase the cost sharing burden of 98.6 percent of Medicare hospital patients in order to diminish the cost to 1.4 percent of those hospitalized.

I will put in the record a table which indicates that for patients hospitalized up to 90 days, the administration's proposals represent an increase in the cost and not a decrease, so that actually the diminished costs applies only to those that are hospitalized for 90 days and longer, and they constitute only one-tenth of 1 percent of total hospitalized Medicare patients.*

Would that be inconsistent with your knowledge?

Mr. GLASSER. Mr. Chairman, I have the same information. Since it was not in print, I decided not to use it, because I could not cite it, and I cited somewhat older evidence. My testimony and the figures you cite are in complete accord.

*See table, p. 201.

Senator MUSKIE. So that actually the inequity is even more.
Mr. GLASSER. Yes, it is.
Senator MUSKIE. Then as suggested——
Mr. GLASSER. Yes, sir.
Senator MUSKIE. I would like to ask you more specific questions and then yield to Senator Fong so I will not monopolize the time.
In your statement you say many physicians will not take elderly patients. Actually, what can we do to change that situation?

PHYSICIAN SHORTAGE

Mr. GLASSER. It is a very serious situation, sir, and it does not lend itself to easy solution. The problem is partly because we have a very real shortage of physicians in this country, and, therefore, physicians must choose their patients. Being economic beings, they will choose those patients who are more responsible and who they can see in the shortest time.
The solutions to the problem relate to making available more physicians and other health professionals, which is not done overnight. We also need to make available organized services so that the time element can be dealt with. We find in our own team practice in the metro health program in Detroit that many of the problems of the elderly can be dealt with by social workers and nurses, whereas in a solo practice system, it is the doctor who has to do all of these things. We are suggesting that this problem is a problem of reorganization of the delivery of service, making available more physicians and other health personnel, so that we can provide more appropriate service.

PHYSICIANS DECLINING MEDICARE ASSIGNMENTS

Senator MUSKIE. That leads to another question, that is, the declining percentage of physicians accepting an assignment under Medicare, which you also addressed yourself to.
What are the reasons for this?
Mr. GLASSER. This is a problem that troubles us very much in the UAW, and no week goes by that we do not have complaints from our members on this subject. The problem is in my view twofold. The problem deals with the reasonable and customary fee schedule which both Medicare and Medicaid have adopted which has a built-in cost escalator with no real control on it because even when ceilings are set, as under phase 2, with the 2.5 percent of physicians' fees overall, physicians do adhere to the 2.5 ceiling by and large and simply increase the number of services. Doctors can increase services by 10 percent with no problem, so as a result costs go up, and so the economic factor is important in this.
The other part of the problem is as long as an assignment is not mandatory, there is an increasing tendency, as the figures show there is, for physicians to charge what Medicare charges, and charge some more on top of it. The patient has no choice because the patient cannot go shopping among physicians. The solution I am trying to indicate sir, is a fee schedule with mandatory assignment.

I am not proposing cutrate medicine through fee schedule. I am proposing an adequate and very good return to physicians. I am proposing that we deal with this problem of more and more overcharges to patients which are creating a very, very serious cost impact on their lives.

Senator MUSKIE. To what extent do physicians provide unnecessary services in order to improve their own programs to Medicare patients?

Mr. GLASSER. That is an exceedingly difficult question to answer, and I do not have any fix on the answer. I simply know in our experience that services have a tendency to go up regularly, as soon as you put a ceiling on the amount of money you will pay for them.

UTILIZATION REVIEW SYSTEM

A good uitlization review system could in fact have some impact on this, but as I have indicated in my testimony, particularly for the out-of-hospital services, we have no such system.

We have a system whereby when one physician in Michigan performed 18 cystoscopies on a patient in 1 year. This was finally flagged down because somebody decided the patient must have been dead by this time, and, therefore, they should not pay for 18 cystoscopies. But there are things more subtle than that. We have very little in the way of controls, and, therefore, it is not possible to review use of services through the control system now in effect.

Senator MUSKIE. Yesterday in this connection, Secretary Weinberger told us in addition to increasing the cost to Medicare beneficiaries, he would institute administrative changes to save money, and one of these I understand is to establish a special $300 million fund to insure prompt payment of physicians.

Now, what effect would this have on the Medicare program, given the tendencies you have been describing?

Mr. GLASSER. Mr. Chairman, I am not an expert on hospital administration. My other virtues are dubious, but I do not know a great deal about hospital administration. I do know from serving on hospital boards, that many hospital boards continue to have severe problems in cash flow because of slow payments from the Medicare administration. I happen to think that the Medicare administration basically has done a good job in organizing the program, but the problem with slow payments is spotty around the country.

Senator MUSKIE. Slow payment has had a serious effect on services provided by Medicare, is that correct?

Mr. GLASSER. Yes, it raises the cost of the services.

I can speak of one hospital in which I knew it actually raises costs, because we have had to go out and take bank loans to meet the payroll. We had good receivables, but the U.S. Government while not going out of business as far as we knew was not paying us and we had to take loans at 8 percent in order to keep the payroll going.

HOME HEALTH SERVICES NOT AVAILABLE

Senator MUSKIE. You say in your statement that home health care services are not available in many communities.

What are the reasons for that?

Mr. GLASSER. I am very glad you asked that question, sir, because it goes to the heart of some of the testimony that was presented by the Secretary here yesterday. It is generally agreed in the health field, and by the administration, the home health care services are desirable, that they are sound alternatives, that they provide better and more appropriate care, and that they may be in fact cost saving over the long run, and yet we have very few communities where this alternative is available.

The Public Health Service made some efforts several years ago to encourage them by offering technical assistance, and it did not help for the simple reason that in addition to technical assistance, these organizations required subsidy funds.

Since we are depending on the private sector for delivery of services, as I believe we should be, it is essential to see new and desirable services put into place for the Government to offer both technical assistance and subsidy funds to get home health services going.

In their absence, most communities will not make them available, and I believe, sir, I know, for with some 240,000 retirees, we have made strenuous efforts to make these services available to our members and they are simply not in place in most communities.

Senator MUSKIE. So if the Secretary and the administration wish to develop that as an alternative, they ought to give some thought to devoting the $500 million and $1 billion in savings, and I am not prepared to accept the assumption those savings are justified, but it ought to be put toward the development of such services.

One final question before I yield to Senator Fong.

You have already touched on this, the effects of coinsurance and deductibles on utilization of health care facilities and resources.

BLUE CROSS-BLUE SHIELD SURVEY—NOT A STUDY

The Secretary yesterday leaned very heavily on his interpretation of a Blue Cross-Blue Shield study, which I think could be interpreted differently than he did.

There is justification that utilization could be improved if these cuts were implemented.

What is your view of coinsurance and deductibles to utilization of health care, and I think it would be helpful to focus on possible difference in their effects as between patients who are able to afford private insurance, and patients who fall in the elderly poor category.

Mr. GLASSER. Mr. Chairman, in the first place, may I make one comment on the Blue Cross-Blue Shield survey, which had a lot of ventilation here yesterday.

It was a survey, not a study. It is not based on evidence. It is based on the reactions, impressions, and reports of Blue Cross-Blue Shield executives around the country.

It conveys the impression, and I am speaking for what the survey says, that they might have an unfavorable cost impact, in all likelihood on those at the lowest end of the economic scale, but I would hope the committee record would show this is a survey of impressions, not a scientific study.

Coinsurance and Deductibles

Now, let me talk a little, if I may, on this issue of coinsurance and deductibles.

I believe the record shows here yesterday that coinsurance and deductibles were adopted initially by the private insurance industry for one purpose only, and that was to get rid of the problem of paying for small claims.

They found that when they had to pay $2, $3, $4 claims, the administrative costs of paying for those claims were in excess of what the income was, and of what the need was.

Therefore, they adopted coinsurance and deductibles to save some administrative cost money, not to increase revenue, not to change the picture relative to utilization. I think it has not been put in the record that the private insurance industry does not provide health care. The private insurance industry is in the business of making money. It trades dollars. It is a perfectly honorable approach. There is nothing wrong with it, as long as we identify it for what it is. It is the trading of dollars, and hopefully a few of those dollars will remain in the coffers of the insurance industry, and that is called profit. It has very little to do with health care. They discovered as they traded dollars, that if in fact they could raise that coinsurance and deductible high enough, they could in fact at some point change the system so that they would save dollars.

This had nothing to do with good health care or bad health care. It had to do with the fact that they could save dollars, and in fact that is the basis of what underlies the so-called major medical approach in the private health insurance industry. However, there is very substantial indication that coinsurance and deductibles have practically no effect on hospital admissions, because when a physician says you are ill, and you have to go into a hospital, somehow you get in there.

It does have an effect, if it is high enough, on length of hospital stay, which in fact might be a desirable impact if there were alternatives.

What I am saying is when a patient is in a hospital 14, 15, 16, 17 days, and he is paying his own bill, and he does not know where it is coming from, there is evidence by examination of the record, it does have an impact, but the impact is primarily on the lower income person, and it is frequently a negative impact, because there is not an alternative.

The alternative is home care as I have been indicating, or nursing home care, which is frequently not available or available in limited form.

When the Secretary said yesterday, and I quote, "It is much too easy to turn to the hospital as a first resort rather than a last resort," he is putting his finger on the problem in reverse, because the evidence that we do have is that when you increase coinsurance and deductibles, it is largely related to income, and it delays physician services, and out of hospital physician services.

If you delay out of hospital physician services, one of the rules of health care is that you increase the likelihood of hospitalization.

Therefore, since the Secretary's own data in the Department shows this is what happens, you delay physician services, particularly for workers and for poor people, and you increase the likelihood of hospital admissions. I would suggest there is substantial indication that the increase of coinsurance and deductibles as proposed here may in fact substantially delay physician services for workers, for poor people, and may in fact increase the utilization of hospital days that the Secretary is concerned about. So while the problem of coinsurance and deductibles is a complex problem, I would summarize a rather involved statement by saying it was devised in a way that had nothing to do with deterring utilization.

We now have evidence that if you raise patient charges high enough, you will delay out of hospital services.

We do not believe it will delay in-hospital services. We believe the delay of out of hospital services will in fact increase the use of in-hospital services.

Senator MUSKIE. Thank you, Mr. Glasser. I think that is a very useful addition to the record.

Senator Fong?

Senator FONG. Thank you, Mr. Chairman.

Mr. Glasser, I thank you for a very detailed and enlightened statement.

In listening to your testimony, Mr. Glasser, I seem to have the impression that many of the shortcomings of Medicare would be obviated by more comprehensive benefits.

Am I correct in assuming that?

Mr. GLASSER. Yes, sir.

Senator FONG. And that if we had more comprehensive benefits, many of these shortcomings would not be there?

Mr. GLASSER. That is correct.

Senator FONG. And yet you point to the fact that there is a shortage of physicians and a maldistribution of physicians.

Mr. GLASSER. Yes.

Senator FONG. Now, how would more comprehensive benefits and more days in the hospital, and more seeing of the doctor affect the shortages of physicians? How are services going to be delivered?

Mr. GLASSER. Senator, in my testimony, you correctly quoted me. I went on, however, to indicate that this has to be related to the reorganization of the five factors, I indicated in my statement. It can be done, and in my view, sir, and it is possible to do it as indicated in S. 3.

HEALTH TEAM APPROACH

You take your own State where you have the Kaiser Permanente health plan. They have one physician to approximately 1,100 patient covered population. That is almost twice the State average.

In other words, the rest of the State has about twice as many people per physician, and the reason the Kaiser plan can serve twice as many people and give comprehensive benefits is because they are using the health team approach, as I indicated in my response to Senator Muskie.

They use nurses, physicians' aides, for a total team approach and the physician is only used to render those services for which he is trained, whereas in the solo practice fee-service system, the physician works between 58 and 60 hours per week. He works exceedingly hard, and he does a great many things for which he is not trained, and he is not able to serve as many patients. This is a way of saying to you that more comprehensive benefits can be delivered by a relatively limited number of health personnel if they work together in teams, as we are suggesting, and the administration is suggesting in HMO's and the like.

Furthermore, the more comprehensive the benefits, the more likely we are to keep people healthy, and, of course, that is our objective. We know regarding prescriptions, that over half the prescriptions written in solo practice are never filled, and this gives us great concern because we do not believe that most people willfully make themselves ill. We believe there is a strong economic factor in that over half——

Senator FONG. Are you saying that our delivery system is obsolete?

Mr. GLASSER. Yes, sir.

Senator FONG. You have referred to the Kaiser plan. I have many complaints against the Kaiser plan that these patients wait and wait and never see the doctor and finally go to the private physician. What do you say to that?

Mr. GLASSER. I shall not speak for the Kaiser plan. I know patients do not have to wait if they have urgent medical needs. Patients do wait for medical appointments, and for regular services. This is inevitable in a system which is only partially developed in the sense it is the only one at the moment in your State.

This would be much less of a problem if we had more of them and hopefully we will, when the HMO legislation is passed; however, at the same time, while the Kaiser plan does have problems, and I know them, we have many members, not in Hawaii, but in Kaiser plans in California, and in Colorado and in Cleveland. Kaiser provides to our members for the same number of dollars as under the solo practice system; 40 percent more services. In our view, it is providing substantially higher quality of care than our members can get through solo practice.

Senator FONG. You specified one of the alternatives is to make a physician accept a certain amount of payment, is that correct?

Mr. GLASSER. Yes, sir; it is correct. I am suggesting that there be a fee schedule such as we have had in the Blue Cross-Blue Shield system until Medicare, and that there be assignment.

Senator FONG. That there be no deviation from that?

Mr. GLASSER. Well, the schedules would be set on a regional basis in terms of costs in that region.

Senator FONG. And the doctors would have to accept it?

Mr. GLASSER. Yes, as they did for many years under Blue Cross and Blue Shield. There is nothing new about that.

Senator FONG. And that is the only way you can keep the costs down?

Mr. GLASSER. No, sir; that is one of the ways.

Senator FONG. One of the ways?

Mr. GLASSER. Yes, sir.

280 Percent Medical Disbursement Increase

Senator Fong. You stated from 1967 to 1971, the cost of medical disbursements have increased 280 percent.

Mr. Glasser. Yes, sir.

Senator Fong. You also stated that the consumer index has increased twice as fast, 6.6 percent versus 3.2 percent.

Mr. Glasser. That is correct.

Senator Fong. In other words, the cost of physicians, of medical services, and hospital services, has increased at a very alarming rate.

Now, you stated that we should in this instance budget the hospitals. Will you explain that?

Mr. Glasser. Yes, sir. It is a system as I indicated has been in operation in Canada for about 12 years now, in the public hospital program, and I am always told that Canadians are not like Americans, but I think basically they are about the same kind of human beings.

The Canadian system simply states that in every community that wishes to participate in the public hospital insurance program, the hospital must have a budget submitted to the regional authority in advance. They negotiate a budget, they say this is what it takes to operate this year, it is reviewed by the hospital authority and approved. The hospital then runs on that budget, and if the hospital over extends, it is the hospital's responsibility to find that money. If the hospital is able to implement an economy measure, the hospital shares the profits with the Government.

Now, that system has its problems, but basically it has worked quite well in Canada. In this country, this seems to be like the wheel, we are just barely discovering it, and I am suggesting it would save many dollars.

Senator Fong. Do you think the hospitals would go for it?

Mr. Glasser. As a matter of fact, in principle, 3 years ago, the American Hospital Association in principle approved of this type of prospective budgeting.

Now, it creates some problems, because if you and I have hospitals on the same street, and you have an open heart surgery unit, and I have an open heart surgery unit, the likelihood is the budgetary authority will say the number of open heart surgeries in your community is only so much.

We only need one open heart unit and you two men will have to get together, and we will support only one on your street. These are some of the problems, and these are some of the reasons we in the public programs are overpaying, and why I am proposing we go to the very conservative route followed in a number of other countries and go to prospective budgeting for hospitals.

Senator Fong. Then you really put the Government into the hospital program?

Accountability and Control of Expenditures

Mr. Glasser. Sir, the Government is in the hospital program over its ears. My concern is that the Government is paying for these programs, and on a cost-plus basis, and I suggest there are very few segments

of Federal Government where we write blank checks for providers, saying tell us what it costs, and we will pay you. I am suggesting it makes good public administration sense when we who put in the public dollars, try to get some accountability and control over their expenditures.

Senator FONG. What you are saying is some of the hospitals and some of the physicians are taking the Federal Government for a ride.

Mr. GLASSER. No, sir, I hope that conclusion does not come from that. That is not so. I do not believe that for a moment.

Senator FONG. You said that we are paying so much bigger a bill for so much lesser a benefit.

Mr. GLASSER. My complaint is directed at the system. It is directed at the system which does not have these kind of built-in controls, so that, for example, it is possible for a hospital to have unnecessary services, there is no incentive to make real economies, and there is no incentive to have good utilization review.

I am not saying that the hospitals are dishonest. That is untrue if anybody would say that. I am saying that there is a Government responsibility to change the system sufficiently so there is control on the way in which Government funds are being spent in hospitals.

Senator FONG. What you are saying is that physicians and hospitals do added things which are not necessary.

Mr. GLASSER. They may.

Senator FONG. Even though they do not have such an intention?

Mr. GLASSER. There is no incentive to make the economies that are possible.

Senator FONG. The other day I read an article in the New York Daily News of a reporter who said he feigned a cold, so he got a Medicaid certificate, took another reporter with him, and said, "this is my cousin," and both of them dressed in clothes which showed that they were hardhat workers.

He went to the clinic in New York City—this was in the Daily News just about 3 weeks ago, I think—and he said he had a cold, so he went to the receptionist.

The receptionist said "I have to send you to the podiatrist."

The reporter said, "I just have a cold, there is nothing wrong with my feet."

The receptionist said, "we give you a very thorough examination here," so they sent him to the podiatrist who looked at his feet.

He said, "well you have a little rash here, we have to give you a prescription to stop it." So he got a prescription, so they sent him to the internist.

Naturally the internist took his blood pressure, took his temperature, and gave him an electrocardiographic study, and so he says, "you have the London flu; we have to give you a penicillin shot." In the article the reporter said that he knew with flu you don't take penicillin.

He said, "No. No, I don't like to be injected."

The doctor said, "you don't want to be injected?" He said, "no." So the doctor said, "I will have to give you a prescription for an oral drug." They gave him a prescription for an oral drug and he came back and saw the internist, who then sent him to the psychiatrist. All

the time his friend was taking pictures—while he was having his feet examined; while he was getting the electrogram; while he was talking to the psychiatrist.

The psychiatrist said, "Oh, you are afraid of measles," and asked him about his love life, and the psychiatrist, after 15 minutes of thought, said, "you have to come back and see me for several sessions." That is when the article ended. He was supposed to have another sequel, but I did not get to read the sequel.

He said he had five prescriptions made for him which cost about $35, and that the medical fees came to about $40-some odd, so where something would have cost about $10 or $15, it cost the Government about $80 to $90.

Now, there is that kind of shenanigan going on, is there not?

Mr. GLASSER. Senator Fong, I was not familiar with the story, but I am very glad you brought it up. Let me test that story against the administration cutback proposals. The administration is proposing cutbacks in Medicare, and a limiting of services in Medicaid, and those cutbacks will do nothing about the problem you have just illustrated.

It will do nothing, except add costs to the people who are genuinely ill who have to pay for these kinds of excesses.

Senator FONG. I understand.

PROBLEMS IN THE SYSTEM

Mr. GLASSER. In terms of this hearing they are illustrative of the nature of the problem because the thesis of my testimony has been that the administration's proposals for Medicare have very little to do with the problems in the system as you're just now indicating.

Senator FONG. What you are saying is that there is not sufficient control. How do you control these things?

Mr. GLASSER. Yes. Now, my further answer to you therefore is that the story you recite is a very sad commentary that illustrates the basic problem in the system, whereby we continue to compartmentalize people.

People who go to Medicaid are only poor people by somebody's definition of poor, and the definition in Hawaii is different than in New York or in Michigan. Therefore, by New York standards, these people are supposedly poor people, but the people who provide the services still have no controls essentially on the quality of care.

There is no utilization review as I have indicated, and as a result, we are bound to get these kinds of excesses.

I believe that the New York Daily News story you indicated is probably a relatively isolated situation.

I do believe, however, that there are many wastes in the system because there is no real system, and because we divide people into classes.

Poor people go into category A, old people go into category B. Unemployed people are out of luck, people who work are in a different program, and the provider will make as much money as he can out of it, because that is in the American idiom.

I think these approaches need to be rationalized. I think it is possible to do so, and that is why we are supporting S. 3, which is an attempt to deal with the situation comprehensively.

Senator FONG. In your statement you say there are a lot of unqualified doctors who become surgeons. Is that correct?

Mr. GLASSER. Yes, sir.

Senator FONG. And these people become surgeons because of the fees that they can get, is that correct?

Mr. GLASSER. No; not by a long means. I think there are many doctors that go into it.

Senator FONG. Why would they become surgeons when they are not surgeons and perform a lot of noncertified surgery?

Mr. GLASSER. Let me take the second one first.

The reason that close to a majority of all the surgery performed in the United States is performed by nonqualified physicians, nonqualified in that they are not board certified, is that there are no controls on this, and as a result we have the economic factor playing a role.

Surgery is a very profitable branch of medicine, and it is possible in a relatively short time in the application of surgery to make a very substantial income.

That this is a very good inducement to most physicians, is an understatement, so many physicians perform surgeries for which they have questionable qualifications.

The question that is also brought up is, is it not true that in the absence of qualified surgeons, in northern Wyoming, if you please, a general practitioner may have to perform that surgery?

That is true of this. But by and large in most parts of this country, we have far more qualified surgeons than we need and half of the operations are performed by nonqualified surgeons, because the economic return is good, and among the elderly, there is practically never a question raised by the paying agents, by those who are paying out our tax dollars.

They rarely raise a question as to the qualifications of the person they are paying for a very large number of surgeries.

MEDICARE AND THE ELDERLY HEALTH CARE BUDGET

Senator FONG. As a last question, you stated that Medicare, even with the vast amounts of money that have been put into Medicare, now constitutes 40 percent of the elderly health care budget. Did you say that——

Mr. GLASSER. Yes, sir.

Senator FONG. It has helped the Medicare patients in 1971 as distinguished from their payments in 1966, by only $9.57?

In other words, with all of the money paid by the Federal Government, because of inflation, because of the accelerated costs of hospitals and doctor's fees, and drugs, these people who are in need of Medicare, will only save $9.57 per year. Is that your statement?

Mr. GLASSER. I want to indicate what that means as you quite properly indicate. In the absence of Medicare, this kind of inflation would have put most of the elderly out of the marketplace entirely. What I am indicating is that since the Medicare legislation said no one shall do anything which will change the way in which services are offered or delivered, it has not been possible to make the kinds of changes necessary to control the delivery, and to control the costs. As a result, costs have inflated, and the elderly have only had a $9 reduction in

their out-of-pocket expenditures. What troubles me, sir, is the administration says we have to make the elderly more cost conscious, and at this moment, they are paying by the administration's own figures, 58 percent of their health care costs out of pocket, I don't know what percentage would make them more cost conscious. Is it 78, 92, 99, where do you draw the line?

Senator FONG. I don't know. Where do you draw the line?

Mr. GLASSER. I don't believe that cost consciousness on the part of the patient does the job. I think it is organization of the services in such a way that the fellow who pays the bill, and it is primarily the Federal Government in Medicare, gets those kinds of controls.

Senator FONG. Would you go so far as to say that there should be no costs paid by the Medicare patient?

Mr. GLASSER. Yes, sir.

Senator FONG. In other words, you would say the Federal Government should take care of everything?

Mr. GLASSER. I would suggest under S. 3 which is the bill I am talking about, the Health Security bill, it is possible to have no patient coinsurance, no deductible on any aspect of the program, and stay within the limits of what this country is now spending for personal health services, providing there are effective controls at the Federal level on the way in which the funds are spent, on utilization review, on quality review, and an opportunity to make possible the delivery of services with the team approach and other methods that have already been demonstrated to be far more economical than the way Medicare is now paying that money.

ESCALATING MEDICAL COSTS

Senator FONG. If you did not have this control for another 5 years, the cost of expenditures would probably be another 280 percent?

Mr. GLASSER. Senator, I represent 1,400,000 active workers and 240,000 retirees. We are going into major collective bargaining this year. The costs of our health care benefits under our negotiated program mean that benefits cover about 60 percent of personal health expenditures of our members. In other words, they are better off than most private programs. We have good programs.

However, the costs have increased in 3 years by 21 cents an hour. That may not mean anything. Let me put it to you differently. Our members are now paying 1 month's wages for that Blue Cross-Blue Shield insurance we have.

It has gone over a period of about 8 or 9 years from a week's wages to a months wages, and based on HEW projections this year, unless there is a major intervention in the system, I have to tell all members of this committee that in 7 years, they will be paying 2 month's wages for the 60-percent coverage of private health insurance. I suggest, sir, that this is an intolerable situation.

Senator FONG. You are saying 10 percent of a man's wages now in your union is going for medical expenses?

Mr. GLASSER. Between 8 and 10 percent.

Senator FONG. Which pays for medical expenses up to 60 percent.

Mr. GLASSER. It is a month's wages.

Senator FONG. Of his income?

Mr. GLASSER. That is correct.

Senator FONG. And he is getting 60 percent, so if he wants 100-percent coverage, it will be 40 percent more?

Mr. GLASSER. Actually it would be higher than that, because the part we are not covering is the part that is so uncontrolled. We are unwilling to pay that insurance, and it is not 40 percent additional, it is probably in the dimension of 60 to 65 percent because it is the part of the package, physician's out of hospital services, for example, that is so expensive. We know if we bought it, it would escalate even more rapidly.

Senator FONG. Would you extrapolate that and say if we had comprehensive medical care for all Americans, it would take about one-fifth of the wages of the American working man?

Mr. GLASSER. No, sir, quite the contrary. I am glad you asked the question. After all, there are only so many people working, there are so many children, and so many other people not working.

Senator FONG. You are just talking about your union, now? Now, how would you extrapolate that?

PRESENT SYSTEM INEFFICIENT

Mr. GLASSER. You extrapolate it, sir, by taking the costs in an uncontrolled system and projecting them on the entire economy. That is just about what the administration was proposing last year in the administration's four health insurance proposals they put before the Congress. It is the main reasons we were opposed to the proposals, because all they were doing was putting more money onto the present inefficient system.

Health Security proposes a Social Security tax on employers and employees, matched by general revenues, and it is our estimate, and we have put it in the record, it is our estimate that it is possible to provide comprehensive health services without coinsurance and deductibles for 210 million Americans at a cost no larger than we are expending at this time with an escalation factor of approximately half of the 10 to 11 percent that we now have. My answer is a complex one, sir, but it is to indicate that one of the major reasons our union has devoted great effort to the development of a sound national health insurance program is that we have now become convinced we can no longer at the collective bargaining table control health care costs for our members because of the fires of inflation, and, therefore, we are making strenuous efforts to get change in the places where it can be controlled, namely, in the society at large.

Senator FONG. Thank you, Mr. Glasser, for your very fine statement.

Senator MUSKIE. Thank you very much, Senator Fong, for your questioning, and Mr. Glasser, I am most grateful to you for an excellent morning of testimony and discussion which ought to illuminate the issues.

Mr. GLASSER. I hope so. Thank you.

Senator MUSKIE. I welcome Prof. Charlotte Muller, Center for Social Research, City University of New York, New York, N.Y.

Without objection, I would like to include in the record her biographical résumé, which I think will be very useful.

BIOGRAPHICAL RÉSUMÉ OF CHARLOTTE F. MULLER

Professor of Urban Studies, Center for Social Research, City University of New York; also Professor of Economics, Hunter College, Graduate Program in Urban Planning

Previous professional experience:

Columbia University, Assistant Professor, 1960–67; full-time, 1966–67; part-time, 1960–66; Research Associate, 1957–60.

Yale University, Lecturer in the rank of Assistant Professor, 1952–53.

University of California, Berkeley, Research Associate in Medical Care, 1948–50; Lecturer in Economics, 1948.

Survey Research Center, University of Michigan, Assistant Study Director, 1948.

Also on economics faculty of Brooklyn College (1943), Barnard College (1943–46) and Occidental College (1947).

Chase National Bank, Research Staff, 1942–46.

Other Activities:

Mayor's Committee on Prescription Drug Abuse (New York City).

Health Financing Committee, Comprehensive Health Planning Agency of New York City.

National Advisory Council, Center for Family Planning Program Development.

Social Science Advisory Committee, Planned Parenthood—World Population.

Program Committee, Medical Care Section, American Public Health Association.

Member, American Economic Association.

Past President, Public Health Association of New York City.

Commission on Health Needs of Women, American College of Obstetricians and Gynecologists (1970–1972).

Board of Directors, Association for the Study of Abortion (1969–1972).

Education:

Vassar College, B.A., 1941.

Columbia University, M.A., 1942, Ph. D., 1946 (Economics).

Senator MUSKIE. Professor Muller, we will be delighted to hear from you.

STATEMENT OF PROF. CHARLOTTE MULLER, CENTER FOR SOCIAL RESEARCH, GRADUATE SCHOOL, CITY UNIVERSITY OF NEW YORK

Professor MULLER. Senator Muskie and members of the Subcommittee on Health of the Elderly, I welcome the opportunity to come before you today and contribute to your efforts to create legislative policy to improve the flow of health care to older Americans. As you enter your schedule of planned hearings, you will be gathering facts and points of view from many sources. I would like to approach the subject of barriers to the receipt of health care from the standpoint of an economist who has specialized in the field of medical care.

It has long been observed that elderly persons suffer from more illness, have more disabling chronic conditions, and require more personal health services than younger persons. The health problems of the elderly, coupled with prevailing policies about retirement age, separate many older Americans from the very labor market in which they would otherwise draw the personal income with which to pay for health care. Hence the financing of their medical care implies to a large degree transfer payments in which the economically active groups support these services. Through Medicare the transfers that previously occurred

through sons and daughters paying for their parents' care, or younger taxpayers paying the costs of a certain amount of public assistance medical care, have become part of national social insurance policy, and this has served to bring more and better care to many elderly persons.

The Effects of Medical Neglect

Age alone is associated with deteriorated health status, but its effects are much more severely felt at lower socioeconomic levels. The condition of health on entering the age group over 65 is greatly affected by the circumstances of their lives in earlier years and thus with their income level. The previous deficiencies in an individual's diet, his exposure to occupational toxins, pollutants, and stresses, the excess parity that a woman may have experienced—all are related to poverty and near-poverty status during the aged person's younger years and set the stage for his or her health experience in older age. Previous medical neglect is part of this too. For example, the retirement history study conducted by the Bureau of the Census in 1969 showed that among persons 58–63, one in every four respondents put off seeking care for conditions that they felt needed attention, finances being named more frequently than any other cause (twice to three times as often as any other reason), and postponement being least likely for marital status groups with highest average income. (It is appropriate to keep this finding in mind in considering the deterrent effect of deductibles on the use of health services.) Heart disease, hypertension, diabetes, pulmonary disease, and many other conditions, if not under regular care, will show greater severity and a variety of complications. This effect of medical neglect is registered in our national statistics about health conditions in old age.

The health status of aged persons is also affected by their current income level and their ability to secure a balanced and attractive diet, well-heated and accident-proof homes, and, of course, needed medical care.

Some of these problems seem overwhelming, but in assessing the possibilities for improving personal welfare through health care, one should not overlook certain aspects that give both the health care professional and the policymaker some room to maneuver. Some disease processes affecting the elderly advance rather slowly, which means that there can be years of activity and interest under optimal medical management. If the goal of recapturing the ideal health status of youth is unrealistic, there remains a vast area of intermediate goals, aiming to preserve whatever level of health exists—and to raise it—to keep the ambulatory patient on his feet, to enable the noninstitutional person to avoid dependency, to apply prompt and appropriate care to the hospitalized person and return him to his community, and, even for the nursing home dweller, to maintain activity, treat acute needs, and conserve the remaining resources of the organism.

Two Types of Health Barriers

The types of barriers that must be dealt with are, broadly speaking, of two kinds. The receipt of health services takes place in the medical marketplace in which provider or seller meets patient or consumer.

Blocks to an exchange that is appropriate in terms of needs can exist on either side of the transaction. On the consumer side, the process of bringing effective demand or buying power into the market is central to this exchange. This process can be divided into general and particular aspects.

The general aspects have to do with the income status of the elderly—the level of their Social Security benefits, their other pension income, and their present earnings—which determines their power to purchase medical care.

Since retirement benefits from Social Security are limited and since many aged persons have little or no income from sources other than their Social Security, the median income in March 1972 for aged persons was reported as $2,044—for males $3,076 and for females $1,522. For the half of the persons with income who were below the median, the power to buy medical care—to make copayments under Medicare, to buy eyeglasses, prescribed drugs and other uncovered items, and to pay for additional units of care beyond stated benefit amounts is strictly limited in view of the necessities that must also be purchased out of income and the possibility of any kind of emergency. In fact this comment would apply to many couples and individuals who are above the median and who have any kind of important health problem, chronic or acute.

Income Barrier

Among the particular aspects of the bringing of effective demand into the medical care marketplace, limitations on health care entitlements through Medicare and private insurance have significant effects and directly complement what has just been said about general income status. Private health coverage is held by 11.4 million aged persons who have hospital insurance to supplement their Medicare benefits, and of these, 84 percent have surgical insurance, 74 percent have regular medical insurance, and only 19 percent (2,158,000) have major medical policies. The total payout from all these policies was only $1 billion in 1970 (in 1971 it was $1.1 billion); this was about one-fifth of private sector payments for the aged. Since the remainder represents out-of-pocket expense (reflecting benefit limits plus the many aged without private insurance), there is clearly a likelihood that an income barrier will stand in the way of receipt of care.

Another limitation on entitlement arises from the copayments and deductibles that we already have in Medicare—that is, what the patient must pay before qualifying for a Medicare hospital benefit, the per diem charge in hospital or extended care facility, and the initial sum payable before benefits start under supplementary medical insurance. Owing to income differences, such charges will erect a barrier to some persons while leaving others unaffected in their decision to see a doctor. The hope—as expressed, for instance, by the Wall Street Journal in a recent issue—that increasing these patient payments will curb unnecessary utilization of hospitals appears to be unsupported by evidence, but the barrier effect of a payment of $100, $200, or $500 appears plain against the background of the median income of the aged cited earlier.

It is a pious wish that a deductible will eliminate some wasteful margin of care and leave essential use of services untouched. It has been shown that members of a group health plan do reduce their use of doctors' services under coinsurance and this is especially true for persons with the least resources. But is this effect desirable under a public program intended to open the door to medical care? It is not unlikely that aged persons with the least resources would defer going to the doctor for fear of the increased hospital expense as well as the copayment of the doctor charge (part B). When they do go, under an increased deductible the cost for those unable to pay would not be wiped out but would usually be transferred to Medicaid—and increased because of the extra work of administration involved. Furthermore, the cost of the stay may be greater because the opportunity for timely care was missed.

How much people value the sense of security attached to removing uncertainties about health care bills is shown by the way enrollees in the various plans for Federal employees elect the broadest coverage offered. For this reason the variability of the proposed deductible is especially disadvantageous. The amount charged to the patient will be affected by price differences among hospitals, and the first day deductible plus the 10 percent copayment involves a substantial sum of money. The Medicare benefit provisions resulting from the proposed charges would be below the rather modest standard announced for marketable insurance by the superintendent of insurance for New York State. In the standard issued October 31, 1972, no company may call its policy "basic hospital insurance" that requires a deductible of over $100 within 20 days or does not pay at least 80 percent of room and board and other charges, or $50 a day for room and board. Since many patients would be obliged to face a deductible much in excess of $100, the Medicare benefit structure would not be acceptable for marketing in New York.

Supplying Health Care

To solve cost problems, it seems to me that attention must go not to misdirected deductibles but to the second broad category of barriers to health care, which concerns the supply side of the health care market, those features of organization and delivery of service that represent an inferior use of resources. These features may have come into being as a result of some complex history, such as that which is involved in the evolution of American specialties into their present form, but they are often sustained because they represent economic advantage to somebody in the market and because public initiative has not been taken to redirect the system. Such initiative, I believe, could be exercised through payment arrangements, incentive structures, specific investment in desired developments and other purposive use of public funds set aside for health care. It is not good economics to believe that parties to a transaction will give up something for nothing, and to redirect economic behavior it is necessary to make the behavior we prefer for public policy reasons stand out as the most advantageous of the alternatives available.

Principal Areas for Policy Action

Let me cite some principal areas for policy action.

1. A population-wide plan of national health insurance emphasizing forms of service delivery that will make primary care supported by consultation of the various branches of medicine and other ancillary services available at all ages within a comprehensive system. This approach protects the interests of the aged by enlarging the opportunities to raise health status before retirement, thus reducing the pressure on high-expense forms of care for late stages of illness. It will also enable aged persons to maintain continuous contact with the health care system, and to be clear about their entitlements and where to go for care.

2. Adaptation of the Medicare benefit structure to support ambulatory and preventive services and thus to redirect professional and technical manpower and institutional capital over a period of time into the work of health maintenance.

For example, we do not now have outpatient drug coverage under Medicare for important medications used by the elderly who are neither in hospitals nor nursing homes.

Many old people who started with one chronic disease suffer from other previously latent diseases made manifest by the medication that they must take for their primary condition. In conditions such as chronic obstructive pulmonary disease, diabetes, hypertensive heart disease, and arthritis, according to Dr. Gary Zucker, clinical professor of medicine at Mount Sinai School of Medicine and Beth Israel Hospital, it is necessary to administer two or more categories of drugs to the same patient. The various therapeutic classes of drugs that may be involved include cardiac drugs (digitalis and diuretics), steroids, insulin or oral antidiabetic drugs, antigout medications, antibiotics, bronchodilators, oxygen therapy, and potassium preparations.

A financial problem that keeps the aged patient from refilling his prescription or filling the new one as the latent condition surfaces may upset the precarious balance of his functioning and cause a hospital admission with charges to the Medicare fund. We thus have a cost effect and a health and welfare effect to consider in relation to ambulatory drug benefits.

3. Use of the benefit structure to encourage substitution of assistant practitioners and other less expensive forms of manpower for the more costly services of physician specialists. We can achieve this, together with an orientation to primary care and health maintenance, by designing appropriate benefits. For example, a payment could be made to encourage use of a clinical assistant for diet supervision of aged patients with metabolic problems or other enumerated purposes within an organized group practice or health maintenance organization.

Assignment of Resources

4. Assignment of resources to overcome patient problems that are intensified in old age and that interfere with timely use of service: Communication, transportation, carrying out of therapeutic routines (such as medication dosage schedules, breathing, and other exercise),

emotional and motivational features of old age that may emerge as social ties are lost and activity levels restricted, difficulty of hospital discharge arrangements, and special problems associated with managing multiple diseases. Although each of these problems of patients has its psychological and sociological attributes and correlates, an economic decision is clearly involved in committing societal resources to their solution, and thus in compensating for the extra difficulties of providing appropriate, timely, and sensitive care to the aged. Sometimes the solutions lie close at hand; for example, benefits for refractions and for eyeglasses and hearing aids—even if limited—would improve contact with information sources, and would make some old persons less fearful of attempting public transportation for health care.

5. Improving managerial effectiveness and public accountability of hospitals and nursing homes. There are some aspects of hospital management in which the range of alternatives is narrow, but the cost of hospitalization under Medicare stimulates a continued search for greater efficiency and it would be surprising if all hospitals were equally adept at finding a least-cost combination of resources. As an example, I cite a study conducted by me at the Center for Social Research at City University of New York, with the cooperation of Associated Hospital Service of New York and the Greater New York Hospital Association, which revealed, in 125 hospitals in southern New York State, some very wide differences in the prices paid by individual hospitals for six drugs in common use. I am referring to their own acquisition price. The findings have been brought to the attention of the member hospitals by the hospital association. Another study shows hospitals differing in their administrative concern with drug purchasing, in the practice of stocking of therapeutic duplicates, and, again, in acquisition costs of drugs. This was a study conducted by the Social Security Administration in nine hospitals in three different States in 1970. My study did not go into possible savings in hospitals from use of therapeutic alternatives, but the effort of one leading hospital to encourage substitution of one analgesic drug for a more expensive one was cited. Similarly, the recommendations of an official committee on drug purchasing in the Province of Manitoba were cited with reference to government assistance in promoting a formulary approach, and serving as an information source on the medical and cost implications of alternative therapeutic choices. Drugs are only a small part of operating costs in hospitals, but this is an illustration of how managerial effectiveness can be influenced by attention to specific aspects of hospital functioning.

In this connection, budget disclosure by voluntary hospitals and other aspects of public accountability form a timely theme because of the possibility that problem areas would be revealed. The fact that an institution cannot under law generate income for individual owners, that it is not operated for profit, does not assure that the way the funds are managed and allocated is in keeping with the public interest. Under the part of Public Law 92–603 that authorizes validation of accreditation procedures, perhaps we will find cases where the public's money is being used to pay for inadequate performance. Finally, protection is needed against the possibilty that a hospital will be

exploited by any party connected with it. Experts in hospital law and accreditation could judge whether existing sanctions and precautions will do, but all steps that could encourage all hospitals to observe appropriate standards should be considered.

Pursuit of effective organization of health care production and delivery needs to be supplemented by study and pursuit of administrative arrangements under Medicare that are least resource using and that involve the least burden or delay, inequality, or uncertainty on the aged patient.

Disproportionate Financial Burden of Women

Finally, I would like to point out another area of concern. The problem of receiving adequate health care in old age in the United States is to a large and disproportionate extent a problem of women, and any measures that shift the financial burden to the beneficiary will be felt by them with special force.

Women make up almost 12 million of the aged population as compared with 8½ million men. Women, both white and other races, have an excess life expectancy over that of men and (if white) at age 62 can expect 18.9 additional years as against 14.8 for men (17.3 versus 13.9 for other races). These additional years, however, come with an expectation of more disability days per person in a given year than men have in the age group 65 years and over, and with 34 percent of aged women either limited in or unable to pursue their major activity With advancing age they have a rapid growth of severe visual impairments and of hearing impairments and more often than men receive surgery for cataract and care of fractured bones. Not all of their health indices are inferior to those of men of similar age, but their economic position by and large renders them even less able to deal with their considerable health problems. This is shown by the fact that in the years before retirement they are more likely to refer to finances as their reason for postponing needed care, and to refer to two or more conditions as being neglected. Their disadvantages are revealed by certain national statistics:

1. They are less likely to have been attached to the labor force in younger years and to build up retirement credits under Social Security or private pensions.
2. They are less likely to have built up entitlement to group health benefits in retirement.
3. They are less likely to be in the labor force after age 65. This is true for all categories of marital status.
4. Their earning level on which retirement credits are based and out of which savings for old age can be set aside is greatly inferior to that of men, even for full-time earners.
5. When ill or convalescing, or severely disabled, those women who are widows are less able to have assistance within the household with personal and health care, and less able to have assistance in being transported to places where medical care is provided.

In view of these aspects of the situation of women, restriction of the benefit structure under Medicare would add to the weight of historical discriminatory policies affecting employment, income and health

care that are now being combatted at the Federal, State, and local levels through implementation of the equal employment opportunities guidelines, and through improvement of cash benefits under Social Security.

It is hard to believe that the concern, the resources and the skills to devise an optimal health delivery system for the elderly are beyond the reach of our Government. If we build on what has been accomplished, we can have a system in which neither the aged nor the younger persons who are concerned for them need fear lack of medical attention or financial disaster when ill, and in which the whole community knows that the orientation of the health care services available for the aged is toward health maintenance and improvement.

Senator MUSKIE. Thank you, Professor Muller, for your excellent statement. I know I have questions, and I suspect my colleagues do.

In the meantime, Speaker Moretti has arrived, and he has about an 8-minute statement.

Would it inconvenience you if we permit him to make a statement, and then turn to you for questions?

Professor MULLER. Not at all.

Senator MUSKIE. It is a pleasure to welcome the Honorable Bob Moretti, Speaker, California Assembly, from Sacramento.

Welcome to the east coast and to these hearings.

I know the problems of reality have also been high on the agenda for public action of the California Legislature, and in the dialog of California, so I think it is most appropriate he be here today. It is my pleasure in welcoming him as a distinguished public servant as well as a friend.

STATEMENT OF HON. BOB MORETTI, SPEAKER OF THE ASSEMBLY, CALIFORNIA LEGISLATURE

Mr. MORETTI. Thank you, Senator, I would like to first apologize to you and members of the subcommittee for not having been here when I was called.

There was a little problem in communications as is not unusual when human beings are involved.

Senator MUSKIE. No problem. We moved more rapidly than you anticipated.

Mr. MORETTI. I'm here today to protest any reductions in Medicare support which are not offset by a better system of federally financed health care services.

The California Assembly is concerned about the senior citizens in the President's home State who will have to do most of the losing for his version of a cut down Federal bureaucracy. I think I have a better idea where fat can be found.

One reason I've come to Washington is to focus attention on the cynicism which pervades an administration not willing to grant Social Security increases until forced by the Congress, and then just before election day, and then which seeks to take away older people's health care dollars after Inauguration Day.

Our constituency is 2 million elderly Californians who apparently have the misfortune of being invisible to the White House.

Not many of the older people I represent have sufficient resources to keep pace with inflation. One-fourth—500,000 of them—are certifiably poor.

Many don't eat properly because food costs are now higher than they have been for 20 years. And the President vetoed an appropriation last year to improve nutrition for the aged.

A large number already are trapped in broken down and dilapidated housing because of the moratorium on HUD subsidies. We have a situation in which the elderly poor can't get into low-cost housing because there isn't enough and those who are in won't be able to stay because rents are going up.

Some may view that as a housing and not a health problem, but it seems to me that the resulting anxiety takes its toll among the elderly.

Medical Research Cutbacks Opposed

The President's budget drastically affects the health research work being done in California.

A very prominent Californian, Jules Stein, who is chairman of the entertainment giant, MCA, Inc., and was a supporter of President Nixon in the past, has taken sharp exception to proposed medical research cutbacks.

He's also Dr. Jules Stein, a former practicing opthalmologist who is chairman of Research to Prevent Blindness, Inc.

He's referred to "arbitrary slashes in health research and research training support in defiance of the wishes of Congress and without any recognition of the consequences to the American people."

He says eye disease will blind 500,000 Americans in the next 10 years if we ignore this "foreseeable catastrophy."

How long will the President's cutbacks delay relief for many of the other illnesses associated with the elderly?

What long-range misery will we buy with this short-term savings?

The President hopes to impress older people on Medicare with the high price of health services by making them pay more for hospitalization—the theory being that they won't take long hospital vacations if their out-of-pocket expense is increased.

He's reinforcing the argument by eliminating Hill-Burton construction grants so that there won't be a hospital for some to get into at all.

If the administration has its way, Medicare recipients also will pay more of their doctor bills themselves, and many will lose the U.S. Government's help with their dental bills through Medicaid.

Let me give you a picture of the impact of these proposed Medicare changes on the lives of the elderly in California, a State, by the way, where there will be 4.4 million people over the age of 55 by 1980.

One out of every seven of the 1.8 million insured by Medicare went into the hospital last year and spent an average of 10 days.

The cost to the patient for that average stay will be increased $148.40 by this new plan—and that's presuming last year's prices.

The $72 a Medicare patient must now pay for the first day of hospitalization might cover the bill in some places, but the average charge per day in a California hospital is $116.

When the President proposes to make the patient pay the full cost of the first day and 10 percent of the hospital charges every day thereafter, it's the elderly sick in California who will suffer the most to finance the system.

The administration points out that there will be a savings to the person hospitalized for more than 60 days.

For that we can all be thankful, but by the latest figures available, we estimate that 267,000 elderly Californians will pay more to ease the hospital costs of 2,700 of their fellow aged.

$70 Million in Extra Hospital Costs in California

On the whole, if this Congress enacts the President's proposed Medicare changes, California's senior citizens will be penalized $70 million in extra hospital costs next year alone.

They'll pay it themselves or an already over-burdened State and local government will have to be responsible.

Let me give you an example of an elderly Berkeley, Calif., woman who was hospitalized a total of 49 days because of multiple injuries she suffered in an automobile accident. Her cost was $72 for the first day and nothing more.

Under the President's proposal, her bill on checking out would have been $646.

Older persons whose illnesses aren't serious enough to warrant hospitalization won't be spared. California's Medicare patients made a total of 9½ million visits to physicians in 1971.

By requiring a $25 higher deductible and also increasing the patient's share of the bill, for example, the older person's share of $500 in medical services will go up nearly $41.

California's elderly who use Medicare will be compelled to pay $44 million more in doctor bills—and that's a conservative estimate. We're now talking about $114 million more out of the pockets of older ill people, if we can control inflation.

Since the turn of the century, U.S. scientific and medical achievements have added 21 years to the average lifespan.

What good are those added years if the quality of life decreases?

This country began to take its first serious look at the problems of the elderly in the early 1930's when it became clear that many who lost their jobs in the depression would never get them back.

The Nation responded with the Social Security Act of 1935.

Nearly 25 years ago, President Truman called the first National Council on Aging to identify the special problems of older Americans. The main needs were found to be income, health, and housing.

Then, in 1961, at the first White House Conference on Aging, came a recommendation for a health care system.

When it was implemented in 1966, Medicare became the first large-scale health insurance program in our history.

President Lyndon Johnson, in signing the bill at the Truman Library in Independence, Mo., said he "marveled not simply at the passage of the bill, but * * * that it took so many years to pass it."

President Nixon, when he addressed the second White House Conference on Aging 2 years ago, said he would give "close personal attention" to its recommendations.

The Nation's elderly told him problems of income and housing remained high in their priorities, but they also recommended, pending a comprehensive national health plan, the expansion of Medicare.

Are we now witness to his response?

"Old age should not be a time of endings, but a time of new beginnings—not a time for stopping, but a time for new starts."

That's obviously not original with me. President Richard Nixon said it to retirees in Chicago less than 2 years ago.

What "beginnings" and what "new starts" are part of this barrier he is now trying to erect between the elderly and their ability to keep themselves healthy?

Medical expenses are a burden for older people because they have greater need.

Medicare is some help, certainly, but it covers only 40 percent of their health care costs. Nationally, we're falling short as much as $7 billion a year.

When the administration says it wants more "cost awareness" on the part of the elderly to "minimize over-utilization of medical services," that offends me because it's a repudiation of 40 years of our history, beginning with President Roosevelt and carried on by Presidents Truman, Eisenhower, Kennedy, and Johnson. It's also a repudiation of Congress as a representative body of the people, and of men and women who are old now but thought when they were younger that they had provided for this time in their lives.

Property Tax Relief for California's Elderly

Despite our limited financial resources, California State government has been making some progress to help the elderly enjoy better lives.

Next year senior citizens who own their homes will receive $62 million in property tax relief, up from only $8.3 million last fiscal year.

We're also providing relief for renters for the first time in history, $110 million next year, which we'd like to see take some of the financial pressure off the elderly.

After five legislative hearings on the subject of nursing homes, the California Assembly is no longer just moaning about the "warehousing" of older people, we're initiating legislation to provide alternatives.

And, in spite of a reluctant State administration, the legislature this year is going to try to create programs to help the elderly with their housing and medical needs.

The White House is not making our job any easier. The Nixon budget proposes to take away dollars certain for programs for people and give back maybe dollars in revenue sharing—at a rate that looks like 3 to 1 to our disadvantage.

That abdication places new and awesome obligations on local governments least able to respond.

We can't spend deficit dollars in California State government. All we can do is raise taxes or likewise surrender our responsibilities and pass the buck to the next level. That means the 58 counties, and all they can do in turn is to raise taxes on homes.

Related to this is H.R. 1 and an anxiety among some of our elderly that they will lose the automatic cost-of-living adjustment California has for years provided for our needy elderly aged, blind, and disabled.

This factor helped protect the needy from the worst effects of inflation.

Under H.R. 1, the full burden of paying for a continuing cost of living provision will be shifted to the State of California. At present levels of grant, caseload and inflation, this could amount to $30–$50 million over and above the so-called "hold harmless" next year and every year thereafter.

That's not going to be easy to swallow, but we must do everything possible to see that California meets its responsibilities and maintains these cost-of-living adjustments.

This time last year the average Social Security benefit for retired workers 62 and over in California was $116 a month—or equal to the cost of 1 day in a California hospital.

The raise in Social Security didn't keep pace with inflation and the expense of just keeping well continues to outrace most other increases in the cost of living.

President Nixon can't do what he wants to do about Medicare alone. This time he can't impound funds or slash a budget unilaterally. He needs the consent of Congress.

I might add at this point, Mr. Chairman and members, that all of you are in for what I think will be a very, very new experience with Secretary Weinberger taking office.

I happen to know Mr. Weinberger very well. He was the director of the Department of Finance in California and I worked with him for a few years.

We also found it extremely difficult if not impossible, most of the time impossible, to ever receive a direct answer to a question.

He uses a method of going on and on and on in avoiding the answer until you get tired and go on to the next question, and then he uses the same procedure again.

I wish the Congress better luck than we had in the legislature. If you are able to get an answer, you have a great deal of credit coming.

For the welfare of the elderly in California and this Nation, I urge you to deny Mr. Weinberger your help. I also hope you will bring your hearings to California—to Sacramento, or Whittier, or San Clemente, or wherever—and listen to the older people who need our help and those of us who are willing to give it to them.

Senator MUSKIE. Thank you, Mr. Speaker. We are going to hold hearings in the field. I think this subject merits that kind of attention.

I am not sure where they will be as yet. California would be an appropriate place, as would my own State, of course.

Mr. MORETTI. We'll go there in the summer, Mr. Chairman. You come to us in the winter.

Senator MUSKIE. Your description of Secretary Weinberger I think is reflected in yesterday's record, but I guess it is our challange to try to prod him in the direction of specific answers, and it is his prerogative to avoid them if he can.

Mr. MORETTI. If you are able to do that, Mr. Chairman, we will be happy to send you a resolution from California, a resolution of congratulations from the California State Assembly.

Senator MUSKIE. I know you are under the pressure of time, and we have already strained, I think, the generosity of our previous witnesses, Professor Muller, by interrupting her appearance.

ALTERNATIVES TO NURSING HOME CARE

In your statement you refer to legislation of California that would provide alternatives to nursing home care.

Could you give us any more detail on that as to what alternatives you are considering?

Mr. MORETTI. Basically our concern, Senator, is that we want simply not to warehouse older people. We just don't want them to go to nursing homes and live out their last few days in an unhealthy environment, mentally as well as physically.

What we are trying to do is to develop programs that will allow them to stay in their own homes as much as possible, to keep them in a natural environment and natural surroundings, and to provide them with some more personal kind of attention.

There's a program in San Francisco called the friendly visitor. It is much less expensive than keeping the elderly in a nursing home.

At the same time it allows them to live a normal life. People go in to pay attention to their needs, whatever they may be, and to talk to them about the problems they may have.

This program demonstrates our willingness to keep these people, to the greatest extent possible, out of warehouses for the elderly and to allow them to participate in a rather active life.

Senator MUSKIE. Senator Percy?

Senator PERCY. I have no questions, Mr. Speaker. We very much appreciate your being here, and I could not concur more in your feeling with what needs to be done to provide the kind of atmosphere that will give some semblance of correlation between the so-called golden years and what they should be.

Some of the nursing homes I have visited have been termed "warehouses for the dying," and they are a total disgrace. Thank you for coming.

Mr. Chairman, I am very sorry my absence from the city did not permit me to be here during Mr. Glasser's testimony.

Senator MUSKIE. You were on an errand of mercy.

Senator PERCY. An errand of mercy in the State of Maine. But I would like to ask if I could question Mr. Glasser for just two or three questions, and perhaps we could have Professor Muller at the same time.

Senator MUSKIE. Why don't we have them both at the table at the same time.

May I say to the Speaker, I would like to take this opportunity publicly to express my admiration for the quality of leadership that I have seen in the California Legislature. You have been at the forefront, I think, in the efforts in this country to improve the State legislation.

You have set an example for other State legislatures. I was happy to see my outstanding legislature this year, and it is controlled by the

other party, respond to the same initiative, the same impulse for reform of legislative processes that was begun in California, and I have enjoyed my contacts with you, Mr. Speaker, and the leaders in the California Legislature.

You exemplify forward, progressive passion at legislative impulse, and I congratulate you and welcome you here to Washington, and I expect to see you later today.

Mr. MORETTI. Thank you.

CONTINUED STATEMENTS OF PROF. CHARLOTTE MULLER AND MELVIN A. GLASSER

Senator MUSKIE. Professor Muller, I wonder if you and Mr. Glasser would come back to the witness table? Since I have had some opportunity to question this morning, I yield to Senator Percy at this point. Maybe he will cover some of the questions I have of Professor Muller.

Senator PERCY. I should report it was a perfectly beautiful day in Maine yesterday, Mr. Chairman. And I did a most unusual thing: At a political fund-raising dinner for the Republican Party, I devoted the entire speech to the problems of aging. And somebody said to me afterward "that is the most unpolitical speech I ever heard."

I don't know how to take that.

Professor Muller, we appreciate very much your testimony. Inasmuch as you have served on the Mayor's Committee on Prescription Drug Abuse, I wonder if you could tell us to what extent you feel hospital costs have increased, first of all, by the use of prescription drugs both in the hospitals, as against generic drugs.

Professor MULLER. You mean brand names?

Senator PERCY. Yes. Is there much of an increase in cost because of the use of brand rather than generic name drugs? And what is the current practice as you see it?

Professor MULLER. In the study I did, we had an opportunity to go into that very question, and the range of hospitals on an index that we devised to measure the prices that they pay for these 6 drugs, went from a value of 1 point up to about 6, among 53 hospitals that had ordered all 6 drugs.

There was clearly an association with the vendor source that was used, and there were cases too, where two brand names might have very different prices attached, and what was very interesting was the way in which individual hospital buyers stuck to their favorite source regardless of price in some cases, and some other hospitals did not do that at all. There were also cases where because of competition within a particular drug, the brand price was not terribly different from the generic, so the situation varied market by market, and it took canny purchasing. You did not find a strong association between the gap between the generic and the brand price and the number of hospitals choosing the one over the other.

In other words, you had in my opinion a margin for more effective use of administrative decisions in making an economical purchase. I think a number of people who have concerned themselves with this would agree that there are clearly opportunities for saving. This is recognized by the practice of some hospitals and by the efforts of some

policy bodies to make it easier for an adequate generic product to be used. However, one should not make the doctor go through a very time consuming procedure each time he wishes to authorize the substitution, because if there is one thing that is clear, it is that doctors in practice have several time constraints, and any measures to control costs that try to tell them, you have got to put a lot more time into some nonrevenue yielding, and nonpatient care activity comes up against this block. This was recognized by the Manitoba Commission I alluded to earlier. Their report was very plain about this, let's not have methods that are going to require a lot of input of busy doctors. So my general answer would be that there is a place to go with this kind of approach.

Senator PERCY. Mr. Glasser, I would like to say I have visited a great many of the retiree programs in the UAW, and I was tremendously impressed with the way the UAW has gone about keeping its retirees within the fold. The UAW watches after their interests long after the retirees have separated from employment and when they paid dues, and I think this is why you have such a steadfast loyalty among your present members, who see that once you leave employment you do not leave the fold of the UAW.

Have you received many complaints, if one is not eligible for payment under Medicare, then he is not covered under the private policies, either? That is, the private policies actually fail to supplement the Medicare coverage?

Mr. GLASSER. We not only have received complaints, Senator Percy, we have done a quite careful research study comparing the Medicare nursing home benefits with those negotiated by our own union prior to the advent of Medicare.

Our program preceded it. The evidence is quite clear in the careful study that we did, that in fact over a period of somewhere in the neighborhood of 1½ to 2 years, the much more liberal eligibility requirements of the UAW negotiated benefit through administrative interpretation by the fiscal act in this instance, Blue Cross, were tightened and hardened to the point that there was no substantial difference in eligibility, and therefore the supplementary nature of our benefit was substantially watered down.

The only difference remaining was we had more days of eligibility, but the other qualifications which were by us designed to be more liberal through administrative interpretation proved not to be.

ELIGIBILITY FOR WELFARE

Senator PERCY. I also wonder if the UAW has ever done any studies to determine the number of impoverished elderly people who are eligible for welfare, but who, for one reason or another, lack of knowledge, sense of pride, simply do not make application for welfare.

I saw one study in Chicago where 1 out of 4 in Chicago were actually eligible, but only 1 out of 20 are actually receiving welfare benefits.

Mr. GLASSER. We had not conducted such studies on our own. There have been such studies, and the numbers range anywhere from 1 out of 4 were eligible to 1 out of 20 or 30 are actually receiving it.

We do know from experience with our older members, our members, an older member by my definition, sir, is somebody past 80.

A retired member is somebody 65 and older, are very elderly members, and we have a substantial number of them, and they have very low pensions, and their Social Security benefits are low because of the time they got out, many of them are in fact eligible for welfare and will not apply.

There is a strong factor of pride. There are in fact administrative impediments to eligibility, there is all of the demeaning factors we know about, and we know that to be true, and we know it to be true even for Medicaid, which is more relevent to the issue here, because in many instances where the Medicare benefits have fallen short and the individual may be eligible for Medicaid, there is tremendous resistance to go through the demeaning process.

Senator PERCY. I have heard, and I was astounded to hear a question put by the same people who argued against our 20-percent increase in Social Security—which we all in this committee fought for together with the staff—I have heard people say, "Why don't the elderly poor go on welfare? If they cannot make the grade, why don't they go on welfare?"

I just think they underestimate the humiliation involved, on going on welfare for people who have worked all their lives, but who cannot meet expenses through no fault of their own.

With ever rising costs, medical needs, rising taxes—the elderly should then go on welfare, when we have the ability to give them the sense of dignity!?

The money must come out of one pocket or the other. It may as well come from the more dignified pocket.

RELUCTANCE TO ACCEPT MEDICAID

Could you give us any indication whether elderly people are reluctant to accept Medicaid because it is a welfare program administered through State departments of public aid?

Mr. GLASSER. There is absolutely no question, at least in our experience in the UAW, that this is the major barrier.

The major barrier is I worked 30, 35, 40 years, I supported myself all through my life, and in a great many instances, I came from abroad and had no education, and I made it, and now at the age of 65, or 70, I will not admit I cannot make it in society, that I have to go through the applying for Medicaid.

It is a medical care system which I regret to say is not accomplishing its purposes, because it is among other things a demeaning process.

Senator PERCY. Will the proposed Medicare changes have a significant effect with respect to many more elderly people being forced to go under Medicaid?

Mr. GLASSER. Senator Percy, it has a dual function, and it is in a sense contradictory.

I am quite certain that there will be some increases in the cost of Medicaid, since we know that about 40 percent of the Medicaid costs are for the elderly, and that a number of elderly will be forced to apply for Medicaid.

I believe, however, there will be cost savings up to a point because of the very pride factor that you indicate, and that people will not apply though they need to apply to make up for the deficiencies in Medicare because of the pride factor, and it is quite reasonable to say that any rational human being who needs services ought to go through the process.

We are also individuals who feel with our hearts as well as our minds.

Senator PERCY. Thank you, Mr. Glasser. Professor Muller, a final question for you.

OVERUSE OF HOSPITAL EMERGENCY ROOMS

I wonder if you could help us on a question I raised yesterday concerning the complaints being made by hospitals now on the overuse of their own emergency rooms, simply because of doctors not wanting to make house calls, people having to come to emergency rooms of hospitals to get assistance and help.

Could you comment at all on that phenomenon, and give us an answer for the hospital administrators as to what they will face. Just a continuation of this? Should they gear up for it? Or is there any better alternative?

Professor MULLER. Well, this is an example of the kind of thing I refer to in my statement about events that have a complex historical evolution. Here we have the continuing opportunity for doctors to use more and more capital aid, in association with their own time and labor in the care of the patient, either in the hospital, or in their office, and otherwise make the most effective use of their time, so that they no longer felt that they could make a house call and maximize their own economic opportunities, and their potential for patient care.

With the decline of the house call, which has been universal and felt in group practice as well as solo practice, the emergency room became an alternative for individuals, and in that sense, it even served a purpose for the community, it gave them some place to go, but it had two defects. One was the noncontinuous care the individual would get.

That is, the asthmatic child might get relief of the asthma, but nothing was done to desensitize him, or to investigate the home conditions that might have contributed to the asthma.

The other disadvantage was related to the sorting out of cases that require emergency hospital processing, which is a function the emergency room served.

It was made much more difficult because you have a general population calling upon the emergency room. I think the answer has to be in terms of giving people a place where they can go. That is where a combination of ingenuity, talent, and resources could help a great deal, for instance, having home service that is rendered by some type of physician aide rather than a physician, having a TV terminal in the neighborhood so that the physician who is in a central place can advise the person who has some training out in the neighborhood and where the patient actually is, can advise about the next steps to be

taken without having to use up his own time by traveling to different locations. Another possibility is using neighborhood pharmacies as health stations.

There are many possibilities for an inventive community and an inventive health care system, but the first step is to take responsibility for delivery of primary care.

Otherwise the initiative is taken by the sick person at the time of the problem and the hospital is then faced with an overload, with rushed care, with trying to do its best against heavy odds, and with this problem I mentioned of not really being able to evaluate the cases that require immediate hospitalization as effectively as it would like.

Mr. GLASSER. Senator, may I supplement this?

The hospital emergency room is frequently associated with poor people or emergencies.

It frequently is no longer that. I am associated with a hospital which is no longer that, and we have updated the emergency room by $1 million, and we are far behind because of the increase of people coming in.

We have significant numbers of our members who have money in their pockets, or insurance, who in Chicago, in Detroit, in Atlanta, in New York City go in the outpatient departments of hospitals because they could not get access to a doctor.

These people are waiting in Detroit from 4 to 7 hours to be seen, and they're extremely resentful, because our society tells them if you have money you ought to be able to have access to things.

They finally made it, and they still don't have access.

NATIONAL HEALTH INSURANCE PROGRAM

The solution that I see is not in fact in better hospital administration, or in spending more money on hospital emergency rooms, though on an interim basis we must do it.

It really has to do with making available the broad range of primary services which could be done through a properly structured national health insurance program, so that most of these people are people that can pay for them, so people can have access to services where they are, rather than be treated as many of them are treated, as cattle in hospital rooms.

Senator PERCY. Thank you, Mr. Chairman. You have been most gracious, and I would like to express deep appreciation for the very, very fine testimony that has been provided. It is extremely helpful to us in what I consider to be important hearings.

Senator MUSKIE. I have two or three questions that I would like to ask, and I think they can be answered quite briefly.

If more extensive answers are called for, you can provide them.

DEDUCTIBLE HURTS LOW INCOME PEOPLE

Professor Muller, is it possible to have a deductible that does not hurt low income people?

Professor MULLER. I think it is very, very difficult. The assumption that has been perhaps never stated behind proposals for deductibles is

that if you have a little deductible, you will cause a certain percent of people to reduce their use of services, and if you increase the deductible by a certain proportion, you will have a proportional reduction in use. The basic assumption there is that people are strung out in an equal dispersion along some kind of income line, whereas the fact is that if you examine the income distribution of the aged, they're clumped way down at the bottom. So in order to touch their utilization at all, to the extent that any of it is within their control, you have to have a deductible that is large enough to reach way down and that is where you will find a lot of people concentrated. What I said earlier would apply, that you cannot cut their utilization without cutting the indispensable and necessary utilization.

Senator MUSKIE. You told us that you have conducted studies of prescription drug costs. What safeguards would you like to see if Medicare would cover some prescription drugs?

Professor MULLER. I think that one could have the basic starting idea of covering selected drugs that were important in old age, and these could be chosen by appropriate professional groups based on the knowledge of the statistics about frequency of certain illnesses.

I don't believe it would be very difficult to make a very good selection to start off, and to have a pretty good idea of what the expected cost will be.

I also think the kind of effort required to devise a listing of formulary items that would be approved would be a help in containing the prescribing choices in a rational way. It is timely for this country to think about supporting its doctors by giving them a lot more information about the probable effectiveness of various therapeutic alternatives and to see what proportion of patients could be helped by each. Particularly of interest are cases where it could be a drug or it could be something else. But in terms of Medicare coverage, I think the idea of paying for maintenance drugs and the promulgation and promotion of formularies would help.

BETTER CONTROL OVER COSTS

Senator MUSKIE. I would like to ask both of you this question.

There has been the assumption—I think certainly in the testimony today, and perhaps yesterday—that we need better control over costs.

The assumption is that we cannot get control unless the Government exerts some kind of pressure. Is there any way it can control costs, by imposing that responsibility with hospitals and doctors? I am not assuming an answer to this question in any way, but is there some way that we can rely more heartily on doctors and hospitals for asserting some of these controls that would keep costs down, not only for patients, but for the Government as well?

Mr. GLASSER. Mr. Chairman, I was once a dean, I have learned always to respect professors. I will let Professor Muller go first.

Professor MULLER. And I was told to respect economic power, and I see over a million autoworkers sitting next to me.

Senator MUSKIE. This business of control.

Professor MULLER. Of control being cut away from Government.

I think you have a situation where once you start something on the right path, you can think of areas where various types of groups can take a strong interest in this.

For instance, consumer accreditation of health facilities has some potential. Another example is information sources where consumers can go.

Unions have even gotten into that, like the Teamsters, in advising consumers where to go for good medical care. I think the professionals have a lot of pride and can be called upon, and that they would like to have the pride of being associated with a hospital with good standards.

I think these things can be drawn upon, but we have to defuse negative incentives that make it easy, or even profitable, to do things that should not be done for patients, or not to let patients alone that should be let alone.

Mr. GLASSER. I think, Mr. Chairman, there has been a false dichotomy established in many places about this issue.

I think nobody has been saying that Government should come in and take control of the cost and quality review.

What many of us are suggesting is that the Government needs to set up the standards, and that essentially the private sector provided with consumer participation who would meet those standards.

We in our, our president in our union rejects the review set up passed by the Congress because we think it turns it over to the medical profession, and we do not see much chance of that working.

We would see that be more effective if that Government in fact required there be consumer participation, and that there be some Government input in the operation of that system, rather than simply a standard set up from Washington with no way of monitoring those standards.

We know from the Medicare utilities review requirements, which are essentially that, that that review system has failed.

Further, that is why we are trying another one.

Further, with relation to the cost and quality of the major part of the problem, of the PSRO system, just by implication brings in but actually does not cover; namely, the out of hospital services, that is where we are having a tremendous problem in quality, tremendous problem in cost and there is no reason we have devised technicians in the country whereby the use of professionals with consumers, and medical economists can in fact provide such reviews under Government standards, but it does not mean the Government does it, it means it is still done in the private sector, whereby the consumer can get the kind of protections, and we can get the kind of controls that would be more effective than the system frankly of saying that we will let you providers determine when you are doing a good enough job.

Senator MUSKIE. One final question, Professor Muller.

I think it has not been raised with administration proposals for Medicare cuts. You mentioned in your testimony that private health insurance, the so-called medigap is held by 11.4 million aging persons.

How do you think the administration proposal would affect these policies?

Professor MULLER. I think what would happen is that the deductibles increasing would place more out-of-pocket expenses on the aged person, and if the supplemental policies attempted to pick this up, they obviously would have to increase their premium costs over a period of time, so that those out-of-pocket costs would be felt by the insured in that sense, instead of in a direct payment, as premiums increased.

Senator MUSKIE. The effect of the cuts bears not only on those who rely totally upon Medicare, but also on those who have supplementary insurance?

Professor MULLER. That is right.

Senator MUSKIE. I thank you both. I am sure if we stayed here for the afternoon, we would continue to learn from your experience and insights.

I think it has been a good morning and we are grateful to you both.

Mr. GLASSER. We are grateful to you for letting us come.

Senator MUSKIE. Without objection, an analysis, Coinsurance and Deductibles in Medicare,* by Agnes Brewster, consultant to the committee, and a letter from the Library of Congress, Congressional Research Service,** in response to a request from the committee, will be printed in the appendix of the hearing record.

The hearings stand adjourned.

[Whereupon, the hearings were adjourned at 1 p.m.]

*See appendix, page 198.
**See appendix, page 200.

Appendix

STATEMENTS FROM NATIONAL ORGANIZATIONS

STATEMENT ON BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

(By Hobart C. Jackson, chairman, National Caucus on the Black Aged)

The Administration's proposed Medicare cutbacks are viewed by members of our Caucus as simply another unfortunate repudiation of the needs of the poorest of the poor. Our recommendations made at the 1971 White House Conference on Aging pointed up the desperate need to liberalize the Medicare regulations rather than taking the opposite course.

Aging and aged Blacks and the elderly of other minority groups will be hit the hardest by these punitive proposals. They already benefit less proportionately than others because of racially discriminatory practices and because of their extreme poverty.

Both research findings and personal experiences document the inescapable conclusion that health and other life sustaining services for the Black aged are grossly neglected. They are denied the health and social support services that should be, in principle, available to them if health care and services are viewed as a "right" rather than a "privilege". The institution of the Administration's proposals will make comprehensive health services more of a "privilege" than a "right" for many of the elderly, while they should be a "right" for all.

Under current circumstances, it is estimated that about one-third of the Black elderly are not enrolled in Medicare because of either lack of information about the program or lack of resources to participate. The cutbacks proposed will mean that even fewer proportionately will benefit from Medicare.

The high incidence of poor health among Blacks of all ages inevitably leads to a higher death rate than their white counterparts have—shockingly high in this sophisticated and enlightened age of medical breakthroughs against the killing diseases. There is an especially serious problem in some hospitals where many Black elderly patients are simply treated as ward service patients even when they are entitled to Medicare benefits.

Our Caucus takes the position that it is time for the poor to be given priority. Our members have the very strong conviction that the best way to remove inequities from our most inequitable system (or non-system) of health care is to start at the point of the greatest inequity to change things.

We've experienced enough of the ineffectiveness of the approaches that start with the affluent and expect services to trickle downward. Unfortunately the services never reach those who live in multiple jeopardy where the problems of age, race, poverty, disability, and so on tend to compound their difficulties.

In like manner we believe the best point to begin to rid our inhumane system of its inhumanities is to start at the point of the greatest inhumanity. If these premises are valid and we are convinced that they are, then why not launch our attack at the point where these most critical problems get our prior attention and consideration?

Here are a few of our recommendations in this area as opposed to those of the Administration:

1. Medicare coverage should be expanded and improved to provide coverage for home care, long-term care, and extended care without prior admission to a general hospital and there should be the removal of the 100-day limit on skilled nursing home care for those patients who continue to need such care.

2. Parts A and B of Medicare should be merged and all deductibles and copayments should be eliminated. Services previously excluded such as foot care,

eyeglasses, eye refractions and examinations for eyeglasses, hearing aids, false teeth and dental care, other prostheses, and out-patient psychiatric care should be included.

3. The implementation of health care legislation should be uniform and mandatory and independent of matching state funds or voluntary participation of individual states.

4. The scarcity of Black health professionals necessitates sufficient federal allocations for training Black people as physicians, nurses, pharmacists, dentists, technicians, social workers, dietitians, and other relevant health professionals and paraprofessionals to increase dramatically available Black health professionals and paraprofessionals in the next decade. Their training curricula should include mandatory geriatric and gerontological exposure.

5. The federal government should strengthen its enforcement of racial desegregration in all health care facilities—including nursing homes—coming under its jurisdiction or using any federal funds. Such policies should apply to all governing bodies, administrators, staff, and patients.

6. The federal government should require adequate hospital and other health insurance coverage for all labor force employees—including domestic and farm laborers—or it should move immediately towards other coverage methods such as nationalized health insurance systems. Irrespective of socioeconomic status and geographical location, all Black aged should have access to good health care.

U.S. CATHOLIC CONFERENCE,
DIVISION OF HEALTH AFFAIRS,
Washington, D.C., March 7, 1973.

DEAR SENATOR MUSKIE: The Administration's proposal to change the present required payment procedure under the Medicare program reflects, in our assessment, a distorted perception of the financial and medical problems of the aged.

We fail to understand the reasoning offered to support the proposal to: (1) assess Medicare recipients actual hospital room and board charges for the first full day plus ten percent of all subsequent charges, instead of the present $72 deductible and nothing thereafter until the sixty-first day; (2) charge the first eighty-five dollars of doctor bills instead of the current sixty dollars, and (3) charge 25 percent, as opposed to the existing 20 percent, for physician services after the Part B deductible is met.

It is difficult to believe that these measures would be taken in order to enhance medical cost consciousness among the elderly, as was suggested in the testimony given by the Secretary of Health, Education, and Welfare before your committee this week. Surely all must realize that our aged are already painfully aware of sharply escalating costs not only of necessary medical goods and services not provided under Medicare, but those of food, transportation, clothing, and shelter.

In New York City alone where nearly ten percent of the elderly in this country reside, over half of the households headed by persons 65 years of age and older have incomes of $3,500 or less and nearly a third of those exist on incomes of $2,000 or less. It is only too true for persons such as these, that cost consciousness has been essential to their survival, and it is ludicrous to suggest that they need further education in this area.

The burden of inhibiting growing medical costs should not be and cannot be borne by the aged. It is not just. More imaginative remedies to the problem of cost reduction should be explored.

We take this occasion to register our opposition to these proposed increases and urge your committee to take those measures which safeguard the present Medicare system.

Sincerely,

SISTER VIRGINIA SCHWAGER, S.P., *Director.*

CATHOLIC CHARITIES OF THE
ROMAN CATHOLIC DIOCESE OF SYRACUSE, N.Y.,
Syracuse, N.Y., March 13, 1973.

DEAR SENATOR MUSKIE: Your letter of February 21, 1973, requesting input concerning "Barriers to Health Care for Older Americans" has been transmitted to me by Mr. H. Ted Olsen of the American Association of Homes for the Aging for reply.

In regard to the specific inquiry concerning the proposed Medicare cuts, we join our voices to that of many others in protecting the injustice of such a procedure. The avowed purpose of these modifications, namely, the curtailment of unnecessary hospital usage on the part of the elderly is particularly reprehensible. Our problem should be developing techniques to make hospital service and other medical care more accessible to elderly rather than discourage them from using it. It would be our conviction that most over-utilization results from a lack of quality nursing facilities and other alternate types of care over which the individual elderly have no control. It is just absurd to think that people are in hospitals on their own volition.

We hope that as you continue your inquiries in this area, you will look to our national commitment to the institutionalized elderly. We are strongly committed to the development of services to people in their own homes or other places of residence but find little national commitment either to this type of service or to real quality care in institutions. We must face the fact that service to elderly is costly and it cannot be borne by them alone. In order to fulfill the recommendations of the White House Conference on Aging, it is essential that there be a supplementation of our Social Security-Medicare system in such a way that a package of medical service will be available to all elderly as a matter of right in such a way that it is both accessible and in consonance with their dignity as human beings.

We look forward at the appropriate time to participate in a formal way with the number of suggestions in this regard. With every good wish, I am

Sincerely yours,

Msgr. CHARLES J. FAHEY, *Director.*

AMERICAN NURSES' ASSOCIATION, INC.,
Kansas City, Mo., March 22, 1973.

DEAR SENATOR MUSKIE: The American Nurses' Association commends your subcommittee on its plan to conduct hearings on "Barriers to Health Care for Older Americans" and offers assistance to the subcommittee in its study of the problem. Nurses, by virtue of their practice and their variety of practice settings—institutions, clinics, day care centers, community health centers, and individual homes—identify on a daily basis the need for and the obstacles to health care for the aged.

Cost is a primary barrier. The proposed changes in Medicare regarding coinsurance and deductibles must be thoroughly studied as to their effect on senior citizens. These changes would have a great impact on older Americans who maintain themselves on minimal incomes derived from Social Security which may or may not be supplemented by pensions and savings. Fixed incomes which were projected to be adequate ten, twenty or thirty years ago are the most affected by decreased buying power of the dollar. For example, an obligation to pay ten percent of a hospital bill for even two weeks could exhaust an entire month's income, leaving little or no money for rent and food. An older American faced with the necessity for stringent spending priorities often postpones seeking attention for health needs. Thus, conditions which may be readily amenable to treatment become either serious and acute or chronic and debilitating problems. When the elderly are asked why they didn't seek care sooner, the response over and over again is "I didn't have the money," or "I had to pay my rent," or "I had to buy food."

Cost is repeatedly the obstacle. Cost of transportation. Cost of drugs. Cost of equipment and appliances. Cost of dentures. Increasing the cost of care for older Americans can be seen as punitive; punishment for living long and developing health problems.

It cannot be assumed that children can absorb the financial responsibility for their parents. Many of the children of older Americans are adults who are in the process of raising children and attempting to save for their old age. Each generation in this country is affected in some way by costs, costs of housing, food, clothing, education and health care.

It has been stated that the proposed changes in Medicare will prevent improper utilization of acute care hospitals. The assumption seems to be that consumers, in this case the elderly, are responsible for the misuse or overuse of this facility. Quite the opposite is more often the case. Our insurance system encourages the overuse of the most expensive health care facility while the elderly would frequently prefer care at home.

An obvious example of that problem is the very low utilization rate for home health services covered by Medicare. The rejection rate for payment of such services continues to rise as lids on spending are enforced.

The present health care system for the elderly does not fulfill its mission. The aged are limited in choices for maintaining health, coping with illness and dying with dignity.

The list of barriers is extensive. Barriers or obstacles exist whenever one begins to attempt to obtain or to provide care. For this reason, we suggest the following as possible topics for hearings you are planning:

—Health problems of the elderly.

—Health care services needed (dental, medical, nursing, allied health services and social services relating to health needs).

—Accessibility and availability of such services.

—Supportive and health-related services (e.g., food services, transportation services, homemaker services, living arrangements or special housing, recreational and occupational therapy).

—Costs of the various services and reimbursement for services and how they are now being handled by Medicare and other third party payment claims reviewers.

We suggest that older people be asked to speak about their health care needs and the personal obstacles they encounter. We suggest that nurses be asked to speak about their observations and experiences in providing care for the aged. (See attachments) The ANA is willing to assist you and your staff in any way possible. We all know we must do more and do it better for this large group of older citizens.

Yours sincerely,

CONSTANCE A. HOLLERAN,
Deputy Executive Director (Washington office).

[Attachments]

[From the American Journal of Nursing, September 1971]

THE CLIMATE OF CARE FOR A GERIATRIC PATIENT

VASCULAR SURGERY WAS INDICATED FOR MR. COX, BUT HIS CIRCULATORY PROBLEMS WERE ONLY A PART OF HIS DIFFICULTIES

(By Sister Agnes Clare Frenay and Gloria L. Pierce*)

When Michelangelo finished his Moses, he looked at the statue spellbound and tapping it with his chisel commanded: "Speak." Like the great sculptor, our patient assessment seeks to put into sharp relief the image of a man—an older adult of our society—John Edward Cox, age 75. His stately features mark him as a man of distinction. For several decades he had voiced his convictions in the role of political leader. Mr. Cox, a healthy man all his life, had sought fulfillment of his broad cultural interests since his retirement from the practice of law at the age of 68. He and his wife had joined the American Association of Retired Person (AARP) and actively participated in their programs, including a guided tour of Europe.

Three years ago, his wife died of metastatic cancer. His son and daughter both lived in California. A dramatic change took place in Mr. Cox's life. He withdrew from social relationships and failed to attend AARP meetings. His bright gray eyes lost their keenness; his energetic steps slowed down as his mounting awareness of loneliness, separation, anxiety, and the impact of retirement impinged upon him. It was possible that a deepening of his social disengagement might eventually lead to a depressive psychosis. Was this personality

*Sister Agnes Clare Frenay, a graduate of St. Mary's School of Nursing, Kansas City, Mo., received her B.S. degree in nursing and her M.S. degree in nursing education from St. Louis University, St. Louis, Mo. Sister Agnes Clare has written 19 articles and is the author of "Understanding Medical Terminology." Miss Pierce, a graduate of St. John's Hospital School of Nursing, St. Louis, Mo., received her B.S. degree in public health nursing from St. Louis University, Mo., and her M.S. degree in psychiatric nursing from Washington University, St. Louis, Mo. Sister Agnes Clare is professor and Miss Pierce is assistant professor at St. Louis University School of Nursing and Allied Health Professions, St. Louis, Mo.

change a profound, apparently unresolved grief reaction or was it related to some irreversible process of aging? The latter seemed a strong contibutory factor because Mr. Cox, a former brisk walker, began to experience severe pain in his right leg after walking a block. His physician, who diagnosed his condition as intermittent claudication due to arterial insufficiency, prescribed a fat-controlled diet and abstinence from smoking to prevent aggravation of the vascular disorder.

Mr. Cox complied with the directives for eight months, and his condition improved. It worsened when he again indulged in unrestricted smoking. He developed nocturnal rest pain in his right foot. Three weeks later, a sudden, tearing, persistent pain forced him to accept immediate hospitalization.

CONSERVATIVE MEASURES

It was Mr. Cox's first admission to a hospital. He arrived by ambulance—alone. His facial expression and overprotective attitude toward his right leg conveyed his primary need for relief of pain. The nurse quickly gave the medication that had been prescribed for him.

In assessing Mr. Cox's circulatory status, the nurse noted that his right leg felt cold and looked pale from midthigh to midcalf. There was obvious muscle wasting and reduced motion. Both femoral pulses were equal and of good volume. The right popliteal pulse, however, was markedly decreased compared to the left one, and the pedal pulses were absent. There was a small, crusty ulcer over the fifth digit of the right foot and evidence of early pressure changes on the right heel.

Arteriograms, which were ordered for Mr. Cox, are indispensible in determining the operability of the vascular disorder. Before signing the permit for them, Mr. Cox expressed his concern about the risk involved in the procedure. The nurse agreed that angiography carried an element of risk, but pointed out that the significant information provided by the arterial visualization had to be weighed against such possible reactions as a feeling of warmth and gastric discomfort at the time of the administration of the radiopaque substance. The dye would record any irregularity and partial or total blocks of the arterial lumen on film.

Mr. Cox was now convinced of the value and relative safety of the procedure and signed the permit. His arteriograms revealed opacification of the popliteal artery beginning about 10 cm. above the knee joint and a patent arterial lumen proximal and distal to the obstruction. Because of the segmental nature of the occlusion, surgery was possible.

The arterial lumen of a vessel may be progressively roughened and narrowed by lipid-containing atheromatous plaques in the intima. When these plaques ulcerate and bleed, intravascular clotting occurs and cuts off the circulation of the tissues which the vessel supplies.

In femoropopliteal lesions, the narrowing of the vascular lumen diminishes the blood supply to the calf muscles resulting in ischemic pain and lameness. Mr. Cox had many episodes of intermittent claudication prior to the total arterial occlusion which preceded his hospitalization.

Havighurst has said, "According to research, the person who is in good health suffers very little impairment in his ability to learn, to initiate actions, to be effective in the ordinary relations of life until he is 85 years old or more." [1] This was true of Mr. Cox. His mental acumen, attention span, and memory retained their original efficacy, but loneliness and pain had modified his behavior. His affect was one of hopelessness verging on apathy.

The nurse, aware of the patient's mental reaction, provided a climate conducive to verbal ventilation simply by being available and listening attentively and purposefully. Her sincerity coupled with her attitudes of hopefulness, acceptance, and consistency instilled confidence in Mr. Cox. Mutual respect was established and Mr. Cox's attitude changed; he expressed his true sentiments more comfortably. He felt someone cared. As his more basic needs were gratified, he was able psychologically to proceed toward the fulfillment and expression of needs of a higher order. He seemed less sad. He gradually became motivated to utilize his potential for recovery and for living.

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[1] Havighurst, R. J. Personality and patterns of aging. *Gerontologist* 8 (part 2) : 20–23, spring 1968.

ESTABLISHING PRIORITIES

There were various priorities in Mr. Cox's care that were identified. The problem of pain, both in the form of intermittent claudication and rest pain, had top priority. Since pain may be occasionally prevented or relieved by external heat, Mr. Cox requested the application of an electric pad to his affected leg. The nurse explained to him that direct heat would increase tissue metabolism and demand an increased blood supply which could not be provided by the impoverished circulation.[2] She kept the ischemic limb warm with a soft woolen blanket and carefully protected the toes from the pressure of weighty bed clothing. To prevent decubiti on his heels, Mr. Cox wore sheepskin boots in bed.

Position is an influential factor in pain control. Mr. Cox was encouraged to lie in supine position with legs fully extended and feet pushing against a padded board to prevent plantar flexion deformity. The head of the bed was elevated to increase the blood flow to his affected limb.

A frequent change of position from lying to sitting was advocated. When he sat up in a chair, Mr. Cox was protected from compression of the peroneal nerve and superficial vessels. The dependent position of the lower extremities improved his peripheral circulation.

Rest pain is a serious problem indicative of advanced vascular disease. Mr. Cox obtained some relief by hanging his ischemic limb over the edge of the bed. To avoid contracture deformity, he was advised to maintain this position for short periods only. The psychologic impact from an altered body image at this time might precipitate additional stress with which he could not cope.

SURGICAL INTERVENTION

Since conservative treatment was unable to provide sustained symptomatic relief, Mr. Cox reluctantly consented to vascular surgery. To help him resolve the apprehension created by the impending operation, the nurse encouraged him to verbalize his feelings. She agreed with him that the operation was serious but pointed out that the surgeon was an expert in the field, that the anesthesiologist would keep him entirely free from pain, and that the nurses would use their particular knowledge and skill to facilitate his recovery. A successful postoperative period would be related to his desire to get well, his faith, and his confidence in the health team. Mr. Cox was able to develop a more accepting attitude toward his operation.

His son and daughter arrived from California the day before the scheduled surgery. To help Mr. Cox maintain this positive attitude, the nurse made a special effort to meet his children before they saw their father. She advised both to assume a hopeful, reassuring attitude when visiting with him.

On the day of surgery, the saphenous vein was removed from the saphenofemoral junction to the knee. The vein was reversed and used as bypass graft to circumvent the popliteal artery occlusion. Following the procedure, an arteriogram confirmed that the vein graft was patent.

IMMEDIATE CARE

Since the primary objective of surgical intervention—the restoration of blood flow to the ischemic limb—was achieved, nursing goals were directed at maintaining the peripheral circulation. Attention focused on the prevention of postoperative complications: hemorrhage, thrombosis, and infection. Allaying Mr. Cox's anxiety and fear was also an integral part of nursing care.

Hemorrhage is a postoperative threat and so the patient's dressing needs frequent inspection. If more than mere leakage is present, external pressure over the bleeding site must be immediately applied. Since Mr. Cox's clotting time determinations revealed some abnormal increase, it was considered unsafe to give him heparin infusions to prevent thrombotic episodes. No external bleeding was encountered.

Another possible complication is clot formation. Clots may form early in the postoperative period in the reconstructed artery or develop late from bleeding intimal plaques of progressive atherosclerosis elsewhere in the peripheral vascu-

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[2] Beland, Irene L. *Clinical Nursing—Pathophysiology and Psychosocial Approaches.* 2d ed. New York, Macmillan Co., 1970. p. 418.

lar bed. Hypotension predisposes to thrombosis. When the blood moves slowly along the freshly created suture line, a rough inner lining of fibrin is formed which tends to entrap the blood cells.

The propagation of thrombi is usually prevented by the rapidity of the circulating blood. For this reason, Breslau emphasizes the importance of maintaining a systolic pressure approximately 20 mm. Hg above the preoperative pressure for the first 12 hours after vascular surgery.[3]

The nurse, knowing the potential danger resulting from hypotension, reported the downward trend of the patient's blood pressure to the surgeon. With appropriate therapy, elevation and stabilization of the blood pressure were achieved without arousing Mr. Cox's concern about his condition.

As soon as Mr. Cox returned from surgery, the nurse checked the popliteal pulse of the operated limb and compared it to the pulse in the other leg. Both were of good volume and of a strength equal to that of the radial pulse. Since pedal pulses cannot be palpated in about 10 percent of normal persons, their absence was of no concern.[4] The posterior tibial artery was felt below and behind the medial malleolus. The color and warmth of the uncovered limb suggested a normal circulation.

To promote the circulation to the lower extremities and prevent the development of decubiti, Mr. Cox was placed in reverse Trendelenburg's position on an air mattress. He was repeatedly reminded of the importance of lying flat on his back to protect the graft from flexion injury which could reduce the blood flow in the affected limb. At regular intervals, Mr. Cox was rolled to his side in log fashion so that his back could be massaged. A padded cradle was placed over his leg and feet to prevent pressure on his sensitive limbs.

On the third postoperative day, Mr. Cox was permitted to ambulate in a stiff-legged manner. Dangling or sitting were forbidden to safeguard the graft.

Infection was prevented through surgical asepsis and antibiotics. When the dressings were changed, it was evident that the wound was healing by first intention.

Older people are less able to tolerate stress. It takes very little to tip the balance.[5] Vascular surgery actually presented a major stress situation for Mr. Cox. During the first postoperative days, he became mentally confused and needed close supervision to prevent self-injury. His daughter was disturbed about his disorientation, but the nurse reassured her that this was only a transient condition.

GOING HOME

Since Mr. Cox made steady progress, his discharge was anticipated. After consultation with his doctor, the nurse discussed with Mr. Cox foot care, exercise, rest, dietary needs, abstinence from smoking, continued medical supervision, and the importance of a positive mental attitude.

In their discussions about care of the legs and feet, the nurses stressed prevention of infections, abrasions, and burns which frequently can lead to major surgery. Mr. Cox learned that daily warm foot baths would add comfort and stimulate pedal circulation. Instead of using hot water bottles and electric pads, Mr. Cox was encouraged to wear loose, woolen bed socks and to avoid exposure to cold.

Exercise assumed a new dimension, Mr. Cox was advised to stroll about leisurely instead of taking brisk walks. The use of a cane would reduce weight on the affected extremity and help him to increase his ability to walk. Calf pain, if recurrent, could be delayed or prevented by walking stiff-legged with knees unbent. To avoid the curious glances of bypassers on the street when he was bothered with aching leg muscles, Mr. Cox could resort to window shopping.[6] He was also encouraged to alternate rest periods with periods to exercise. Mr. Cox knew from experience how effectively rest relieves that pain.

The possibility of progressive atherosclerosis was an undeniable threat. Warning signals such as recurrence of intermittent claudication or a small ulcer on a

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[3] Breslau, R. C. Intensive care after vascular surgery. *Am. J. Nurs.*, 68:1672, August 1968.

[4] *Ibid.*, p. 1675.

(suppl.):36, July 1967.

[5] Schiele, B. C. Management of emotional problems in aging. *Dis. Nerv. Syst.*, 28

[6] Abramson, D. I. Medical treatment of arterial disorders of the extremities. *Mod. Treat.*, 4:352, March 1967.

toe should not be ignored. If either appeared, Mr. Cox was advised to reduce his exercise to a minimum and to seek medical advice.

Since his basic problem was atherosclerotic occlusive disease, the doctor advised Mr. Cox to remain indefinitely on a fat-controlled diet to delay or perhaps prevent the development of new atheromatous lesions. The dietitian met with him and gave him a booklet on *Planning Fat-Controlled Meals* prepared by the American Heart Association. Mr. Cox became vitally interested and asked for more information.

Abstinence from smoking was a distressing issue. Mr. Cox had been accustomed to smoking two packs of cigarettes a day. He learned that nicotine causes vasoconstriction and thus reduces the blood flow to the lower limbs. Smoking is considered one of the contributing factors in the causation of atherosclerosis.

When Mr. Cox first attempted to overcome his smoking habit, his irritability was a trial to himself and others. However, the nurse's nonjudgmental attitude and support helped him to accept this deprivation as a possible way to prevent recurrent pain.

Mr. Cox realized that his future health depended partly on his own efforts and partly on early medical care. He understood that periodic femoral arteriography would provide objective evaluation tools of his circulatory status and could accept that these would have to be done.

Before Mr. Cox's son and daughter returned to California, the nurse discussed with both them and Mr. Cox plans for the future. The pros and cons of several possibilities were considered, such as a return to his own home or transfer to a local residence for senior citizens. His son and daughter invited him for a prolonged visit to their homes which were located near a California retirement community. Such a visit would provide opportunity to explore the morale and social interaction of the older people living there. This sincere gesture on the part of his children fulfilled his need for love and belonging. No pressure was put on Mr. Cox to make a particular decision. His personal dignity and sound judgment were respected, and Mr. Cox decided to remain in his own home.

With his son's and daughter's return to Cailfornia, however, loneliness seemed to overtake him. The nurse fearing a pending depression, encouraged AARP members to visit Mr. Cox. The results were most gratifying. His interests in the Association revived. He envisioned opportunities for living a useful, active life by becoming involved in educational and philanthropic endeavors. His strong personality would reassert itself in a climate of acceptance and trust.

When our geriatric patient left the hospital, it was evident that he had found a new lease on life. Why? An expert surgeon had freed him from pain, and a concerned nurse had shown interest and provided genuine care. There was no doubt that Theodore Lidz's words were verified in John Edward Cox: "Even as life draws to a close a person still requires self-esteem and a purpose that provides meaning beyond the day, a week or month." [7]

[From Nursing Outlook, vol. 20, No. 2, February 1972]

THE 1971 WHITE HOUSE CONFERENCE ON AGING

They came, they listened, they spoke. Most important of all, the delegates agreed, this was only the beginning

(By Catherine L. Callahan*)

Four days of tumultuous activity marked the second White House Conference on Aging, held in Washington, D.C., November 28 to December 2. It might be said, with some reservation, that the meeting gave evidence that the subject of aging was itself coming of age. This was made manifest by the statistics. Ten years ago, when the first conference on aging was held, the number of older people in organizations concerned with their destinies totaled about 250,000. Today, six million belong to organizations of senior citizens and retired people, and they are organized at national, state, and local levels.

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[7] Lidz, Theodore. *Person—His Development Throughout the Life Cycle.* New York, Basic Books, 1968, p. 490.

*Mrs. Callahan, who attended the conference and prepared this report, is assistant editor of Nursing Outlook.

One issue loomed as central to the conference, acknowledged by most of the 3,400 participants—namely, inadequate income—the most serious problem that older Americans face. The U.S. Senate Special Committee on Aging, which had helped sponsor legislation for the conference, reported in a preconference summary the critical nature of the problem. It cited the findings of its Task Force, which reported that "each passing year increases the economic problems of old age."

It named as complicating factors the increasing numbers of persons who have reached their 65th birthday, together with the larger proportions of the aged groups attaining the very oldest ages. It pointed to the fact that an aging population means a greater number of widows and other women living alone—a group that has always been low in the economic ladder. It also noted that any economic slowdown that means unemployment for the older person means longer years of life eked out on an inadequate retirement income. Inflation, too, eats up the resources of those living on a fixed income. Finally our growing urbanization, together with decay of metropolitan centers and widespread social strife, increase the economic insecurity of the elderly, many of whom are clustered in old neighborhoods of large cities. Members of the minority groups were acknowledged to be in double jeopardy.

The overwhelming truth is that, low as incomes of the older citizen have been in the past, the problem is becoming more dire. Today, more than 4.7 million older Americans (about one of every four) live in poverty.

It was within this critical framework that the White House Conference considered the various problems which are common to all people, but which gain special significance for older people who, either through discrimination, lack of resiliency, or enforced unemployment, cannot satisfy their basic needs.

The 1971 White House Conference was authorized in 1968, when President Johnson signed the joint resolution of Congress calling for what was then conceived of as a follow-up to the 1961 conference. President Nixon, in calling the 1971 conference, said, "I hope it will fully consider the many factors which have a special influence on the lives of the aging and that it will address precise recommendations not only to the Federal Government but also to government at other levels and to the private and voluntary sectors as well."

CONFERENCE PROLOGUE

A plan of massive dimension was then developed, consisting of three parts. The first involved older people where they lived, as some 6,000 forums across the country drew more than a million older Americans who spoke up loud and clear on what they saw as the needs of the elderly. According to John B. Martin, Special Assistant to the President for the Aging, the response was "overwhelming."

The second step involved those national voluntary organizations that work with and for aging. Meetings of task forces of these groups brought together nearly 500 representatives from 257 organizations.

And finally, regional hearings were conducted, and the policy decisions and recommendations by these community and state conferences provided the input for deliberations of this second national conference on aging.

The preconference structure was complex, but bit by bit it was prodded into place. As the planning developed, the dimension of the problem became clearer, and instead of merely following the developments since 1961, a more aggressive approach was taken.

Arthur S. Flemming, former Secretary of the Department of Health, Education and Welfare, was named conference chairman and the theme became "Action." The delegates to the conference—many of them older persons themselves—had been chosen by the governors of each state from among those persons who had demonstrated both concern and leadership in relation to the problems of the elderly. Many of them had been active in the preconference forums and task forces. Among them were representatives of various professional organizations in the health and welfare field, but these were limited to one out of four of every state's delegates.

Dr. Flemming was a reassuring agent to some, for his activist position seemed to calm the skepticism of those who considered the meeting a political forum that would result in much talk and little action. He was not sufficiently reassuring to the National Caucus on the Black Aged, however, which held its own con-

ference early in November. Acording to Caucus President Hobart Jackson, the White House Conference would "dilute the critical and special needs of the black and other minority aged thereby weakening the effects of the total attack on the problems of the nation's elderly."

ACTION NOW

As the conference convened, the delegates seemed to look to it with both hope and distrust. The first White House Conference on Aging, in 1961, had broken ground. Medicare and Medicaid had come from that conference, as had the Administration of Aging, which was established by the Older Americans Act of 1965, and was now functioning in all states and in touch with agencies that are concerned with the aging.

Perhaps at this second conference, it was thought, the curtain could be pushed back further, especially with a growing segment of older people organized to act in their own interest.

On the other hand, there was considerable doubt. How would the recommendations that had been worked out at the two years of preparatory meetings be implemented? There were misgivings, too, about the Administration's ability or willingness to provide necessary funds seen by many as indispensable in carrying through remedial action of such magnitude.

The original plans called for 14 sections on as many topics. In an attempt to overcome some criticism as the conference planning developed, sixteen "Special Concerns" sessions were added for simultaneous meetings on one morning. In addition, to offset suggestions that the delegations were politically "stacked," an evening was set aside for any delegate or observer to speak briefly at an open forum, which was chaired by former Chief Justice Earl Warren.

Although it is not possible to report on all of the meetings that were held, the ones that this reporter attended and the reports about others indicated a common consideraion—the need to sustain the aging individual as a self-respecting part of society. The older delegates were impressive themselves and showed no signs of giving up. Someone aptly described them as "swinging."

Discussion at the section meetings was for the most part constructive. The delegates, representing organizations of older people and organizations that work with them, were by and large middle-class people of all ages. Some very old. Most seemed knowledgeable and articulate; some eloquent. Inevitably, a few were garrulous. However, the section and subsection meetings—some 35 of them altogether—were orderly and constructively managed, and the chairmen, using tact and sometimes pressure, held the participants to the recommendations and policy proposals on which each section had to reach a consensus.

The section that dealt with physical and mental health of the elderly was of special interest to the nurse delegates, who numbered about 100. The final recommendations of this section—which had been broken down into nine subsections to take care of all the participants—were introduced by a preamble, asserting the rights of older people to have available to them a comprehensive system of health care. The system must provide assessment of health, education to preserve it, outreach service, supportive services—physical, mental, and social—rehabilitation, and maintenance and long-term care when disability occurs, the statement asserted.

HEALTH CARE POLICIES

There was general agreement that though health care for the aging must, in the long run, be provided as an integral part of a coordinated system of care for the total population, it was necessary in the meantime to give special attention to the elderly in the face of the urgent situation. Speakers emphasized the necessity for a continuum of care for these people.

The section recommended a national health plan that would provide a public-private partnership in delivery of services and federal financing and control. In the meantime, Medicare should be expanded, with greater use of general revenues, it was stated.

A minority report called for a continuing national program for education of all persons about the specific physical, mental, and social aspects of aging, to be addressed to persons of all ages.

Closely allied to the provision of health care as discussed in these health subsections was how to care for older citizens on a long-term basis. A Special Con-

cerns session one morning undertook to come up with some answers. Although there was passing acknowledgement that this care includes not only inpatients but patients in their own homes as well, most of the discussion centered on institutional care.

This subject was hotly debated. The schism lay between delegates representing proprietary nursing homes and homes for the aged, on the one hand, and delegates from nonprofit organizations providing such care, as well as delegates with other affiliations, on the other.

Twenty recommendations came from the 4-hour session. Almost each was challenged, though rarely did the opposition raise the 15 percent necessary for a minority report to be recorded in the proceedings.

The difference between the two schools of thought was made sharp when a delegate from the floor recommended that nursing homes be required to be certified by the proprietary American Nursing Homes Association. This brought a sharp retort from another delegate who declared that more was needed for this responsibility than an accountant, the implication being that the proprietary people are mostly concerned with the profits.

Two recommendations from this session deserve special note: the first called for preventive and restorative dental care to be made available for everyone over 65, funded by the government for those who cannot pay; the second called for more registered nurses to be placed in leadership positions in all programs involving health care for the elderly. Both resolutions passed unanimously.

The Special Concerns session on Homemarker-Home Health Aide Services stressed that old people are best served by keeping them in familiar surroundings—in their own homes whenever feasible—rather than in institutions.

Nutrition, too, was investigated, both as to what old people need in the way of nutrients and how to make meals pleasant social occasions for often lonely people.

Among the many other aspects of the aging in our society that were reviewed, a hard look was taken at the current policies on retirement. Not only were there recommendations for helping elderly people find meaningful activity after retirement, there was also emphasis on the contribution to society that older persons can make, given proper resources, opportunities, and motivation. It was noted, too, that these persons are capable of being effective advocates of their own cause and should be included in planning, decision making, and implementation of programs, despite any differences in language and ethnic background that may exist. "The lives of Americans of all ages will be enriched as the nation provides opportunities for developing and utilizing the untapped resources of the elderly," the statement asserted.

Numerous caucuses were held by special groups to try to unify the understanding of their special needs and bring them to the attention of the conference and in the postconference period. Among the caucusing delegates were those from the large urban areas. There aim was to coalesce the activities of those in large cities, who faced special and knotty problems, and to find common ground for further action. The Indians, the Asian, the Spanish-speaking delegates were other caucusing groups. Some 38 nurses met one morning for breakfast with a view to making themselves known to each other and keeping a special alertness to the nurse's part in developing the program for the elderly.

POLITICS, TOO

A goodly parcel of political figures were on hand during the 4-day conference. They were there to respond to the issues in their speeches to groups, at luncheon meetings, and the like, and they made clear the political import of the conference.

Four Cabinet members and four other top Administration officials explained some of President Nixon's programs for the elderly. Their remarks were not always warmly received, and some drew prompt and harsh criticism from the experts among the delegates. Some delegates, according to Dr. James G. Haughton, director of health and hospitals in Cook County, Chicago, considered an HEW report on maintaining federal standards for nursing homes to be a political ploy to divert attention from the real issues the conference faced. The real issue, he said, was the quality of care—not merely the physical plant.

Mr. Romney, of the Department of Housing and Urban Development, drew fire from Dr. Jean Mayer of Harvard, who was co-chairman of the committee on nutrition. He called unrealistic Romney's suggestion that "self-help is vital."

"What the hell does that mean," asked Dr. Mayer, "when you are talking about someone who is arthritic, who is deaf, who is partly blind, whose children have moved away and who is not properly covered by Social Security?"

President Nixon addressed the final session of the conference. Many of the elderly had made it clear that they wanted to hear a commitment for expanded federal funding for programs that benefited the aged. The President pointed to several existing programs and promised to consider the recommendations of the conference. He urged delegates to urge their Congressmen to support H.R. 1, the welfare reform bill that has President Nixon's support.

IN THE END

As the conference drew to a close, there seemed to be an increased feeling that if the projected programs were to be carried through, a concerted effort would be required from all those present at the conference. In the meantime, the conference recommendations were referred to the President's new Cabinet-level Committee on Aging to be considered for action. The commitee met on December 22 and reported that it had taken note "of the President's directive that the recommendations . . . be put at the top of the committee's agenda."

Dr. Flemming concluded, "The 1971 White House Conference on Aging is not an end in itself. It is part of a continuous process—one, I believe, that is going to result in moving the elderly from an inferior place to a position where they will be given a higher priority than they have ever had in the history of our country."

[From the American Journal of Nursing, vol. 73, No. 3, March 1973]

TERMINAL CARE AT HOME IN TWO CULTURES

Cultural mysteries that nurses could never penetrate did not interfere with effective care of a Navajo Indian woman in Arizona and an Italian man in Harlem

(By Jean French[1] and Doris R. Schwartz[2])

Nurses, physicians, and other health workers often fail to recognize how much culture affects the way a patient and his family seek treatment and respond to medical personnel.

It is easy to recognize the barriers to accepting medical care when one is working with a relatively isolated culture. On the cosmopolitan urban American scene, it is often harder to recognize the influence of culture on a patient's behavior.

Two examples from widely separated home care programs of New York Hospital (Cornell University) bear out this observation.

IN A NAVAJO HOGAN

Mary T. was a 50-year-old Navajo woman who was diagnosed as having an epidermoid carcinoma of the cervix. She was admitted to a private hospital for radiation therapy. From there she was transferred to a government (Indian) hospital and was discharged a month later with a poor prognosis. After discharge, she was followed in her home community by the Cornell-Navajo clinic. Here an additional diagnosis of osteoblastic carcinoma was made. She was rehospitalized for 10 days at a mission hospital, but her family wished to give her terminal care at home.

Family members came to the Cornell-Navajo clinic to ask if the staff would help care for Mary after her discharge from the hospital. The clinic physician re-explained the nature of her illness to the family and told them there was no known cure for her condition at this time. The family replied that a Navajo medicine man had given them hope that Mary might be cured and they wanted to seize every opportunity.

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[1] Dr. French (B.S., Cornell University-New York Hospital School of Nursing, New York, N.Y.; M.A., Columbia University; M.P.H., Johns Hopkins University; Dr. P.H., University of Michigan) is head of the Family Nurse Practitioner Program and is associate professor in the School of Medicine, University of California, Davis.

[2] Ms. Schwartz (Methodist Hospital School of Nursing, Brooklyn, N.Y.; B.S., M.S., New York University) is associate professor of public health nursing, Cornell University-New York Hospital School of Nursing.

The clinic physician agreed with the family about using the "sings" of the medicine man, but asked that simultaneously, with the medicine man's approval, the Cornell clinic staff be permitted to extend whatever help the patient required and could accept.

Mary T. returned to her camp by horse and wagon. The camp consisted of two hogans, the earthcovered lodges of the Navajo, and a sheep corral. One hogan was occupied by the patient and John T., her husband, the other by Mary's niece and the niece's husband. Several nephews, whom the patient had raised, lived in the camp from time to time.

The public health nurse from the clinic and her Navajo aide (the health visitor) made biweekly visits to show the family how to nurse the patient and make her comfortable. When it seemed indicated they gave Mary direct nursing care.

The clinic provided medications, dressings, and necessary equipment. The patient's husband improvised a trapeze, at the nurse's suggestion, so that his wife could alter her position with less pain. Her back had become excoriated while she was hospitalized, and the nurse taught the husband to give back care. He did this so effectively that he was able to halt the development of a decubitus ulcer.

When the nurse checked the supply of medicines on successive visits, however, it became plain that the family was not giving medicine as directed. The Navajo aide believed that the family withheld the pills because they associated the patient's physical decline with the medicines which she had begun to take in the hospital and feared that more would make her worse.

The Navajo people do not distinguish, as most of us do, between health and religious practices. They see health as a perfect balance between man and his environment, an environment that includes people, nature, and the supernatural. We would call this the natural, religious, and social surroundings of a patient. The Navajo believes that illness means that a person has fallen out of his delicate environmental balance and that health can be restored by the acts of a fellowman who has proper and exact knowledge of myth and ritual. That fellowman is the Navajo medicine man and the ceremonies which he performs are known as "sings."

The public health nurse made several visits while the patient was having a sing. On occasions when a sing was interrupted by her visit, the nurse was permitted to give care in the presence of the medicine man.

During the patient's downhill course, the family kept her as comfortable as possible and followed the nurse's suggestion to maintain adequate fluid intake. Shortly before the patient's death, the family called in a native diagnostician, the *ni delnuhi*, who said that the patient would die at noon that day.

The Navajo must burn the hogan in which someone dies, so the patient was moved to an expendable, temporary hogan made of logs and bushes, about 500 yards from the hogan in which she had lived.

The nurse noticed that Mary seemed very cold, although she still responded to sound and movement. John T. had purchased two new woolen blankets and a satin comforter for Mary, and as she became progressively colder, the nurse thought their use seemed indicated. However, the family explained that these new blankets could be used only after death. For the first time, the public health nurse found it difficult to accept the family's ways. By now, Mary was aphasic, her respirations shallow and rapid, but her pulse was still strong.

On the following morning, family members came to the clinic to report that the patient was dying. The physician, public health nurse, and a Navajo aide went out to the Hogan and found Mary T.'s condition as it had been on the previous day. The family were taught how to check the patient's pulse and a small mirror was left with them to check her breathing. Later that day the family sent word that Mary had no pulse and that her breath no longer coated the mirror.

NAVAJO DEATH RITUALS

A hogan visit was made to confirm the fact of death. The immediate family and other relatives were gathered outside the temporary hogan. They asked the nurse if she would prepare the patient for burial. The Navajo are afraid to touch a body after death, because they believe that the spirit or ghost of the departed person is contaminating. Yet the family said that the two nephews could help the nurse and the patient's husband, John, went into the shelter to supervise the activities. It was unusual for a Navajo family to permit Navajos to touch a body,

and they later arranged for a cleansing sing to counteract any contamination of the nephews.

When the nurse had completed postmortem care, the husband asked her to dress his wife's body in her best squaw dress, with a long, satin, pleated skirt and a long-sleeved, velvet blouse trimmed with silver coins. A kerchief was put around her neck and her turquoise jewelry—ring, bracelet, and necklace, were put on her body. A clay resembling red ochre was given the nurse to rub on Mary's face to give it a more natural appearance. Her hair was brushed, rolled, and put into a net.

Then John T. took all his money out of his wallet, put it into a little red purse, and had the nurse put this on Mary's body. The squaw blanket was put on her, then the two new woolen blankets, and finally the new satin comforter.

The Navajo aide had been in the temporary shelter during all this time, but the nurse was aware of her reluctance to touch the body and did not ask her to help with the procedure. The husband thanked the nurse for her help and wept when he spoke of what a fine woman Mary T. had been. The family waited outside the hogan for a Christian missionary who was to bring a wooden coffin and officiate at the burial service.

Later that evening, the temporary hogan in which Mary had died was burned, in accordance with Navajo tradition.

IN AN URBAN TENEMENT

Anthony F., a 73-year-old, partly retired junk dealer, who was born in Italy but had lived most of his life in New York City, was discharged from the New York Hospital after a course of radiation therapy following a diagnosis of cancer of the bladder. He had refused consent for an operation, which the doctors thought essential. His several adult children were told of his poor prognosis. Mr. F's. wife had recently been hospitalized with a myocardial infarction, and was being cared for at home by the youngest, unmarried daughter, Catherine, aged 24.

Since the nursing care of two seriously ill parents seemed more than this daughter could cope with, the hospital staff recommended a nursing home in the vicinity for Mr. F. Both he and his family vigorously resisted this idea.

Six married sons and daughters and Mr. F.'s widowed sister lived in the neighborhood. They were willing to contribute to the financial support of the F. household and they declared that both parents could be adequately cared for by Catherine.

The home care nurse-coordinator and the social worker both tried to explain how heavy the burden of round-the-clock care would be, but the patients' sons were adamant. Catherine seemed fearful of the responsibility of caring for her father but willing to try. She was able to think about care at home on a tentative and possibly temporary basis. Her brothers were not. So Mr. F. was taken home by ambulance, and the visiting nurse was asked to assist the family's need for assistance and to give what help was acceptable to them. Especially, she would teach Catherine such essential technical procedures as irrigation of her father's indwelling catheter and would help Catherine talk about her own problems.

When the visiting nurse first entered the home, she found Mr. F. sitting in a chair. His catheter had not been irrigated since he left the hospital, although two married sons had been taught to do this before his discharge. Neither the sons nor Catherine were willing to do it now, ostensibly because they were "afraid of contagion." In spite of explanation and reassurance by the nurse and later by the physician, this fear persisted or was used to cover another unexplained reluctance.

This was something the family never really appeared to grasp. They continued to keep the patient's linen and household equipment entirely separate, and his laundry was done at a different time from that of the rest of the family. The only explanation that Catherine could give was that her brothers and her aunt and father wanted it so. Cancer, in this family, was apparently seen as "a plague."

The patient was taught to irrigate the catheter himself, with Catherine willingly bringing and removing the supplies. He learned this procedure quickly. Mr. F. always appeared to be the dominating figure in the home. His orders were quickly carried out by Catherine, who never seemed resentful but, rather, as eager to please as a preschool child.

At first, Mr. F. did very well at home, though his demands were often difficult for Catherine to meet. She had always conformed to the authority of her parents.

Throughout the next 11 weeks. Catherine with the support of the visiting nurse gave skilled nursing care to both of her parents and tried to remain undisturbed by their increasingly competitive demands for her attention.

Then, as her father's physical condition worsened and his appetite, weight, and strength decreased, he became severely depressed and insisted on almost constant attention from his daughter. The visiting nurse took over more of Mr. F.'s care, but her help was never acceptable to the father, who became dependent on Catherine for his entire physical care and wanted her close by him night and day.

At this point, the patient's wife required rehospitalization as her cardiac condition was increasingly hard to manage. Catherine noticed that although her father was able to retain both food and fluids, when she was at his side, he became excessively upset and vomited whenever she left him briefly to visit her mother. He was no longer able to irrigate his own catheter, and since neither Catherine nor her brothers could accept this task, external drainage was substituted for the indwelling catheter, with the nurse asking herself why an indwelling tube had been considered essential all this time. The sons and daughter still spoke of "contagion" in begging to be relieved of this one responsibility.

PSYCHIATRIC CONSULTATION

Mr. F. now complained constantly of Catherine's inattentiveness, although she was seldom away from his side. She waited on him continually as his condition deteriorated. The conflict between her father's inappropriate demands and her own inability to appease him was so upsetting to Catherine that the nurse requested a psychiatric consultation through the home care program. It is not easy to say whether Catherine or the professional staff found the greatest need for this consultation.

The psychiatrist considered that organic brain disease was responsible for much of Mr. F.'s personality change. As he talked with the family, it became clear that Catherine was the member long since chosen to remain with and care for her parents in their old age and that this decision, made by the family years ago, was looked upon as natural. They saw no reason to question it. Catherine herself had a good deal of hostility toward her parents and siblings and especially toward her father's sister, because of this. Yet she was bound by her training and conscience to fulfill a responsibility, which she could not question.

Unable to take a stand against her own family, Catherine insisted that her father remain at home to die, although alternative plans were again made available. Yet while insisting on caring for him at home, she stated at the same time that she was unable to bear the burden of doing this.

Once the staff fully recognized the neurotic nature of this seemingly simple statement, some of their frustration ended. They began to regard Catherine as a patient who needed their help. During the final weeks of her father's illness, only she could give the physical care that was acceptable to him, but the home care staff, regarding Catherine as their patient, gave her greater medical and nursing support.

During the final week of illness, when Mr. F. became unconscious, the visiting nurse took over more and more of his care with Catherine assisting her. Catherine held up well throughout this terminal phase, and her father died quietly at home.

Following his death, Catherine expressed great pride in having been able "to stand it," and gradually settled into an easy and more casual relationship with her sick mother, who was now again in the home. Her mother's needs were complex, but she was far less demanding of Catherine, and both were always able to accept a full measure of the visiting nurse's help.

After her mother's death six months later, Catherine—for the first time in her life—worked outside the home, accepting gainful employment at an unskilled job with enthusiasm. She adjusted well to it and began to make friends among her co-workers.

ACROSS THE BARRIERS

Culture played a part, although only a part, in the behavior of both of these families in a time of terminal illness. One common factor was the extent to which these two families—low on the economic scale by any standards—strapped themselves financially to provide handsomely for the deceased.

Mr. F.'s family went heavily into debt to provide a most elaborate funeral for their father: two carloads of floral wreaths led the procession to the cemetery and this, plus elaborate expense for a handsomely finished coffin, gave great

solace to Catherine and her mother, although their own living expenses were sharply curtailed by it during the final months of the mother's life.

John T., providing new woolen blankets, and a satin comforter for Mary to be buried in, proscribed their use to warm and comfort her as life ebbed in the expendable brush hogan where she died. After her death, he asked the nurse to place the red purse with all of his money on Mary's body for burial. The turquoise and silver which represented their family's wealth, was buried with her.

Charon, the boatman, was a familiar figure in ancient Greek mythology, one who ferried souls across the river Styx to the underworld of Hades. The common custom was to place coins in the month of the deceased, so that he would be able to pay his fare across. Neither John T. nor the F. family had ever heard of this myth. Yet both, in the way of their cultures, followed a similar custom at the cost of providing for the living.

Each family labored earnestly—or at least one member of each family did, with strong approval from the others to provide care and comfort at home before the death. Each family refused an easier out, institutional care, although this was readily available. Each family accepted medical guidance and welcomed public health nursing care of the sick at home throughout the whole of the terminal experience. Care by the significant helping family member was given tenderly, and professional direction was sought and generally used well.

Yet in each situation, when culture directed otherwise, advice was not accepted. This discontinuation of Mary T.'s medication and Mr. F.'s catheter irrigations represented sharp breaks in care. No amount of teaching, explaining, or requesting could scale the barrier of resistance to these unacceptable procedures and no real understanding of the underlying reasons for the resistance was ever gained.

These two effective interactions show that, even in the absence of full understanding; respect for the family's rights to their own beliefs can enable a nurse to work comfortably and helpfully despite cultural differences.

In most long-term illnesses which are coped with at home, critical incidents will arise which have their roots in the culture of the people. Adair and Deuschle[1] comment:

"One of the greatest problems (in bringing health services) to such people is the refusal—conscious or unconscious—to recognize the peculiar conditions under which (care) must operate. Persons from one culture tend to view another culture in terms of their own. Variations are seen as oddities, to be ignored or reserved for conversational anecdotes and the whole complex of customs and behavior systems peculiar to the other culture is put out of consciousness. . . . In the end, ignorance of these customs and behavior systems result in confusion, inactivity or frustration and the program breaks down because of blocked communication, lack of response or antagonism."

When a public health nurse is giving care to a family who's lifestyle is molded by a different culture, the underlying beliefs which influence behavior can often be identified, either by the giver or the receiver of care. Sometimes they cannot, or at least cannot at the time that nursing is required.

We believe that even when the precise explanation cannot be surfaced and validated, respect for the personhood of patient and family makes it possible to continue a relationship that permits the nurse to give care effectively while continuing the search for the cause of the behavior. That respect for personhood we believe to be among the patient's and the family's rights.

[From the American Journal of Nursing, December 1972]

AFFECTION: KEY TO CARE FOR THE ELDERLY

(By Diana S. Wilkiemeyer*)

Ever since I began working as a visiting nurse, my district has always included a generous number of elderly people—rich, poor, all races, all religions, all different. But among all of them there was always a common need—to have someone care and to be important to someone.

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[1] Adair, John, and Deuschle, Kurt. *Personal Communication*. 1970.

*Ms. Wilkiemeyer works part time with the Visiting Nurse Service of New York City and part time at Alderton House, a supplementary educational center for girls. She is the author of "Unbinding the Homebound" in the August 1966 *AJN*. She graduated from St. Mary's College of Nursing, San Francisco, Calif., received her B.S. degree from St Louis University, Mo., and her M.S. degree from Loyola University, Chicago, Ill.

I have read the experts and I am grateful for all that they have taught me about the geriatric patient. But, when the moment comes to knock at the door of another new client, my biggest help is the advice of a little old lady with burns she had received from a hotplate fire.

Ms. A. lived in a tiny room. The walls were covered with pictures of her affluent friends who had scrawled loving words across them. With a gesture, she remarked, "They send me a check now and then. But what I really could use is some affection."

Affection. It's not a very scientific term, but it is the human ingredient that makes the science of nursing an art. And this art is necessary in the care of the elderly. As Alvin Goldfarb has pointed out, elderly people ". . . often come to value being well regarded as more important than being well cared for." [1] Each geriatric patient has had many years to become unique. The key that will encourage such patients to accept care, to overcome the fears that grow as time passes is, I believe, a demonstration of true concern on the part of the nurse.

I vividly remember visiting an elderly lady with congestive heart failure. Between her many hospital admissions, I had given her injections of a diuretic and had evaluated her cardiac state. She was chronically dyspneic, with respirations so noisy they could be heard from the front door of the building. Ms. T. clung to her 20-year old daughter. The girl had lived with her mother since she arrived from Poland many years before, but was now eager for a life of her own. Consequently, Ms. T. was often alone in the dingy apartment, and usually she was so ill, I was often afraid to leave. When I called the doctor in alarm, he always told me, "There's nothing more that can be done—just leave her telephone close to her bed."

All the nurses who cared for Ms. T. felt the need to spend some extra time with her. Only when a nurse sat down beside her and chatted a few minutes would she remember that she hadn't taken her digoxin or her potassium that morning. The nurses tried to find many ways to make her more comfortable. She refused a hospital bed, so they put blankets under the head of her bed to raise it and convinced her to keep a bedpan on a chair by her bed to conserve her energy.

Just before Christmas, one of the nurses, on impulse, sent her a tiny Christmas tree. It wasn't until she was two blocks away from the lot that the nurse realized that she hadn't indicated on the card who had sent the tree. The next morning, however, she was to visit the woman. When she entered the dark apartment, the nurse could not believe her eyes. The tree was next to the bed, laden with old-fashioned ornaments and even a small string of lights.

"How you like it?" the old woman asked.

"It is beautiful," the nurse answered honestly.

"My daughter send to me. She no come home yesterday. I worry. I cry. But she send this. She love me."

The nurse didn't say anything.

When she returned the following day, the very stillness of the hall filled the nurse with apprehension. She opened the door. The tree was still lit. The patient was lying on the bed, quiet. She had died.

This could have been just another patient with chronic congestive heart failure. But because the nurses cared, because they knew this patient and all her circumstances, because there was a real affection for her, the assignment became a challenge, success a heartwarming experience, and death a kind of peace for all concerned.

Sometimes, nurses feel depressed or discouraged when they realize that many of the physical problems of the elderly cannot be cured. And because the nurses feel that way, they suspect that the patients will sense this, too, and that nothing positive will come out of these visits. But prevention and palliation, coupled with affection, can make these visits the most meaningful of all.

Another afternoon, when one of the nurses in the agency called in late in the day, her apologetic supervisor asked if she could possibly make one more visit. A patient with a daily dressing was supposed to have gone to the hospital, but was still at home and very upset about the condition of his leg.

When the nurse arrived, he exclaimed, "Am I glad to see you!" Then sighing, he heaved a bandaged foot onto a stool.

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[1] Goldfarb, A. I. Responsibilities to our aged. *Am. J. Nurs.* 64:80, November 1964.

"Skip the soaks. It's late. God, I don't know what I would have done if you couldn't have come. It hurts and it stinks."

"Don't worry about it. There is time for the work." But she felt a twinge of guilt. It *was* late.

The soaks took 20 minutes, and during this time they talked mostly about his day. The old widower was very upset.

"The doctor told me I would have to go back to the hospital for skin grafts. I gave my word. Even set the date for today. And now there isn't any room for me!"

She looked at him with real sympathy, inwardly annoyed at all the red tape involved in getting a little old man into the hospital. But she just listened. During the moments that the wound lay open, he evaluated it with a practiced eye. "It's green. That's bad. You don't think they will amputate, do you? If they ever tell me that. . . ."

She was careful not to hurt him as she applied the medication to the wound.

He went on. "Don't be upset if I tell you something. I have over 100 phenobarbitals in my cupboard. They're old, probably dead by now. But I always keep them, just in case."

"In case?" Now she was becoming concerned and even a little afraid.

"You know, in case I should ever want to end my life. Not that I am thinking of any such thing now, mind you, but you know some day I may want to and it's the easier way."

Suddenly, he asked, "Do you believe in God, nurse?"

"Yes, I do."

"Does God care?" he asked, almost as if he were thinking out loud.

"I know He does." Her voice told him she meant it.

He relaxed a little and began talking about lighter matters.

The nurse finished his dressing with a fluorish that made him laugh. And, for once, the stockinette ended exactly at the spot he liked. She washed her hands and reached for her coat. It was almost five o'clock.

"Do you have time for one more little thing?"

"Sure."

"Throw those damn phenobarbitals down the toilet for me."

"Sure!" She felt weak with joy.

This patient had had leg ulcers for four years. He had arthritis, was old, and to the nurses who had been making daily visits, there had been little progress. But they kept him comfortable, prevented his condition from worsening, kept his physician informed, and cared for him. and that combination finally made all the difference in his life.

One patient I'll never forget because we had neglected to add affection to our nursing plan for him. He was recovering from a CVA, and we made several rehabilitation visits to him weekly. No one was very eager to go, and it was hard to pinpoint why.

"He won't look you in the eye," one nurse said. "When you talk to him, he looks right past you." "It's the way he looks," said another. "His shirt is half on and his pants are unbuttoned, as if he didn't care about anything." Everyone was annoyed because he did not use the pulley the physical therapist had set up or do the daily exercises.

One day, while doing routine finger exercises with him, I noticed a package from the library, a record stamped "For the Blind." "Who are these for?" I asked. "Me." "You?" "Yes, I'm legally blind. I can see images, but not much more."

All of us saw a different man when we looked at him from then on. We saw a man who cocked his head when we talked so he could hear us better, a man who did not know his shirt was inside out, a man who could not find the button holes and who, because he was in a new apartment, could not even walk down the hall alone. He was a man who had two handicaps, and we had not known about the most important one. We had been too impatient. We did not study the nursing history when he was transferred to our office. We did not make enough effort to really get to know him. We had not cared enough, and he knew it.

I have learned that for most old people a human relationship, in which there is affection is a vital part of their association with a nurse. Somehow, she has to convey to them: "You're not just one of my duties—you're someone I really care for." And when that is felt, it is the beginning of a satisfying and fruitful relationship for everybody. Affection is a real part of the prescription for care.

[From the American Journal of Nursing, vol. 72, No. 9, September 1972]

PRESERVING HOME LIFE FOR THE DISABLED

(People across the country are asking welfare officials and nurses in Oklahoma about this novel project that enables about 3,200 disabled men and women to stay out of nursing homes and other long-term care institutions.)

(By Dora J. Stohl*)

We are being confronted more and more in our rapidly changing society with the problems of the aging or handicapped who have reached the point where they can no longer care for their own daily needs. Many would not require institutionalization if someone in the home could look after them.

Many times, if there are other adult members in the household, they are out of the home working or traveling or are caring for dependent children. Or relatives may be living at some distance, so the person is alone most of the time. A spouse, if there is one, may be physically or mentally unable to cope with the situation. For the person himself, there may be real problems in preparing a meal or remembering to take medicine or a treatment, or forgetting that medicine was taken and repeating it.

Eventually the plight of such a person will come to the attention of a neighbor, a friend, or a caseworker in the welfare department. Neighbors, for a time, may help with hot meals or weekly shopping, or give other assistance, all with the intent of helping the patient stay in his own home as long as possible.

The patient, in turn, becomes more fearful of what his future holds. He is comfortable in his familiar surroundings, humble though they may be. They belong to him; his memories are there; he is in the center of all activities he has become accustomed to over the years. He is thinking of what his alternative will be: being sent to a nursing home! This means going to a strange environment where he will be among strangers, and, even with the best of facilities, his activities will be regimented.

In his mind, he will lose his sense of independence and, above all, his dignity and, perhaps even his identity. Furthermore, his friends and relatives may forget him—out of sight, out of mind! This is where Non-Technical Medical Care fulfills a real need.

It began in Oklahoma with a man who "had a dream." He saw approximately 3,200 public assistance recipients in danger of being placed in institutions and he was well aware that they neither wanted nor needed this. This man was Lloyd E. Rader, director of Oklahoma Institutions, Social and Rehabilitative Services, and he had a plan that would enable these people to remain in their own homes if interested persons could be trained to give care and be supervised by licensed nurses.

To be eligible for in-own-home care, the patient (termed recipient) must be bedfast, chairfast, or able to ambulate only with assistance and be so certified by a physician. Also, they must meet economic eligibility criteria determined by social workers.

The individual (termed provider) giving the care to in-own-home care recipients would be selected by the family or recipient and then certified by the physician as competent to give the care as ordered by him. When all eligibility requirements had been confirmed, the "case" then would be given to a nurse working in the area for her evaluation of needs of the recipient and the provider.

The plan he developed for home care was presented to the Oklahoma State Nurses Association (OSNA) and received their enthusiastic support. The OSNA and the nurses of the Oklahoma Department of Public Health believed such a service was needed, that it would supplement or continue care when health department services (skilled nursing of a technical nature) were terminated.

The OSNA took the plan, after the welfare department secured project funding from the United States Department of Health, Education, and Welfare, and wrote the scope of function, objectives, and job specifications for the staff of licensed nurses in the program. The OSNA has remained with the program; an advisory council of OSNA members gives needed support to the nursing staff.

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*Ms. Stohl is the state supervisor of the 39-nurse staff in the Non-Technical Medical Care Program, a program of the Oklahoma Department of Institutions, Social and Rehabilitative Services. She retired from the Army Nurse Corps in 1970. A lieutenant colonel, her last military assignment was chief of nursing services at Reynolds Army Hospital, Fort Sill, Okla. She has B.S. and M.Ed degrees from the University of Minnesota. Her home and office are in Oklahoma City.

FIRST NURSE—FIRST STEPS

The first nurse to supervise providers began her work in March 1970 in Oklahoma City. There was no precedent to guide her because such a program had not been tried before. She began by going to the county welfare staff in Oklahoma County to determine where the home-care recipients were located. The first two weeks she went on home visits with caseworkers to determine what kinds of medical problems existed, who the persons were who were giving services to the receipients, and what was needed in the way of training and supervision.

Each visit was an education in itself. The problems of the providers and recipients were so different. The quality of care was variable, the experience of the providers running the gamut from none up to retired registered nurses. Two findings were consistent: first, there definitely was a need for the program of training and supervision, and second, recipients left no doubt in anyone's mind that they wanted no part of a hospital or nursing home, but wanted to stay at home and, when the time came, to die there.

The providers, however, reacted to the nurse's visit with anxiety. They were fearful of being replaced on their jobs by nurses. They needed much reassurance that the nurse was there to help them. The nurse went on to say that the plans were to have classes so they could learn certain patient care and other procedures.

Suggesting they needed classes was a mistake. Initially, the provider "wouldn't be interested in any of that kind of schooling. I have been taking care of sick folks for years and don't need anyone telling me what to do." The very thought of classrooms, books, and maybe tests was a threat to many of these persons, who, we discovered had limited formal education. Their feeling, naturally, was that if they did not pass, they would lose their jobs.

A new approach was needed. The nurse suggested a group meeting concerned with the providers' working conditions and an exchange of ideas on how the providers were caring for *their* patients' problems. Such meetings, said the nurse, would make their work easier and the care better for their patients. The meetings would also help the providers become better acquainted with the welfare nurse in their area, who would be available to help them with any problems. The nurse indicated she expected to be making visits to the home every two or three months, and more often if needed. Also, she told providers she would be available by telephone for any assistance they needed. The providers liked this solution.

This, then, was the first hurdle and appeared to have been successfully cleared. The nurse had met the recipients and the providers, explained the program, and made plans for the first meeting, which would be September 1970 in Oklahoma City for whatever numbers of the 200 plus providers in the county would attend. There was no way we could make attendance mandatory.

While the program was starting in Oklahoma County, the state was divided into six districts, each to have a supervisor and one to eight registered nurses or licensed practical nurses, depending on case loads. The nurses work out of county welfare offices and work closely with the county administrators and caseworkers.

Each month, nurses were added to the staff. They came with variable backgrounds but most were institutionally oriented. Of the 39 nurses now on the staff, only 5 have any formal teaching experience, 8 have degrees, 13 have public health nursing experience, 1 was an operating room supervisor, 1 has retired three different times and has worked in almost every subfield in nursing, and 10 are licensed practical nurses. What they all have in common is dedication, a pioneer spirit, and enthusiasm. This is an enviable spot for most nurses, for here they can assert independence and use their creativity.

Determining what the training program would encompass resulted from many brain-storming sessions of the staff from all areas of the state. Different geographic locations presented different problems because of ethnic, economic, and occupational differences of the providers and recipients.

AFTER THREE MONTHS

In three months, the staff had pretty much decided that the American Red Cross Home Nursing course should be the basic program.[1] Added to it would be instruction in rehabilitation, nutrition, home management skills, use of surplus

[1] American Red Cross. *Home Nursing Textbook.* 7th ed. New York, Doubleday & Co., 1963.

commodity foods, and diversional activities. This would total 20 hours of instruction, climaxed with a graduation ceremony and presentation to each of a "Certificate of Completion," a pin indicating NTMCA (Non-Technical Medical Care Aide), and a Red Cross Home Nursing card and pin.

The first class was graduated in November 1970 with pomp and ceremony, including pictures and publicity in the newspaper. Relatives and friends, county welfare staff, and supervisors attended. Their pride in this accomplishment cannot be described. For many, this was the first time they had completed any program. It was an emotional evening and gratifying to the staff as well as to the providers. Such ceremonies continue and staff consider them to be important.

The grapevine proved more effective than any other method to publicize the program statewide. Immediately people started asking when the next class would be held because they had heard "you learn so much." We believe the little incentives such as graduation and pins might have been a motivating factor. Visiting in the homes after graduation, nurses found some providers who had previously worn slightly soiled dresses were wearing clean uniforms. All were proudly wearing their pins.

PATIENT BENEFITS

More important, we have seen patients who had been completely bedfast now sitting up most of the time, taking meals at a table or, in some situations, walking with the aid of a crutch, walker, or another person. This activity of course, reassures them that the trip to an institution is put off, if not forgotten, because of the independence—limited though it may be—they have attained with the help of the provider.

Mr. A. was a 68-year-old bachelor, an accountant, who had been extremely self-sufficient. He had a history of fractured femur and almost a year in the hospital with numerous operations. Finally, all his resources were depleted. He was forced to apply for public assistance and for a time was forced to go to a nursing home, because he could not care for himself at home. He had lost his independence and was certain it meant vegetating for the rest of his life.

A caseworker, his doctor, and a niece helped him find a suitable living arrangement, including a provider who could live in with the patient. Physical therapy services were provided, too. Gradually, over six months, Mr. A.'s outlook changed. He began to socialize with old friends. He did more and more for himself because of conscientiously exercising.

His provider no longer needs to stay 24 hours, but she comes in a few hours a day to help prepare meals and care for the house. Now, Mr. A. can drive his own car. This all happened in a six-month period. He now wants to do a little accounting work in his own home and, in a few months, will go back to his former place of employment.

The next incident reflects advantages to both recipient and provider. Mr. B. had been in a nursing home for several years and was completely bedfast. During this time, he tried through his caseworker to return home, but his doctor would not approve the transfer because there was no one to give him the care he needed. When the NTMC program started, a live-in provider was found and trained.

The recipient can walk short distances and has become an interested member in a community again. He believes this has happened because his doctor's orders were carried out so much better on a one-to-one basis in his home. In the nursing home, they did not always have time to help him walk four times a day or give sitz baths three times a day as the physician ordered.

Also, the provider was able to regain custody of her two sons (ages four and five) from the county, because she could not provide a home and support for them. The entire relationship is healthy—the boys have a grandfather figure who is loving and supplies the discipline. Mr. B. knows he is needed and loved. The provider has someone to help her plan for the future. So in this instance, four persons were helped by the NTMC program.

Not all providers are desirable. Irate neighbors were calling the welfare office about one irresponsible provider supposedly caring for an 89-year-old, confused, and bedfast recipient. The house was a shambles—old, rundown, unsafe. The provider was dismissed but no amount of persuasion was going to get Ms. C., the recipient, out of that situation and into a nursing home.

She would point to her two dogs and a young man who frequently stopped to visit her and say those were her friends and she needed no one else. The case-

worker offered this young man, aged 19, a provider's job. He was known to be mentally retarded, but assured the case worker he had cared for his own grandmother during a long period of illness.

Charles was a gem. He immediately went to work on improving the house and yard—put up flower boxes and put artificial flowers in them. He kept the recipient clean and daily there were sheets and gowns drying on the clothesline. Ms. C. is no longer belligerent or embarrassed and Charles has a purpose and love in his life.

Ms. D. is an 83-year-old recipient, who fell and fractured her hip two years ago. She had returned home after several operations and had the help of a live-in provider, who was 73. She required a great deal of care, but now she can walk with a cane and even help with the dishes and is pleased that she is able to do a few things for herself. One day, however, her provider fell and fractured her wrist. During the time the provider's arm was in a cast, the recipient helped her dress and get meals and so forth. All in all, two persons are happy and independent—the recipient progressing from a complete invalid state to one of being a helper herself in less than two years.

PROVIDERS' REACTIONS

A provider is to a recipient as a seeing-eye dog is to the blind, a life-line. Ms. E. lived alone with 12 cats in a remote area. She had been hospitalized for malnutrition and circulatory disorders and was mentally confused. She vehemently refused to go to a nursing home.

On a trial basis, a provider agreed to go into this remote area and work under substandard living conditions. A month later, with good nutrition and medication, Ms. E. had gained 10 pounds and was again in contact mentally. The provider has stayed on. Ms. E. is happy that someone is interested in her and her welfare and also likes her cats. Some of the cats, however, were removed to other homes. A little understanding, love, and tolerance has sustained her and she probably will remain in her little, but now comfortable, home for the rest of her life.

A recipient who had suffered a cerebrovascular accident was cared for in the home of a provider. This provider was an untrained but concerned person, who thought that keeping the patient in bed was beneficial. After the nurse's first visit to this home, she visited the doctor and learned he was unaware that his patient was not getting up. The nurse then began return visits and gave individual instruction to the provider. The provider began getting the recipient out of bed and dressed and in a chair every day. She began helping with ambulation. A dramatic change came in the next month. After six months and frequent nursing visits, the recipient walks with the aid of only a cane.

Another provider said she saw no reason for taking classes because she had cared for her recipient for many years. But, she would "go along" with policy of the department and take the classes she said. After she completed the course of instruction and was graduated, it happened that her patient's condition deteriorated rapidly, ending in death. Ms. F., the provider, commented that she would never have been able to cope with the many problems such as incontinence, disorientation, and, finally, coma of her patient if she had not had the instruction.

Ms. G. was in the initial provider's class in Oklahoma City. She came from a deprived situation, was shy initially, but faithfully took part in class. Several months after graduation, her patient's condition became so poor that it was necessary to place him in a nursing home. Ms. G. went to the nursing home and worked with him without reimbursement. The nursing home staff was so impressed with her ability that when her patient died, the administrator hired her as an aide.

A young provider who had not completed the fifth grade was understandably reluctant to attend the course of instruction. With encouragement from the nurse, she finally consented to attend. The satisfaction of learning simple tasks so stimulated her that she decided to do something about her education. Arrangements have been now made for her to complete high school.

OBSTACLES FOR TEACHERS

After all the counties were opened, that is, home visits had been made, on-the-spot evaluations completed, a file opened, a class organized and taught, and a

group graduated, it became apparent that we could not find a useful workbook or textbook. Staff members out of necessity wrote their own training manual and illustrated it generously with caricature-type pictures suitable for persons with a limited educational background. The manual has room for notes to be pencilled in, if desired. This manual is given to each provider as classes are conducted.

Many providers cannot attend group classes for a variety of reasons: They cannot leave their patients alone; they have no transportation; other employment fills their time; or, their age prevents them from getting out alone.

In such instances, a nurse plans and gives instruction on an individual basis in the home. Individual instruction is, of course, more time consuming, but more personal attention can be given, especially to that patient's particular problems. The greatest deficiency in this method is that the provider has no opportunity to exchange ideas and realize from the group contact that she is not alone in doing this kind of work.

Most of the groups, on graduation, have asked to continue to study and meet perhaps monthly to discuss specific subjects. They have suggested having a heart month, a stroke month, and a diabetes month. The problem is finding a time to squeeze more classes into an already tight program.

We still have obstacles. One is finding suitable facilities for group meetings, especially in some rural communities. The aid of other community agencies is enlisted and somehow a class gets going—in a community-action center, a conference room over a bank, a recipient's home, an abandoned school house, and so forth.

We try to get some experts from other fields to aid with instruction—home economists, rehabilitation specialists, and directors of diversional activities. When available, they can make a class much more interesting and can answer many questions.

Transporting providers to class is a continuing problem. We hope volunteer organizations will help, but often the nurses have to provide transportation.

SUMMARY

Praises come from providers and recipients. Radiating joy, one 97-year-old recipient, whose picture is on the preceding page, aptly put it:

"If I didn't have anything to eat or a dime to spend, I'd still be happy because I'm at home and alive. I can eat anything at any time. I can sit here looking out this window and remember those big catfish I got out of that creek, and I know I'll live another 97 years with Ms. I. looking after me."

This program is one answer to the question: Who is going to look after me when I can no longer physically cope with just the daily activities of living? Any of 3,200 home-care recipients in Oklahoma can tell you this.

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COST AND CHARGE FOR HOME CARE SERVICES TO THE SICK—1972[1]

(While both rates are rising, costs are rising more rapidly. These and other differences, including regional ones, are among the latest NLN annual survey findings.)

In the long history of public health nursing, fees for nursing visits in the home have received much attention.[2] As early as 1912, when cost information became necessary to provide a basis for insurance company payments to visiting nurse associations, the NOPHN (predecessor organization to the NLN) was involved in developing methods for costing. Since its organization in 1952, the NLN has continued this responsibility as well as the practice of conducting annual surveys of cost and charge per visit in public health nursing agencies.[3]

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[1] This report was prepared by Leah Brock, statistician in the Department of Home Health Agencies and Community Health Services, National League for Nursing.

[2] Notter, Lucille. Fees for public health nursing service. *Nurs. Outlook* 6:326–329. June 1958.

[3] National League for Nursing, Public Health Nursing Department. Fees charged by public health agencies—for nursing visits in the home. *Nurs. Outlook* 10:756–757, November 1962.

With the expansion of programs offered by such agencies and a shift in financial support from contributions to tax funds and fees from patients, there has been pressure to decrease existing discrepancies between cost and charge. Today, this pressure is further stimulated by Medicare reimbursement practices, the decreasing sources of revenue, both governmental and voluntary, and the demand for alternatives to expensive hospital and nursing home care.

In an effort to provide up-to-date information about these costs and charges, the Department of Home Health Agencies and Community Health Services, National League for Nursing, has gathered such information annually in the Yearly Review of policies and practices in community health nursing services. This report is based on the most recent statistics as of April 1972, compared with similar data for 1969 through '71.

Questionnaires were returned by 581 local voluntary, official, and combination public health agencies, 461 of which reported care of the sick at home as a regular service. Included in this latter group are all of the voluntary and combination agencies that were surveyed and 61 percent of the official agencies. In addition to nursing service, information also was collected on charges for physical therapy visits and home health aide service offered by these agencies.

NURSING VISITS

The present data on nursing visits are based on replies from 427 agencies—those that reported both the cost and the charge per visit. These data represent the cost to the agency and the charge to the community for a care-of-sick visit in those agencies where a differentiation is made, and the cost and charge for the average visit of all types where these were the only figures provided.

Apart from refinement of costing methods, cost per visit is affected by administrative practices, staffing patterns, travel requirements, cost of living and salary levels in the community, and population characteristics. Furthermore, the most recently calculated cost, as of April 1, 1972, would be for fiscal year 1971 and, in some cases where a 1971 cost analysis had not yet been completed, the cost figures would be based on fiscal year 1970 experience.

TABLE 1.—MEDIAN COST AND CHARGE PER NURSING VISIT BY REGION,[1] 1969–1972

Region	1972		1971		1970		1969	
	Cost	Charge	Cost	Charge	Cost	Charge	Cost	Charge
Total	$13.00	$10.47	$12.03	$10.24	$10.50	$9.52	$8.98	$8.12
New England	11.53	10.23	10.33	9.30	9.70	8.68	8.28	7.10
Mid-Atlantic	14.10	12.05	12.40	10.51	10.95	10.11	9.78	8.36
Southern	12.26	10.38	11.18	10.18	9.70	8.05	8.52	7.52
Great Lakes	12.40	10.40	11.48	10.10	10.27	8.80	8.50	7.48
Heartland	12.50	10.07	11.87	10.10	9.80	8.70	9.40	8.67
Western	16.88	14.85	15.13	13.80	13.67	12.03	12.45	11.48

[1] New England: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont. Mid Atlantic: Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania. Southern: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, West Virginia. Great Lakes: Illinois, Indiana, Michigan, Ohio, Wisconsin Heartland: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota. Western: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming.

TABLE 2.—MEDIAN COST PER NURSING VISIT BY TYPE AND SIZE OF AGENCY, 1972

Size of agency (number of full-time registered nurses)	All agencies	Voluntary and combination agencies (268)	Official agencies (159)
Total	$13.00	$12.71	$14.05
One nurse	[1] 10.60	[1] 9.40	[1] 11.20
2 to 9 nurses	11.93	11.27	12.25
10 to 49 nurses	13.95	13.30	14.76
50 nurses or more	17.07	16.80	[1] 17.60

[1] Based on reports from fewer than 20 agencies.

TABLE 3.—MEDIAN COST PER NURSING VISIT, BY TYPE OF AGENCY AND REGION, 1972

Region	Voluntary and combination agencies (268)	Official agencies (159)
Total	$12.71	$14.05
New England	11.80	10.60
Mid-Atlantic	13.52	15.80
Southern	[1] 12.80	12.20
Great Lakes	11.10	13.90
Heartland	12.60	12.20
Western	16.80	16.90

[1] Based on reports from fewer than 20 agencies.

Cost: The median cost per nursing visit for the 427 reporting agencies in 1972 was $13.00, an increase of 8.1 percent over last year and 45 percent since 1969. Thirty-five agencies reported a cost of less than $8.00 and 21 a cost of $22.00 or more. The lowest reported cost was just under $5.00, and the highest slightly more than $30.00. On a regional basis, as in previous years, New England showed the lowest median and the Western region the highest (Table 1). Costs increased with the size of the agency as measured by the number of full-time registered nurses employed, as shown in Table 2.

The overall median cost for a nurse's visit in official agencies was $14.05, which was 10.5 percent higher than the $12.71 median cost for voluntary and combination agencies. From the standpoint of regions and type of control of agency, the largest differential was found in the Great Lakes region, where the official agencies had a 25.2 percent higher median cost than that of voluntary and combination agencies (Table 3). In agencies of similar size, the costs were consistently higher in official than in voluntary and combination agencies (Table 2).

Charge: The median charge per nursing visit for all agencies as of April 1972 was $10.47, an increase of only 2.2 percent over the previous year, while in the same period the median cost increased 8.1 percent. (The increase in charge since 1969 was 29 percent, compared with a 45 percent cost increase since 1969.) The 1972 charge was 19.5 percent less than the 1972 cost.

In the past, charges reported for one year closely reflected costs for the preceding year; however, we now see a *1972 median charge slightly below the 1970 median cost.* This indicates that from April 1971 to April 1972 charges have been held down while costs continue to rise. (It should be noted that charge per visit refers to the publicized full fee to the community; some agencies provide service without charge or charge fees only to Medicare or other third party payers.)

As was true for costs, charges generally increased with the size of the agency. On a regional basis, however, costs and charges did not vary in the same manner. For instance, New England, which showed the lowest median cost, ranked higher than both the Great Lakes and Heartlands in median charges (Table 1).

PHYSICAL THERAPY VISITS

Among the 461 agencies providing care of sick nursing services, 76 percent also provided physical therapy service in the home. Often this service is purchased by the agency on a contractual basis. Many agencies do not add their overhead costs in setting their charges for these services. They simply report the rate charged by the contractor as both their own cost and the charge to the community. For this reason, only the charge data are presented here (Table 4).

The median charge for a physical therapy visit rose 3.9 percent from $11.83 in April 1971 to $12.29 in April 1972. Nineteen agencies reported charges of less than $8.00, and seventeen had charges of $20.00 or more. The highest median charge was found in the West, and the lowest in the South and Heartlands. The average physical therapy fee was 17.4 percent higher than the fee charged for a nursing visit in 1972; in 1971 the physical therapy fee was 15.5 percent higher than the nursing visit fee.

TABLE 4.—MEDIAN CHARGE PER PHYSICAL THERAPY VISIT BY REGION, 1969–72

Region	1972	1971	1970	1969
Total	$12.29	$11.83	$10.65	$10.15
New England	12.40	12.24	12.06	10.18
Mid-Atlantic	12.11	11.10	10.27	10.03
Southern	10.33	12.06	10.03	9.07
Great Lakes	12.24	12.31	11.00	10.40
Heartland	10.36	10.24	[1] 11.20	[1] 10.12
Western	15.03	14.60	14.17	12.60

[1] Based on reports from fewer than 20 agencies.

TABLE 5.—MEDIAN HOURLY CHARGE PER HOME HEALTH AIDE SERVICE BY REGION, 1969–72

Region	1972	1971	1970	1969
Total	$3.69	$3.57	$3.26	$3.03
New England	3.60	3.40	3.26	2.78
Mid-Atlantic	3.52	3.48	3.05	2.63
Southern	[1] 4.50	[1] 3.70	[1] 3.90	[1] 3.47
Great Lakes	3.44	3.14	3.01	2.70
Heartland	[1] 4.06	[1] 4.04	[1] 3.33	2.90
Western	6.55	6.57	5.67	4.50

[1] Based on reports from fewer than 20 agencies.

HOME HEALTH AIDE SERVICE

Of the total number of agencies, 295 reported that they provide home health aide service. As in the case of physical therapy service, this is often based on contractual agreements: the agency's charge to the patient is the same as the contractor's charge to the agency.

Hourly charges for home health aide service were reported by 207 agencies. An additional 81 agencies, however, reported charges for home health aide service on a per visit basis. These agency reports have been excluded from the tabulations since differences in length of visit make comparisons valueless.

As seen in Table 5, the median hourly charge for home health aide service in April 1972 was $3.69—an increase of 3.4 percent over the previous year. The Great Lakes region had the lowest median—$3.44 per hour, and the Western region the highest—$6.55 per hour. Only one agency reported an hourly charge of less than $2.00 and that was in the Great Lakes region.

COINSURANCE AND DEDUCTIBLES IN MEDICARE—TO WHAT EXTENT? WITH WHAT RESULT?

(An Analysis by Agnes Brewster, Health Economics Consultant, U.S. Senate Special Committee on Aging)

According to Richard P. Nathan, writing in the Wall Street Journal of February 6, 1973, the President's proposal for upping the cost-sharing under Medicare will result in "about $1 billion in savings." The proposals could not have been conceived by any group conversant with health economics or even with the elementary aspects of the economic process.

In the first place economic security for an individual, whether old or young, stems from certainty—the certainty that in an emergency resources will be available to meet the crisis. Medicare as it exists on the statute books provides a large measure of that security but leaves uncertainties with respect to the coinsurance, the uninsured kinds of services and the interpretation that a bureaucracy will put on a person's need for hospital care and extended care.

If deductibles and coinsurance were indeed the incentive for using the medical care system correctly, this would have been amply demonstrated by now. Increasing the uncertainty by raising the coinsurance from 20 percent to 25 percent holds little promise of controlling utilization. Charging the elderly the full room and board charges on the first day of hospital care and ten percent thereafter adds an uncertainty to the health security of at least 5 million elderly Americans annually.

The result will be largely a transfer of the source of funding the care. This transfer will come about in one of several ways which I'll outline.

Older Americans anxious to have health protection have purchased voluntary insurance to "fill in the gaps" of Medicare, *when* they can afford the premiums. Since the President's proposal widens the gap, premiums for private insurance will rise—a mere transfer of spending, not a true economy and having no effect on utilization.

For those who cannot afford the private insurance but who indeed need medical and hospital care, they can turn to Medicaid as a resource—as many elderly must already. Or they can do without care. Was this what Congress intended? Use of Medicaid and the need to turn to it because of no other resources merely transfers the expenditures from one government pocket to another with increased costs for administration of the dual coverage as a biproduct. While general revenue is looked on as a less regressive form of taxation than a tax based on payroll (as is the Medicare tax), any such impact will certainly be largely offset by the effects of transfering the income of the elderly from the purchase of food, medicines and other consumer goods to spending for insurance and medical services hitherto financed by Medicare.

Additional evidence of the validity of our objections to coinsurance and deductibles are outlined below.

The introduction of a coinsurance feature in a closed insurance plan led to a substantial reduction in the use of physician services in a group of employed persons and their dependents according to a study by Scitovsky. The lowest socioeconomic group reduced its utilization the most.[1] This is the effect one would anticipate with the aged.

The present hospital deductible of a flat amount should be abolished. Advancing it from $40 to $72, an 80% increase, has worked a hardship on many poor, sick persons. It has the virtue of being a known amount alike for all. The Administration's proposal would substitute an unknown figure that would vary from hospital to hospital and from place to place with inequities resulting inevitably, and no guarantee to the Trust Fund that the same proportion of funds would be shifted on to patients, their insurance or Medicaid as now holds true.

In addition each compounding of the paperwork that is the inevitable accompaniment of such proposals for deductions of charges (as distinct from actual costs of care) increases the overhead of the whole system.

The Administration has been an advocate of the health maintenance approach to the delivery of health care. It is best exemplified by the Kaiser Health Plan where capitation payments can be substituted for fee-for-service billing and all the expenses of hundreds of clerks, computers, delays, etc., as well as compounding the aged person's problem of determining what he is entitled to. Is it any wonder that, given a choice, consumers elect as broad insurance as it is possible to obtain?

The Federal Employees Health Benefits program has provided ample demonstration of these facts. Only the higher income person who can truly afford to take the risk elects to self-insure. Yet the Administration would increase the extent of self insurance for every old person—the vast majority of whom are poor or near poor, not rich.

We would like to see an examination in depth of the true costs of administering the Medicare program—not only SSA's costs to operate BHI but the sums spent for deciding on the validity of claims and on the paperwork to reject claims, and on the overhead the system has added to hospital business offices and to physicians' overhead. Considerations of these kinds of hidden costs would seem to dictate elimination of deductibles and coinsurance as many organizations with genuine concern for the plight of the elderly have urged.

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[1] Scitovsky, A. A., and N. M. Snyder. "Effects of the Introduction of a Coinsurance Provision on Physician Utilization," published in (SS Bulletin).

Another point—both the elderly who are being penalized and the contributors to Medicare who are being taxed find the suggestion of decreased benefits and no reduction in payroll taxes illogical. If there were any merit in increased coinsurance as a reducer of utilization, why should the program require ever increasing amounts of withholding tax—ever increasing as employment and wage rise?

The elderly should be provided with a unitary and completely adequate system of health security and we should oppose any suggestions that run counter to such an approach; further fragmentation of health care of the elderly is a big step in the wrong direction.

LIBRARY OF CONGRESS,
CONGRESSIONAL RESEARCH SERVICE,
Washington, D.C., February 23, 1973.

To: Senate Special Committee on Aging.
From: Education and Public Welfare Division.
Subject: Patient cost-sharing under medicare—existing law and proposed changes.

This is in response to your request, on behalf of the Members of the Committee, for a brief explanation of the Administration's proposed changes in the current patient cost-sharing requirements applicable under the medicare program. The information about the Administration's recommendations in this area comes from the lengthy statement issued by the Office of the Secretary, Department of Health, Education and Welfare, on January 23, 1973. This statement, as you know, outlines the Administration's FY 1974 budget strategy and legislative plans for HEW.

Attached to this report are two tables. The first describes in capsule form the patient cost-sharing requirements contained in existing law and the requirements recommended by the Administration. The second table gives some examples of the financial impact on beneficiaries under both sets of cost-sharing requirements.

For the construction of the second table, it has been necessary to make certain assumptions regarding the charge structures of hospital, since the Administration's proposals tie patient cost-sharing to such charges. The figures used in the examples, therefore, are meaningful only to the extent that the assumptions regarding charges are valid. For example, among other things, the Administration's plan calls on the beneficiary to pay one day's room and board charges. It is assumed that this means patients would pay one day's average daily service charge in an institution. The average daily service charge includes room accommodation, food service, routine nursing care, and minor medical and surgical supplies. In January 1972, the average daily service charge for all community hospitals, according to data published by the American Hospital Association, was $52.11. This has been rounded in the example for purposes of calculation. Patients are also charged for the use of a variety of ancillary services that they may require during a period of hospitalization—X-ray procedures, operating rooms, pharmaceuticals, etc. The use of such services and the charges for them, of course, vary greatly from patient to patient and from institution to institution. Table 2 simply adds to the average daily service charge an additional $20 a day for ancillary services.

We hope this information is helpful and, if we can be of further assistance to the Committee, please let us know.

GLENN MARKUS.

[Enclosure]

PATIENT COST-SHARING REQUIREMENTS UNDER MEDICARE

	Present law	Administration proposal [1]
Hospital insurance (pt. A): [2]		
Inpatient hospital care—90 days [3]	1 through 60 days: $72 (initial deductible); 61 through 90 days: $72 (initial deductible) and $18 (coinsurance) for any days after 60.	1 through 90 days: 1 day's charges for room and board and 10 percent of all daily charges for any period thereafter.
Skilled nursing facility care—100 days [4]	1 through 20 days: no patient cost-sharing; 21 through 100 days: $9 (coinsurance) for any days after 20.	1 through 100 days: 10 percent of all daily charges beginning with the first day.
Home health care—100 visits	No patient cost-sharing	1 through 100 visits: 10 percent of all charges for each visit.
Supplemental medical insurance (pt. B): [5] Physicians' services.	$60 initial deductible and 20 percent of, "reasonable charges" [6] the remaining.	$85 initial deductible and 25 percent of the remaining "reasonable charges." [6]

[1] Based on a description of the recommendations described in an HEW press release on the Department's fiscal year 1974 budget, Office of the Secretary, Jan. 29, 1973.
[2] Benefits available during each "spell of illness"—i.e., benefit period.
[3] Beneficiaries also may draw after 90 days in a hospital from a "lifetime" reserve of 60 additional days. The coinsurance applicable when these days are used is currently equal to ½ of the initial deductible amount, or $36 a day.
[4] Formerly known as extended facility care.
[5] Benefits available and cost-sharing requirements apply annually.
[6] Beneficiaries are also responsible for any charges in excess of those recognized as "reasonable," unless a physician has agreed to accept an assignment of benefits from the patient to himself. Under such conditions, the physician must accept the "reasonable" changes as the full charges for his services.

IMPACT OF COST-SHARING REQUIREMENTS ON PATIENTS

	Present law	Administration proposal [1]
Hospital insurance (pt. A): Hospitalized:		
5 days	$72	$78
12 days	72	127
21 days	72	190
60 days	72	463
85 days	450	638
95 days [2]	720	708
Supplementary medical insurance (pt. B): Physician's charges: [3]		
$225	93	120
$350	118	151
$500	148	188

[1] Assumes that daily room and board charges are about $50 and that charges for ancillary services average $20 for each day.
[2] Includes use of 5 "lifetime" reserve days.
[3] Assumes that such charges would be deemed "reasonable" and, therefore, wholly eligible for reimbursement.